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MENTAL HEALTH AND CRIMINAL JUSTICE

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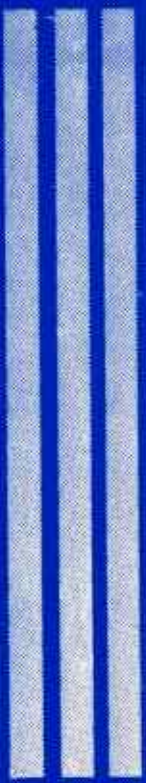

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MENTAL HEALTH AND CRIMINAL JUSTICE

Linda A. Teplin
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Foreword by
Harold M. Visotsky

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To my parents,
Joseph and Shirley Teplin,
who I thought could do (almost) anything

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FOREWORD

The interface between the mental health and criminal justice systems must be seen within the historical context of mental health law. Persons with mental illness have always been plagued by myths surrounding their illness, and have suffered from prejudice and stigma. Within this context, two sets of laws formulated during the nineteenth century became legion in that they were the first to establish policies for treating the mentally ill: the so-called "Regimen for the Alienated" was adopted by French law in 1838, and later the English introduced "the Lunatic Act of 1890." Although enacted by two different judicial systems, these laws had the same objective: to regulate internment of the mentally ill with a view toward protecting society, while simultaneously favoring treatment and curtailing abuses concerning individual liberty. Compared to the arbitrary treatment of the mentally ill in preceding centuries, legislation in the nineteenth century provided significant gains. More recently, the principle of adequate treatment in mental hospitals has been confirmed as the legal right of the involuntarily confined mental patient. The direct order issued under Wyatt v. Stickney (1972) regarding minimal standards of adequate treatment was crucial in that it was the most noteworthy attempt to date to guarantee the individual rights of persons treated within mental health and mental retardation facilities.

The linkage between the mental health and criminal justice systems is a far from recent phenomenon. The insanity defense is deeply rooted in Anglo-American legal tradition and dates back over 800 years. It is based on the concept known as *mens rea;* i.e., a person must have a "criminal mind" at the time that an offense was committed in order to be guilty of a crime. The so-called M'Naghten rule, established in the trial of Daniel M'Naghten, confirmed that a person suffering from a mental illness could be found not guilty by reason of insanity. This was confirmed in the trial of Monte Durham in 1954,

where the bench set forth a rule that a defendant is not guilty if his or her act was a product of mental disease or defect (Durham v. United States, 1954).

Until relatively recently, persons not guilty by reason of insanity could be incarcerated almost indefinitely. This practice was abolished by the court in Rouse v. Cameron (1966). In this case, Charles Rouse was committed to St. Elizabeth's Hospital in Washington after being found not guilty by reason of insanity. He was charged with carrying a dangerous weapon, a misdemeanor with a one-year maximum sentence. After three years of confinement, he petitioned for release by a writ of habeas corpus, alleging that he had not received psychiatric treatment during his confinement. On review by the Circuit Court of Appeals, Justice Bazelon ruled that the purpose of involuntary hospitalization is treatment, not punishment. Without treatment, the hospital is transformed into a penitentiary where one could be held indefinitely, without being convicted for an offense. The judge's decision strongly implies that a constitutional right to treatment exists under due process, equal protection, and cruel and unusual punishment clauses.

Although the concept of mental disorder as an extenuating circumstance in criminal culpability is perhaps the most publicized link between the mental health and criminal justice systems, it is by no means the only one. Moreover, recent "progressive" policy changes in both the mental health and criminal justice systems have served both to increase the possibility of intersystem diversion, as well as to complicate the process. As mentioned above, the right to treatment has been confirmed. In addition, the courts have ruled that individuals have the right to refuse treatment; i.e., they may choose to accept some types of treatment and reject others. This ruling pertains both to those patients who have been committed to hospitals, as well as to those treated as voluntary patients. However, while such legislation enhances the rights of the mentally ill, it is a source of difficulty for mental health professionals. The right to refuse treatment may produce a conflict between the treating physician or staff and the patient who may have inaccurate perceptions and judgment about his or her illness. The right to refuse treatment has other potentially negative consequences as well. If an outpatient has the right to refuse treatment, the untreated illness may cause that person to act in such a way as to exceed the tolerance for deviance within a given community. The result may be arrest, a disposition likely to be more harmful than the refused psychiatric treatment.

Given the longstanding stigma of mental disorder, any judicial and legislative progress can only be considered within the sociopolitical context. Unfortunately, society's fears of the mentally ill have

restricted the implementation of truly innovative treatment policies and, indeed, seem to color much of the discussion vis-à-vis alternative sets of legislation and regulations. These prejudices may have served to reduce the benefits of the civil rights legislation pertinent to mental illness. Thus, although the means for humane treatment of the mentally ill are in place, it is questionable whether these public policy changes have actually improved the lot of the mentally ill. What is frequently obscured in the public debates about legislative remedies for the treatment of the mentally ill are the historical moral standards that confirm that mentally disordered persons may not be accountable for their actions. Seemingly normal people may be stricken with illnesses that distort their reason at times and limit their ability to control their actions. While we are ready to leap at legislative reforms that may restrict our ability to aid the sick, we ignore the legislative reforms that might help many of these individuals to lead healthier lives. In a sense, we are guilty of increasing the stigma of mental illness for the nonviolent mentally ill when we charge recklessly into reforms designed solely to allay these fears of society.

This book examines some of the critical issues relevant to the relationship between the mental health and criminal justice systems. The authors attempt to clarify the problem confronting a society that prides itself on its sense of fair play and justice. In so doing, this volume provides some needed insights into balancing the needs of society with the rights of the mentally ill.

—Harold M. Visotsky, M.D.

CASES

DURHAM v. UNITED STATES (1954) 214 F 2d 862 (D.C. Cir.)
ROUSE v. CAMERON (1966) 373 F.2d 451 (D.C. Cir.)
WYATT v. STICKNEY (1972) 344 F.Supp. 373 (MD Ala.)

PREFACE

The link between criminal justice and mental health issues dates back to common law and has long been a somewhat problematic relationship. As a result of recent case law, statutory modifications, and public policy reformulations, this association has become increasingly complex. This book examines the interface between mental health and criminal justice from a social science perspective. What this means is that the book will not merely present a passive review of the legal context vis-à-vis the mentally ill. Rather, the focus will be to discover the modus operandi of the system. As such, this volume is designed to be of interest to both researchers and public policy makers. In addition, the organization of the volume lends itself to classroom use in criminal justice, psychology of law, and sociology courses.

Section I presents important background information pertaining to the laws and statutes governing treatment of the mentally disordered offender. The chapter by Norval Morris is a provocative piece of fiction that examines the age-old issue of the extent to which the mentally incompetent can be held responsible for their actions. Section II contains four chapters that look at the dynamics of intersystem processing. The focus of this section is to ascertain how changes in one component may have unintended consequences for the system as a whole. The third section examines the way in which police manage the deinstitutionalized mentally ill on the streets. Section IV contains two chapters, both of which present important data on the way in which deviant behavior is defined and processed. Finally, Section V contains three chapters, all of which focus on one point in the processing of the mentally disordered offender. The contribution by Bruce Sales and Thomas Hafemeister takes a fresh look at the insanity defense. The chapters written by Eliot Hartstone et al. and by John Carroll and Arthur Lurigio examine aspects of the incarceration experience and probation and parole. In sum, the book provides an encompassing

view of the relationship between the mental health and criminal justice systems at their myriad points of interface.

ACKNOWLEDGMENT

I would like to thank Judith Wray for her editorial assistance.

—Linda A. Teplin

EDITOR'S INTRODUCTION

This book will examine the interface between the mental health and criminal justice systems from a social science perspective. The rationale underlying this approach is twofold:

(1) Law makes action possible, but it cannot prescribe particular responses for every contingency. Of necessity, discretion is used to make decisions as to the most "appropriate" disposition, be it a competency hearing or a decision to transfer an offender from a prison to a mental hospital. In order to understand the ways in which the legal structure is implemented, it is necessary to observe the law in action. In this way, the behavioral or social scientist discovers the informal normative codes that determine how the laws are actually implemented and utilized. Using this approach, we may then make recommendations for public policy change based on observable problems with current praxis.

(2) As a result of the increasing points of contact in mental health and criminal justice processing, the systems have become quite interdependent. The result of this is that any change in one system can affect the entire process. As a consequence, we can no longer make modifications in one system without incurring changes in other social institutions. The social science approach permits an in-depth examination of this phenomenon which, in turn, will facilitate a more thoughtful approach vis-à-vis the development of public policy.

Thus this book will examine the law in action, with particular emphasis on the ways in which recent changes in case law, statutes, and public policy have interacted to produce the current mental health and criminal justice process.

BACKGROUND

A number of recent developments in mental health law and public policy have complicated the always delicate relationship between the

mental health and criminal justice systems. Six major changes underlie the increasing intricacies of this interface: (1) changes in commitment laws and procedures; (2) the community mental health movement; (3) the "psychiatrization of the criminal"; (4) the changing characteristics of public hospital patients; (5) decreased financial support for mental health programs; and (6) public perception of the use of the insanity defense.

(1) Changes in Commitment Laws and Procedures. More rigorous criteria and procedural safeguards have made civil commitment of the mentally ill increasingly difficult (Dickey, 1980; Halleck, 1980). It has been speculated that, as a consequence of these changes, the criminal justice system is being used as a way to obtain treatment for persons who do not meet the criteria for commitment (Teplin, 1983). Once a person is arrested, evaluations for incompetency are invoked. The arrest charges are then dropped after the initial evaluation period expires (Steadman and Hartstone, 1983). In this way, mental health care is assured for persons who are thought to require treatment but who do not meet the legal requirements for commitment (Winick, 1983). The enormous number of persons found incompetent to stand trial provides some support for this thesis; defendants found incompetent to stand trial make up approximately 32% of all admissions of mentally disordered offenders (Steadman et al., 1982).

(2) The Community Mental Health Movement. As a result of the Community Mental Health Movement, large numbers of persons have been released into the community who formerly would have been given custodial care in a state or county facility (NIMH, 1983). Moreover, the right of the mentally ill person to live within the community without treatment has been confirmed (see O'Connor v. Donaldson, 1976; Rennie v. Klein, 1981; Rogers v. Okin, 1982). These changes have resulted in an unknown number of deinstitutionalized persons now residing within the community, many of whom choose to function without the assistance of psychological support programs. Unfortunately, many communities may not tolerate the presence of the mentally ill, particularly given the stereotype of the mentally ill as being "dangerous" (Shah, 1975; Fracchia et al., 1976; Steadman and Cocozza, 1978). As a consequence, citizens may invoke the criminal justice system to handle situations involving the mentally ill, particularly in instances where persons publicly exhibit the more bizarre and disruptive symptoms of mental disorder. Unfortunately, once law enforcement officials are involved, their dispositional options are limited, both by the "protections" afforded the mentally ill, as well as by the limited number of psychiatric placements available (Teplin, 1984, Ch. 7, this volume). As a

consequence, arrest may become one of the few remaining ways to handle the situation (Teplin, 1984).

(3) The "Psychiatrization of the Criminal." The right to psychological treatment for prisoners has been confirmed in a number of cases (see Rouse v. Cameron, 1966; Millard v. Cameron, 1966; State v. Harvey, 1978, 1979). Although the constitutional right to treatment is somewhat questionable, such a right will often be recognized as a matter of statutory interpretation (Dix, 1983). This may result in an increasing number of transfers from prisons to mental health facilities.

(4) The Changing Characteristics of Public Hospital Patients. Over the last forty years, the characteristics of patients in public hospitals have drastically changed. One study found that the proportion of inpatients with arrest records increased from 15% in 1947 to 40% in 1975 (Cocozza et al., 1978). By 1978, the proportion of patients with arrest records was over one-half (Monahan and Steadman, 1983a). Steadman et al. (1982) feel that this increase is a result, at least in part, of overcrowding within the prisons. They postulate that as prisons have become overcrowded, other alternatives for detention have been sought with the state mental hospitals (Steadman et al., 1982). This movement results in what Warren and Guttridge (Chapter 5, this volume) have aptly termed "transinstitutionalization."

(5) Decreased Financial Support. When inflation is taken into account, federal support for mental health treatment has actually declined since 1975, resulting in a lack of available treatment programs for the deinstitutionalized person (NIMH, 1983; Kiesler et al., 1983). If sufficient treatment is not available, the mentally ill have no choice but to live within the community without the benefit of treatment. As a result, their symptoms go untreated and unabated. This may result in their being arrested for minor offenses that are merely symptoms of their mental illness, such as trespassing or disorderly conduct (Teplin, 1984). In a sense, the unavailability of funding for treatment results in the mentally ill being arrested for the symptoms of their disorder.

(6) Public Perceptions of the Use of the Insanity Defense. Both legislators and the general public erroneously presume that the insanity defense is frequently pleaded and often successful (Morris, 1983). In reality, successful use of the defense is rare, and the proportion of persons who have been found not guilty by reason of insanity (NGRI) is only 8.1% of those admitted to facilities for mentally disordered offenders (Steadman et al., 1982). However, as a result of their comparatively longer length of stay, they comprise a fairly high percentage (22.4%) of residents in those facilities (Steadman et al.,

1982). As a consequence, from the standpoint of institutional administration and programming, NGRIs are a very significant problem (Steadman and Braff, 1983). More important, the controversy regarding the successful NGRI defense of John Hinckley, Jr. has already resulted in a number of public policy reformulations regarding both the utilization of the NGRI defense, as well as the treatment of persons acquitted as NGRI (see American Bar Association, 1983; American Medical Association, 1983; American Psychiatric Association, 1983). An exploration of the vast array of issues surrounding the insanity defense is thus both timely and provocative.

These changes in the legal and sociopolitical context have resulted in a unique permeability between the mental health and criminal justice systems. Moreover, the inherent complexity of this relationship means that modification of one point in either the mental health or criminal justice process has an enormous impact on the system as a whole. This book presents a study of the myriad points of interface between mental health and criminal justice. In so doing, the goal is to generate a gestalt of the way in which persons are defined and processed as being "mentally disordered" and/or "criminal," and in so doing to gain an increased understanding of the treatment of the mentally disordered offender.

CASES

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I

LEGAL STRUCTURE AND SOCIAL DEFINITION

This section presents preliminary background concerning mental health and criminal justice. The first chapter, by Professor Weiner, outlines the legal context vis-à-vis the processing of the mentally disordered offender. Chapter 2, by Norval Morris, is a parable illustrating the dilemma of the criminal responsibility of the mentally ill/mentally incompetent offender. In this story Morris presents, quite poignantly, the problem of the treatment of mentally ill persons whose disorder results in criminal acts.

Chapter 1

INTERFACES BETWEEN THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEM
The Legal Perspective

BARBARA A. WEINER

There has been an increased recognition that a disproportionate number of mentally ill and mentally retarded individuals come into contact with the criminal justice system, as compared to their representation in society as a whole (Whitmer, 1980; Dickey, 1980; Teplin, 1983). The fact of their mental disability can have an impact at many points during the criminal justice process. It can affect whether they are tried, their disposition at trial, where they are institutionalized, and what type of services (if any) they receive while institutionalized. A defendant's mental disability also may permit him or her to remain in the community, but with limits on personal freedom. There has been an increased ability by people in the criminal justice system to recognize the existence of mental illness or mental retardation, and this has led to a greater demand for the services of mental health professionals to evaluate and treat the mentally disordered offender (Hiday, 1983).

This chapter will set forth the points of interface between mental health professional and the criminal justice system. These occur when: (1) the issue of competency to stand trial is raised, (2) the insanity defense is raised, (3) the defendant is acquitted by reason of insanity, (4) the person is mentally disabled within a correctional institution, and/or (5) diversion into a treatment program is considered during the sentencing process. Over the past decade the rights of the mentally disordered offender have been expanded. The goal of this

chapter is to provide the reader with an understanding of the legal standards and the implications that arise at each point of interface.

COMPETENCY TO STAND TRIAL

The issue of competency in the criminal justice setting relates to the defendant's present ability to understand the proceedings and cooperate with counsel. The issue can arise at any stage of the trial process—during the trial, before sentencing, or before execution. It is most commonly raised during the trial and is the issue that most frequently dominates trials involving mentally disabled defendants. Although most of the legal literature and media attention focus on the insanity defense, the number of people found incompetent ("unfit" is used in some jurisdictions) to stand trial each year is far greater than the number of persons found not guilty by reason of insanity. It has been estimated that as many as 9000 persons each year are declared incompetent to stand trial (Steadman, 1979). Because of the numbers involved and the potential consequences, some consider the issue of competency to be the most significant mental health inquiry pursued in the criminal justice process (Stone, 1975).

The legal definition of competency was expressed by the United States Supreme Court in Dusky v. United States (1960):

> The test must be whether he (the defendant) has sufficient present ability to consult his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him.

This test codified the common law requirement that an accused not be tried while "insane" and reflects the concept of competency which has been adopted by every American jurisdiction.

Four principles have been advanced to explain why the defendant's competency is critical to a fair and just criminal proceeding. First, there is a need to safeguard the accuracy of the proceedings. The accused must be able to assist in providing facts relevant to the case, particularly where he or she is the only party, in addition to the complainant, who has knowledge of those facts. The second concern is with procedural fairness. The accused must not only be aware of the facts and able to communicate them, but also be able to assist an attorney in the preparation of a defense. The defendant must have the capacity to understand the general nature of the proceedings and his or her role in them, and have at least some grasp of the substantive and tactical options that are available. The third principle has broader scope; it

concerns the preservation of the integrity and dignity of the legal process. The specter of trying an incapacited defendant does little to promote general respect for our judicial or law enforcement system. Finally, the defendant's competency is necessary to assure that, if found guilty, he or she will understand the punishment imposed and the reason for it.

The competency issue can be raised at any point during the trial process and may be raised by the defense, the prosecution, or the court. Once raised, the trial proceedings are suspended until an evaluation can be made. If the defendant is found to be incompetent, the consequences are great: (1) The trial is suspended until he or she is restored to competency. As a result of delaying the trial, witnesses may disappear and memories fade. In some cases this is advantageous to a defendant; in others it may be detrimental. (2) Bail may be revoked or denied. (3) The defendant will be hospitalized, sometimes for a longer period than if he or she had been convicted of the charge. (4) The defendant may be stigmatized by being labeled "mentally ill" or "mentally defective."

The Role of the Mental Health Professional

Once the issue of competency is raised, a mental health professional—usually a psychiatrist, but in some states a clinicial psychologist—will become involved in evaluating the defendant to determine if he or she is competent to stand trial. No matter who is conducting the evaluation, the issue is a narrow one: whether the defendant presently understands the charges against him or her and has the ability to cooperate with counsel. Because it is often missed by practitioners in both the legal and psychiatric professions, it is worth emphasizing that the issue of competency to stand trial relates to *present* mental ability, whereas the issue raised during an insanity defense relates to the defendant's mental state *at the time* of the criminal act. Instruments have been developed to assist the evaluator in determining the defendant's competency. Most notable is the competency screening test developed by McGarry (1973).

During the course of the evaluation, some special mental functioning problems may arise that make the decision as to the defendant's competency more difficult. Most notable are the issue of competency while taking psychotropic medication and mental retardation.

Medication. Initially, there was a great deal of confusion among the states about the impact of psychotropic medications on the issue of competency. Today, however, every state accepts the notion that a

defendant can be found competent to stand trial, even if that competency has been achieved as a result of medication. In many cases an individual may be evaluated for incompetency while in a psychotic state. Within a short period of time after taking medication, the symptoms of the illness can be brought under control and the defendant restored to competency. Psychotropic medication has had a great impact on reducing the length of time that people remain hospitalized as incompetent. The courts have not yet addressed whether incompetent defendants have a right to refuse medication (as do other mentally ill patients) when medication may provide the only means of rendering them competent and thus able to return to the criminal justice process. Some legal commentators have suggested that forced medication may be appropriate for a limited time to assure the integrity of the criminal justice process (Winick, 1977).

Mental Retardation. A finding that a defendant is mentally retarded is not in itself sufficient to find him or her incompetent. Yet if the defendant does not truly understand the charges or cannot grasp the alternatives, then he or she is incompetent. Often attorneys are unaware that a client may be retarded and take his or her nodding approval of everything they suggest as understanding, when it may be an indication that the defendant understands nothing but doesn't want to admit it. The evaluator also may not be well trained in identifying mental retardation, or in understanding its impact. Determining an IQ score is not sufficient for reaching a conclusion as to a defendant's competency. Sometimes the evaluator will need to meet with the defense attorney to find out if the latter has the ability and patience to work with a client who may be mildly or moderately retarded. This may become the determining factor. If a defendant is found incompetent due to mental retardation, the consequences may be severe. He or she will probably be unable to be rendered competent and thus may remain hospitalized for the maximum period permitted by law, receiving no training and not having his or her legal status resolved.

Disposition of the Incompetent Defendant

During the past decade there has been a reexamination of what happens to a defendant after having been declared incompetent. This attention was spurred by cases publicizing the plight of defendants in state hospitals who were hospitalized longer than if they had been convicted and sentenced. This situation was deplored as a violation of the constitutional rights of the accused. In 1972 the U.S. Supreme Court in Jackson v. Indiana (1972) held than an incompetent defendant

could be confined no longer than was reasonably necessary to determine whether he or she would attain competency within the foreseeable future. This provided the impetus for many states to rewrite their statutes to include similar limits on the length of time that a defendant could be confined while incompetent.

Although the Supreme Court has never defined what is a "reasonable period" to determine when a person may attain competency, most states provide that the defendant will remain in a mental hospital until restored to competency or for some maximum period that may range from six months to five years, depending on the state. At the end of that period the criminal charges must be dismissed and the defendant either released or civilly committed. The problem arises when a defendant is incompetent but is not in need of hospitalization. The defendant's constitutional rights mandate that he or she be kept in the setting least restrictive of personal liberty. Most typically, incompetent defendants are kept within a maximum-security hospital within the state mental health setting. A growing number of states are now providing that these defendants can be treated on an outpatient basis. This is particularly appropriate when the person has been stabilized on medication and needs monitoring to remain stable while going through the trial process.

Proposals for Change and Development

Concern about the impact of a finding of incompetency permitting a defendant to be hospitalized for a lengthy period when he or she may not need hospitalization and without resolution of the criminal charges has resulted in numerous proposals to change the system (Burt and Morris, 1972; Roesch and Golding, 1980). The major changes would drastically reduce the adverse consequences of being found incompetent. They would eliminate indefinite commitment; provide the opportunity for selected legal procedural issues to be raised, possibly leading to a dismissal of the charges; give the incompetent defendant the opportunity to raise the more obvious substantive defenses, possibly resulting in acquittal; help assure that the trial is held while witnesses are available and their memories still accurate; and set a limit on the amount of time the defendant will be in the legal limbo of being an accused suspect without a decision on the charges. Many of these ideas were proposed by Burt and Morris in the late 1960s and have now been adopted in part by many states (Weiner, 1984).

Perhaps the most noticeable problem when the issue of competency to stand trial arises relates to the identification and evaluation of

mentally retarded defendants. At the outset, attorneys are often unlikely to recognize that their client may be retarded or to understand the impact this may have on the defendant's ability to cooperate. Programs must be developed, primarily aimed at public defenders, to help them recognize mental retardation and to give them an understanding of its potential impact on the trial process. Additionally, since psychiatrists often evaluate defendants for competency to stand trial, they will need further training in recognizing mental retardation and the impact it can have on a defendant's ability to participate in the trial process.

In addition, some type of outpatient program must be developed for mentally retarded offenders in order to habilitate them. This would not only focus on giving them the skills to become competent to stand trial but would also educate them as to what is "right" and what is "wrong" and perhaps develop skills so that offenders will not feel the need to resort to crime.

Outpatient programs for incompetent mentally ill defendants must also be developed. This would be appropriate for the defendant who would normally be eligible to make bail. For these defendants, outpatient treatment will assure protection of their rights while avoiding the costs of unnecessary hospitalization. Outpatient programs can stabilize offenders on medication and keep them stable throughout the trial process.

There is also a need to further educate evaluators as to the difference between competency to stand trial and criminal responsibility. These two concepts are often confused, yet are very different. The evaluator who does not understand that competency is a narrow issue may suggest that someone is incompetent who is fully able to participate in the trial process. This not only delays justice but can have serious adverse consequences for the defendant.

THE INSANITY DEFENSE

> For well over a century, the insanity defense has attracted more attention than any other issue in criminal law. It has engaged the minds and emotions of lawyers and psychiatrists, philosophers and laymen, to an extent entirely unrelated to the numerical importance of the problem. Some of the interest undoubtedly traces to the repellant fascination of the crime ostensibly committed by a madman. But more of it is probably due to the challenge, and the difficulty, of setting limits on man's responsibility to his fellow man [Goldstein, 1967].

Insanity becomes the condition that excuses someone from criminal responsibility. It is interwoven with our concepts of blame and the view that it is unjust to punish someone who is not blameworthy. Yet how one distinguishes the person who should be considered insane and thus not blameworthy creates tremendous problems. Media attention to the sensational case in which the insanity defense is raised has given the public the erroneous impression that the defense is raised frequently and often successfully. The jury verdict finding John Hinckley not guilty by reason of insanity after shooting President Ronald Reagan and three others focused renewed debate on the insanity defense.

This section will discuss the development of the insanity defense and the standards now in use in the United States. The issues raised by the insanity evaluation will be presented along with statistical data on who succeeds with an insanity defense. Finally, the section will close with proposals for changing the defense.

Development of the Defense

Our criminal justice system operates from the fundamental presumption that all persons, including the mentally disabled, are responsible for their criminal acts. This assumption is premised on the view that people are normally capable of free and rational choice between alternative modes of behavior, and that individuals who exercise that choice so as to harm others should be held accountable for their actions. However, if a person is for any reason incapable of such choice and consequently unable to conform his or her behavior to that which is expected of the rest of society, moral and legal culpability are excused.

Most crimes consist of two elements: the *actus rea* or physical act, and the *mens rea* or mental state. To convict someone of a crime, both elements must be proven. In raising the insanity defense, the defendant admits that he or she committed the physical act but is arguing that, due to mental disease or defect, he or she could not form the required mental state. Thus, if the mental state is negated, the defendant cannot be held criminally responsible. This notion has a long history dating back to the biblical Hebrews, who made a distinction between intentional and unintentional crimes; neither children nor insane persons were held criminally responsible for their acts, nor did they have to compensate their victims. Beginning with Plato, the Greek philosophers recognized that individuals have free will, which makes

it possible for them to be responsible for the good and evil in their lives. By the sixth century, the Code of Justinian contained the principle that children and insane persons could not be held responsible for their acts. During this period there appeared the beginnings of a "heat of passion" test which recommended that punishment be mitigated for one who commits homicide in a brawl. By the time of Elizabeth I of England, these concepts had evolved into the doctrine that insane persons should be exempted from punishment for their acts because they could not comprehend the morality of what they had done. Although an individual may have been exempted from the traditional punishments of, say, losing an arm for stealing or one's life for killing, he or she would still be restrained. This usually meant spending the remainder of one's life in an asylum for the criminally insane.

In the United States, the insanity defense has gone through various stages of development and taken a number of forms, as discussed below.

M'Naghten Rule. Until the 1960s, the vast majority of states used the M'Naghten rule as their standard for exculpation from criminal responsibility when an insanity defense was raised. The rule originated as a result of the case of Daniel M'Naghten, a Glasgow woodturner, who in 1843 shot and killed Edward Drummond, the Secretary to the British Prime Minister, Robert Peel. M'Naghten was suffering from the delusion that Peel and the Pope were conspiring against him. To protect himself, he decided to kill Peel but shot Drummond, believing him to be the Prime Minister. M'Naghten's trial resulted in his being found insane. This created a tremendous furor in Britain and resulted in the Parliament debating whether M'Naghten's acquittal would set a precedent, making it easy for criminals to be excused for their behavior. The Parliament developed a new rule that became known as the "right-wrong test" and provided:

> it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.

Thus, to meet the M'Naghten standard, the evaluator is only to consider the cognitive functioning of the defendant. Although some states still use the M'Naghten rule in its original form, others felt it was too narrow and harsh and have since modified it.

Irresistible Impulse Test. The irresistible impulse concept is used to modify the M'Naghten rule in a few states. Although there is no uniform definition, the essence of the concept is that even though a defendant may know the nature and quality of an act and may be aware that it is wrong, he or she is nonetheless driven to commit the act because of an overpowering compulsion that has its roots in a mental disability. This test rests on four assumptions:

> First, there are mental diseases which impair volition or self control, even while cognition remains relatively unimpaired; second, that the use of M'Naghten alone results in findings that persons suffering from such disease are not insane; third, that the law should make the insanity defense available to persons who are unable to control their actions, just as it does to those who fit M'Naghten; fourth, no matter how broadly M'Naghten is construed there will remain areas of serious disorders which it will not reach [Goldstein, 1967].

This test would be more appropriately called a "lack of control" test and had wider use before the adoption of the ALI rule in many states.

The American Law Institute Rule (ALI). In the 1950s the American Law Institute began to develop a model provision that sought to end the complaints raised by other insanity defense standards. The test provided:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of law. As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.

This standard has been widely accepted and is used by the majority of states and in all federal jurisdictions (Weiner, 1984). It was perceived as having numerous advantages over M'Naghten, since it includes a volitional aspect as well as the cognitive approach of M'Naghten.

Diminished Responsibility. Diminished responsibility or diminished capacity does not excuse someone from criminal responsibility but recognizes that an individual's mental illness should be considered as a mitigating factor in certain instances. It is most frequently used when a defendant is charged with first-degree murder (Brooks, 1974)

The diminished capacity concept provides a way to mitigate the penalty by introducing psychiatric testimony to show that the defendant's mental condition at the time of the crime was not such as to be able to formulate the required intent. Thus, in a first-degree murder case, this would be introduced to attempt to reduce the charge to second-degree murder or manslaughter.

The diminished responsibility concept was first espoused by the California Supreme Court in 1949 and has been used by at least fifteen states, most of which use the M'Naghten standard (Fingarette and Hasse, 1979). The test has been criticized as being one that is difficult to apply and administer and that results in uneven and inequitable outcomes (Fingarette and Hasse, 1979). Its use appears to be decreasing, and the California legislature recently banned this approach in criminal cases (California Penal Code, 1982).

The Evaluation

Sanity evaluations are most frequently conducted by psychiatrists, but some states also permit clinical psychologists to participate in the process. The issue for the evaluator is to determine whether the defendant *at the time of committing the crime* meets the legal standard of sanity. This requires first a determination that a mental disease or defect existed, and then a determination that, as a result of that disease or defect, the individual was unable to meet the standard. Thus, in an ALI jurisdiction the evaluator determines if a mental disease or defect existed, and whether as a result the defendant was unable to appreciate the criminality of an act or to conform his or her conduct to the requirements of the law.

In states using the M'Naghten approach, the test is purely a cognitive one. In those states employing the ALI approach, the test involves both cognitive and volitional aspects. In either type of jurisdiction, the evaluator must retrospectively try to determine what was occurring in the defendant's mind at the time of committing the crime. This requires not only examining the defendant to ask what his or her view of the incident was, but also complete knowledge of psychiatric history. The evaluator needs to know the facts of the crime, read witness statements and police reports about the incident, and when possible speak to the victim. In this way the evaluator will have a broad enough database to determine the defendant's mental state at the time. Although "mental disease or defect" has not been definitively defined, it has generally been interpreted to mean that the defendant was psychotic at the time of the crime.

In some cases a person's insanity is so obvious that there is little room for question. In other cases the issue is more difficult. Since there is no precise way to answer the question, the evaluator must try to obtain as much information as possible and then rely on his or her clinical skills and expertise. The ultimate decision is not the evaluator's but belongs to the judge or jury.

The Successful Insanity Plea

Although there is a great deal of media attention and debate surrounding the insanity defense, there have been few studies that have looked at its usage. One national study estimated that of over two million felony and misdemeanor cases disposed of in state and federal courts each year, approximately 1600 defendants, or less than 1 percent of all persons charged with crimes, were successful in using an insanity defense (Steadman et al., 1982). It has been estimated that when the defense is raised, it is likely to be successful in between 10 and 25 percent of the cases (Pasewark, 1981; Criss and Racine, 1980). Most frequently the defense will be successful in a murder or attempted murder case, particularly when a family member in involved (Carnahan, 1978; Criss and Racine, 1980; Silver, 1982).

The most likely predictor of success is whether the pretrial evaluator determined that the person was insane. One study revealed a 93 percent agreement rate with the evaluator (Steadman et al., 1983), while others have indicated a slightly lower rate (Blunt and Stock, 1983). Determining that the defendant was psychotic at the time of a crime was the critical factor in the evaluator suggesting that the person met the insanity defense standard.

A comparison of insanity acquittees with the general prison population reveals that the former group is likely to contain more women and more whites, and to be older (Carnahan, 1978; Steadman et al., 1983; Criss and Racine, 1980). Many of the acquittees had no previous involvement with the law, although they may have had numerous previous psychiatric hospitalizations (Pasewark, 1981).

Proposals for Change

The proposals to change the insanity defense take four forms: (1) abolish the standard, (2) narrow the standard, (3) enact a guilty-but-mentally-ill law, and (4) make procedural changes.

In 1982, Idaho became the first state in recent times to abolish the defense (18 Idaho Code 20). This was accomplished by ending an

affirmative defense of insanity and providing that "a mental condition shall not be a defense to any charge of criminal conduct." Montana and Utah soon followed. Although this approach eliminates the insanity defense in the traditional sense, the concept of *mens rea* was retained. Whether this approach can withstand constitutional attack remains to be seen. In the early part of this century Louisiana, Mississippi, and Washington tried unsuccessfully to abolish the defense.

The most recent suggestion has been to narrow the insanity defense standard in ALI jurisdictions to consider only the cognitive aspect of a defendant's actions rather than any volitional elements. This view, which has been primarily expressed by Bonnie (1983), has been accepted by the American Bar Association (1983). This approach is thought most likely to avoid the occasional mistakes that are sometimes made when the volitional aspect is considered. Thus far, however, it has not been adopted by any jurisdiction.

The enactment of guilty-but-mentally-ill (GBMI) laws has had the most impact, having been adopted by about 25 percent of all jurisdictions (Weiner, 1984). Under GBMI, a defendant can be found not guilty, guilty, not guilty by reason of insanity, or guilty but mentally ill. The notion was that this would avoid the constitutional problems raised by abolishing the insanity defense, yet would provide the jury with another dispositional alternative. It was believed that this would result in fewer successful insanity pleas and possibly guarantee the person treatment while in prison.

The experience of Michigan, which has had a GBMI law since 1976, indicates that the same number of people are acquitted by reason of insanity after GBMI as before (Blunt and Stock, 1983). In Illinois, more people have been acquitted by reason of insanity since the GBMI law became effective. The Michigan experience also reveals that those found GBMI did not meet the insanity defense standard (Blunt and Stock, 1983). Thus, it is unlikely that they had a serious mental illness that rendered them psychotic at the time of the crime. The GBMI verdict is viewed by many in the legal community as a hoax on the public. It does not abolish the insanity defense, as the public often thinks, and it does not guarantee that the individual will receive treatment while incarcerated. It is therefore viewed as an unnecessary piece of legislation (American Bar Association, 1983). As more information becomes available about the experience of GBMI in various states, the notion of adopting this type of legislation may die.

Finally, there have been proposals to change the way the insanity defense works at trial. These proposals have two elements: (1) shifting the burden of proof to the defendant to prove that he or she was insane,

and (2) limiting the scope of psychiatric testimony. There are probably merits in each proposal, and whether they will be accepted by the states remains to be seen.

In conclusion, recent proposals to change or abolish the insanity defense seem to ignore the history of the defense and its purposes within the criminal justice system. Given that the defense is rarely used and more rarely successful, one must question why there is any need to change the defense. In a just society, there must be compassion and the moral judgment to excuse those rare individuals who cannot comprehend the wrongfulness of their actions. The insanity defense is the exception that proves the rule of free will. It is this vision of the law which has been the basis for resistance to abolition of the insanity defense.

DISPOSITION OF THE INSANITY ACQUITTEE

Although the insanity defense has generated much controversy, the disposition of the insanity acquittee merits greater attention, since the public's real concern is with what happens to this person upon release by the criminal justice system. Until the 1970s, it was likely that if someone was acquitted by reason of insanity, he or she would automatically be committed to a state mental institution for the "criminally insane." Often the person would remain there for a lengthy period, possibly longer than a prison sentence would have been, and frequently stayed for life. However, as a result of the development of psychotropic medication, the community mental health movement, and legal cases establishing that the mentally disabled have a right to be treated in the least restrictive setting, insanity acquittees are eventually returned to the community. During the 1970s, a few of these acquittees became involved in repeated violent criminal activity, thus raising the issues of whether the defense should be abolished and what type of changes should be made to protect the public from persons found not guilty by reason of insanity.

Today, the state laws are in a state of flux relating to insanity acquittees. Upon a finding of not guilty by reason of insanity, one of four things can happen, depending on the jurisdiction: (1) no special provisions, meaning that the person can go free, unless civil commitment proceedings occur. This is true in the federal jurisdictions, as well as numerous states; (2) automatic commitment for a period of evaluation to determine if the person meets the civil commitment criteria; (3) automatic commitment with no set date for a hearing on the continued need for hospitalization; or (4) commitment after an

immediate special hearing on the acquittee's present mental illness or dangerousness.

Thus, the length of hospitalization may be directly related to the process used to institutionalize the acquittee. If the person is treated the same as other civilly committed persons, he or she can be discharged by decision of a hospital administrator when no longer deemed to need hospitalization. Where the state has special criminal commitment procedures for insanity acquittees, a person may be hospitalized longer under a broader commitment standard. Release may be dependent on his or her being considered no longer dangerous, and the approval of release may be decided by a judge or parole-type board, rather than by the state mental health agency. In some states, hospitalization can be no longer than the maximum sentence the acquittee could have received. However, in a 5-to-4 decision, the Supreme Court in Jones v. United States (1983) recently held:

> there is no necessary correlation between severity of the offense and the length of time necessary for recovery. The length of the acquittee's hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment.

This case also denied insanity acquittees the same due process procedural protections afforded other persons who are institutionalized. Presumably, this decision will not cause other jurisdictions to rewrite their laws in a way that does not distinguish between the violent and nonviolent insanity acquittees. The Jones decision is very disturbing because of its denial of rights afforded to other persons who are institutionalized for a mental illness, with no cut-off date as to when regular civil commitment procedures must occur.

In many of the states that require court or board approval of the discharge decision, conditions can be required as part of the release. Thus the person can be required to participate in mandatory outpatient programs, drug or alcohol rehabilitation programs, or other types of treatment that are likely to guarantee his or her successful adjustment in the community.

Numerous proposals for change regarding the disposition of insanity acquittees have been made. There seems to be a growing consensus that there should be a distinction made between persons acquitted by reason of insanity after violent acts, and all other people who may need institutionalization for a mental illness. These proposals have some common elements, including broadening the commitment criteria, requiring court or board approval of the dis-

charge decision, and requiring mandatory outpatient care upon release from institutionalization.

The notion of a broader commitment standard for violent insanity acquittees recognizes that if an individual has been found competent to stand trial, he or she would be unlikely to meet the civil commitment criteria. Yet if the person stops taking medication, he or she may decompensate to being in an active phase of mental illness and thus pose a danger to society. Under these proposals, there would be an automatic commitment for a period of evaluation, and hospitalization would be based on a determination of whether the person could benefit from inpatient psychiatric services (Weiner, 1979; American Bar Association, 1983).

Requiring approval of the discharge decision by the judge who heard the criminal case, or by a parole-type of board, assures not only that the individual's psychiatric state is considered, but that there is a consideration of what impact the person's release may have on the community if he or she has not been successfully treated. This type of approach permits a review of the recommendations of mental health professionals and may require that gradual releases, such as day passes and weekend passes, be tried before the person is discharged from the hospital. It also recognizes that due to the economics of running a mental health department, there is often pressure to release patients as quickly as possible. Because these patients have manifested their illness through violent acts, someone besides the mental health professional should evaluate whether release is appropriate.

Finally, the proposals for change have recognized the need for developing outpatient treatment programs to assure that individuals are likely to succeed in the community (Weiner, 1979; American Psychiatric Association, 1983). These programs would be under the jurisdiction of the releasing authority. If the acquittee did not follow the treatment plan, he or she would be subject to rehospitalization. This approach is the most important aspect of assuring that insanity acquittees, once discharged from the hospital, will not become involved in repeated violent activity due to their mental illness, because experienced mental health professionals would be monitoring their care and determining if they were deteriorating. At that point a treatment intervention could occur that would result in rehospitalization or an appropriate change in the treatment program.

The debate surrounding the insanity defense should center on what procedures need to be enacted to assure that violent insanity acquittees are treated and then released when they are no longer dangerous. There is a need to develop systematic programs for the treatment of

these individuals on an outpatient basis. States that are considering making changes in their laws should study carefully the Maryland, Illinois, and Oregon laws and programs that have resulted in taking a systematic approach to treating acquittees (Silver, 1982; Bloom and Bloom, 1981). These programs have proven very successful in reducing the likelihood that acquittees will become involved in repeated violent activity.

MENTALLY DISABLED PRISONERS

The American correctional system has a great need for an infusion of mental health services. The mentally disabled are disproportionately represented in correctional facilities as compared to their numbers in the general population. It has been estimated that of the 6.2 million people who go through this nation's jails each year, 10 percent of them are seriously mentally ill (National Coalition for Jail Reform, 1982). Estimates of the mentally ill within prisons range from 14 percent who are considered psychotic to as high as 50 percent when behavior disorders are included (General Accounting Office, 1979). Between 10 and 29 percent of the prison population is also estimated to be mentally retarded (Santamour and West, 1977). These numbers present unique problems to correctional administrators, as well as to mental health professionals who seek to provide services to the imprisoned mentally ill offender.

Although the number of mentally disabled within the correctional system is startling, there are few—and in some cases no—treatment programs for these individuals (GOA, 1979). This is due in part to the lack of recognition by prison administrators of the extent of the problem, and in part to the lack of funds available for such programs. Additionally, there are tremendous problems in attracting qualified staff to work in correctional systems that often have no facilities for treatment.

The U.S. Supreme Court in Estelle v. Gamble (1976) recognized that prisoners are entitled to medical care. Lower courts have recognized that prison inmates may be entitled to psychiatric or psychological treatment if this is viewed as a medical necessity (Bowring v. Godwin, 1977; Finney v. Malery, 1982). This may be provided in part by transferring the prisoner to the mental health system. Usually states have special procedures to initiate such a transfer. However, in Vitek v. Jones (1980), the Supreme Court required that before an inmate could be transferred from a prison to a mental health facility, certain due process procedures had to be followed, including holding a hearing.

Although a transfer may work in a specific case, in order to meet the needs of the disabled in the prison system, either massive transfers would have to occur (heavily overburdening the mental health system) or, more logically, treatment programs would have to be established within correctional facilities. In the case of jails, where persons are awaiting trial or serving sentences of less than a year, transfer to a mental health facility may seem the most logical approach. However, in large urban areas the jail may have thousands of prisoners, of which more than a hundred may be mentally disabled. In such cases, psychiatric services within the jail is essential.

Although the establishment of treatment programs within correctional facilities seems the only sound approach, one must recognize the problems presented for mental health professionals who are trying to provide treatment in such settings. First, they are presented with the discouraging prospect of helping a person to gain control of his or her mental disability only to remain in prison. Second, there is the conflict as to who is the client, the prisoner or the prison system. Finally, in most circumstances there is little support for the mental health professional's efforts from correctional authorities, and little financial gratification or status within the profession as a result of working with prisoners.

Yet the needs of the mentally disabled within the jails and prisons are great. The retarded prisoner is more likely to be victimized by other prisoners, as is the psychotic prisoner. This area requires the most concerted effort to bring about change. Correctional authorities must learn to identify the mentally disabled and then develop treatment programs in separate facilities for them. This will only be accomplished with a recognition of the problem and funding support to bring about the needed changes.

DIVERSION TO TREATMENT PROGRAMS

The final point of interface for the mental health professional with the criminal justice system is at the point where treatment programs are being considered for the defendant. This is most likely to occur at the time of sentencing, when a treatment program may be ordered as a condition of probation and diverts the offender from incarceration. It also may be considered at the time of discharge from a prison, when treatment may become a condition of parole. In either case, a review of the defendant's previous record and possible treatment needs is made. Potential alternative programs are then explored to see if there is one that meets the needs of the defendant and that will consider accepting him or her.

Most common are diversion programs for defendants who are drug abusers. The majority of states have laws that permit diversion into specialized drug treatment programs. To meet their criteria, the defendant will have to have a drug habit that is considered to be related to his or her criminal history. However, if the person has an extensive criminal record of violent crimes, he or she will be barred from such a program. These programs not only aim at helping the offender, but also anticipate that by reducing the amount of drug abuse, there will be a decrease in drug-related crime. The same type of principles would apply to programs for alcohol-addicted offenders.

If the defendant has a previous psychiatric history or is mildly or moderately retarded, and if he or she has not been involved in a serious crime or does not have an extensive criminal history, then treatment or habilitation programs might be considered. In these cases the presentence report may include an evaluation by a mental health professional who suggests a specific program that will become a condition of probation. The offender will be required to follow the rules and regulations of the treatment program and keep all appointments. If not, he or she will be considered in violation of probation, which might result in imprisonment.

The major problem in this area is the lack of programs (GAO, 1979). There is a desperate need for more drug and alcohol rehabilitation programs aimed specifically at offenders. There are now very few outpatient treatment programs that will provide psychiatric care to mentally ill offenders, and programs providing habilitation services to retarded offenders are almost nonexistent. These programs not only must provide treatment but also serve on some level as an agent of the court by reporting on offenders who do not follow their rules. Working with involuntary patients often poses problems for mental health professionals, who may believe that coercion will limit the likelihood of treatment success. Additionally, there is usually community opposition to establishing such programs in the neighborhood. Yet these hurdles must be overcome, because the prisons are overcrowded and seemingly incapable of treatment. Prisons also provide an extremely costly alternative to workable outpatient programs. The future direction of the interface between mental health and criminal justice will be to develop workable outpatient treatment programs that can demonstrate success in reducing the recidivism rate.

CONCLUSION

The law necessitates many points of interface between the mental health and criminal justice systems. Class action lawsuits and statutory

changes have mandated more rights for the mentally disabled offender. Treatment programs are required in part as a result of this litigation. Yet, although the law has brought about many victories for the mentally disabled offender, these are often only paper achievements not supported by meaningful change. The time has come to address how to accomplish the types of changes that will provide the treatment necessary for the mentally disabled person to complete the criminal justice process and return to society a healthier individual.

Treatment programs must be developed within the correctional system. Equally important, new treatment alternatives must be attempted on an outpatient basis. There must be a recognition of the unique problems presented by the mentally retarded offender, and these must be addressed at each point of interface. Attorneys must be trained to better identify when their client may be mentally disabled, and evaluators need to receive more training in distinguishing between competency to stand trial and the insanity defense. Finally, the time has come to develop mandatory outpatient treatment programs for persons found not guilty by reason of insanity after committing violent crimes.

There is also a great need for specific data in this area. Few states gather statistics on their mentally disordered offenders, the nature of their disability, and the nature of their offense. Public perceptions of the frequency of use of the insanity defense are grossly distorted. Without specific data, we cannot set aside misconceptions nor make meaningful public policy decisions. Funding is needed to do research in this area—not only to gather statistics, but also to determine if treatment programs reduce recidivism and are cost-effective. Once we have these answers, we can decide if other changes are warranted in the mental health/criminal justice system.

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Chapter 2

THE BROTHEL BOY
A Fragment of a Manuscript

NORVAL MORRIS

The piece is handwritten, in Eric Blair's characteristic, cramped, meticulous script. There are frequent crossings out and emendations. There are occasional spelling inversions, such as "gaurd" for "guard," which are surprising, considering the obvious overall attention the document apparently received.

As an essay it is uneven. Parts reveal Blair-Orwell at his most masterful—phrases and sentences that he will use again in his later writings; parts are verbose and pretentious, like the early effort of one ambitious to be a writer but insecure in the craft, struggling too hard for effect.

The document also foreshadows many of the ideas its author later developed in depth and subtlety, themes that supported novels and essays. That alone would assure its lasting importance. It is a major find.

I bought it for the equivalent of $185 while on a holiday pilgrimage retracing Blair's travels during his period in Burma. The vendor was a Parsee; at least he was either a Parsee or a half-caste Anglo-Indian, but I think probably a Parsee since he did not affect an English accent. He had bought the manuscript, he said, from some Dacoits who had boasted to him of their courage in breaking into a government bungalow. He confessed to having purchased the few sticks of furniture and the few personal effects they had stolen, and he had quickly got rid of everything other than these papers, which he now held in a crumpled,

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yellow, paper bag. All this was many years ago; he had turned to legitimate business long since of course—on that I could rely. He had heard of my interest in Eric Blair and thought I might like to see these papers.

It is true that Blair once wrote to his mother about a burglary of his quarters—"who should guard this guardian if he can't guard himself"—though he had not, possibly for reasons of embarrassment, reported it to his superiors in Mandalay: but he had made no mention to either of the loss of a manuscript, which was surprising.

So much for my find. The amount I paid for it, annas to the value of $185, still puzzles me: the sum is a tribute either to the vendor's ignorance or to the purchaser's gullibility.

Here it is, gaps and all.

Moulmein
Upper Burma
1927

I wonder does any other Old Etonian roll his own cigarettes? And I'm not sure why I do. They are cheaper, of course, but the taste is not very different and bits and pieces of tobacco do drift into one's mouth and require picking off the tongue or lips, which seems to disturb some who observe it. In the Club they make no secret of their disapproval—"A frightfully low-bred habit."

"No thanks, I prefer these," and I watch their foreheads wrinkle in revulsion.

I had carefully rolled a cigarette and was about to moisten the paper, my tongue protruding, mouth agape, when a native boy burst into my office shouting. "Come, Come Sir. Hurry please. They are killing the brothel boy."

I knew of course, of the local brothel, but not of any "brothel boy." A homosexual prostitute seemed most unlikely in Burma, quite out of character with local values and prevailing behaviour—but I had mistaken his role. At all events, I hurried to where I was led to find several village men standing over the unconscious youth but desisting now from further violence. They were, it seemed immediately obvious, the remainder of a mob of assailants, though how I knew remains unclear to me.

The boy was unconscious, bleeding from the head and face from wounds inflicted by repeated kicks. His shoulder was twisted, obviously broken. His clothes, when whole scarcely adequate, were now gaping, torn, and bloody. He lay in a foetal curve, clutching his groin. The expression on what was left of his features was of anguished

surprise, the lips drawn back, mortal fear apparent. The smell of fear and violence, of sweat and vomit, was pervasive.

Resentfully they stood back to allow me to inspect him. Then, not concealing their reluctance, they helped me carry him to the police station, where I telephoned Dr. Veraswami at the nearby hospital. By the time Dr. Veraswami had arrived I knew the outline of the events that led to the brothel boy's beating. Some villagers returning to the fields in the afternoon had heard a girl's screams from a heavily overgrown area near the river customarily used for washing, but not at this time of day. When they reached her the screaming had ceased: she lay, a young girl, naked in the brothel boy's arms. She had been raped. In her struggles she had apparently struck her head violently on a sharp rock. The boy had made no effort to flee.

The girl was taken to her home. More villagers arrived. The boy was attacked. He might or might not have been killed—my arrival may have saved him for the hangman. Or the villagers may have overcome their dislike of the Raj's justice sufficiently to bring him to me. It was, after all, a fairly clear case—a young girl, a virgin, raped and injured by the brothel boy.

And it became an even clearer case when, a few days later, she died from the combined effects of the head wound and septicaemia. A villainous mixture of local herbs which the villagers had applied to her head wound probably hastened her death. Dr. Veraswami had not been called.

The law began it processes. By this time I had been long enough in the service of the magistracy to know what must be done to prepare for and carry out a trial in a capital case. In such cases I usually acted only as judge and prosecutor, avoiding the further incongruous role of defense counsel I also assumed in less serious crimes. It was not required, but I had fallen into the practice of asking one or other of the three Burmese claiming some forensic skill to represent indigent natives accused in serious cases. But this time my requests were firmly rejected. There was nothing to be said. He had raped her and she had died. He had been caught immediately. He did not deny what he had done. The only question was whether the villagers would kill him or whether the Raj, with its quaint, imported formality and pretense of independence, would do so. They could see no reason in impeding the Raj. So I was judge, prosecutor, and defense counsel, equally untrained in all three roles, though with developing experience in minor disputes and less criminal matters. Certainly the boy could not do much for himself.

I interviewed him under close gaurd in the hospital. I tried to talk quietly to him; I didn't hurry, sitting silent for long periods. He would

look down and away, immobile, never volunteering a word or a gesture. The emanation was of one cloyingly anxious to please, but not knowing how to. Whenever I asked him what happened by the river, he would rush to sweaty verbosity, his head and shoulders bobbing forward with exaggerated sincerity, "Please Sir, I paid, I'm sorry Sir. . . . Please Sir, I paid, I'm sorry Sir," the words running on with rising inflexion, flooding incoherently into one another, until he would begin to sob. When the crying stopped he would return to his motionless silence. And if I again even remotely probed the events by the riverside, the same miserable routine would be followed.

If I asked him to do something, to stand up or sit down, to open a window or a door, to bring me that chair, he would leap to obey, diligence gleaming in his eyes, ingratiatingly obedient, like a well-trained dog. But I could achieve no communication with him beyond his prompt obedience to simple order. I tried different tacks to relate to him, asking him about many things, always speaking clearly and slowly, but to little effect. Sometimes he would seem to understand and give a monosyllabic reply, accompanied always by a clipped "Sir," and sometimes would offer a shy and innocent smile, but words and smiles seemed quite random, having little to do with my question. And as soon as I approached the matter of the girl, or washing by the river, or even money, out would spill the "Please Sir, I paid I'm sorry Sir" flowing to tears, sometimes preceded by the incongruous smile.

"A 'perseveration,' I believe it iss called," Dr. Veraswami told me. "Over and over and over he says the same things in the same words in hiss mind, believing them completely I think, but not an idea what they mean. Sometimes he will say it all, sometimes bits and pieces, you will find, but always in the same sequence, going round and round, exactly the same. You will get very little more from him. It iss all hiss silly mind will let him think about. Perhaps not silly, issn't it. Safer so. But I doubt he pretends; he does not malinger, I think. He tells you all he can tell himself."

So it proved. The boy was obviously stupid. And the meaningless repetition and cringing self-pity became increasingly distasteful.

I went to the brothel to try to learn more of the boy. He had, it seemed, been born there some twenty or so years ago. Who his mother had been was remembered—she had worked for the previous owners of the brothel but had died a few years after the boy's birth. His father was, of course, undiscoverable; any one of the older male population of this or neighbouring villages could be a candidate for the unsought honour. The present brothel keeper, a smarmy lady of large physique, expressed unqualified praise of her own virtue in having let the boy stay when she bought the brothel some years ago. He was, she said,

until now an entirely reliable punkah puller, willing to keep the fans moving for the more prosperous clients who wanted them and would pay for them, while he faded into the background.

I could understand how unobtrusive he would have been. As interested in him as I was, I found it hard to see him as a person at all. On any subject apart from the crime, he only said what he thought he ought to say. Otherwise, immobile, slight, turned away, he seemed as present as the furniture.

"How did he keep himself?" I asked the proprietress of the brothel. She was lyrical in her praise of her generosity. She kept him without charge. Actually let him sleep inside. Clothed and fed him. And sometimes, she said, customers, anxious to show off, would give him a few annas. And she would, in her bountiful kindness, let him keep them. This was, I supposed, the source of his savings, which he had tried to give to the girl he killed. "Did he help the girls if they were treated badly by a customer?" I further enquired. Indeed not; that was her job. And, archly, there were always men of the village to whom she could look for assistance if she needed it. But that was very rare. The girls knew they should expect, even encourage, vigour in some customers. They were often the best customers. And the girls knew she would care for them if they were hurt. It would be most improper for the boy to intervene. He was enough trouble to her without that.

All he was expected to do, she explained, was to keep the punkah moving gently to begin with and perhaps later slightly more swiftly so that, by different methods, he and the girl could cool the customer. She laughed with betel-gummed delight at her own wit and then explained to me that the boy's job was very easy, that often he did it on his back, his arms pillowing his head, his heel in the loop of rattan which by regular pressures waved the overhead punkah. She developed this theme of his sloth and her generosity at some length.

"What of his schooling?" I asked. And this confirmed her view of the idiocy of the white servants of the Raj. Powerful eye-rolling laughter was her response, so that I had that often recurring sense of how alien and useless I was in this Burmese setting. A brothel boy at school would be more at home than this assistant police magistrate in Upper Burma. And about as useful, I suppose, in her view.

I asked the brothel keeper if she knew how the boy had met the girl he killed. Her already ample bosom rose, swelled, and trembled with indignation. He had met the girl when he helped her with her parents' laundry. Washing was men's work, but the girl's father was often unwell and the girl did it for him. It was, of course, the brothel boy's duty, in return for the brothel keeper's munificence towards him, to do the washing for the brothel, which took him daily to the river. The

boy had, she thought, on occasion assisted the girl by helping her carry some of her parents' laundry to and from the river. She had, it appeared, most unwisely chatted and played with him in a friendly way when they met. The proprietress had on one occasion made it her business, indeed gone out of her way, to warn the girl that the boy was a fool, a simpleton, not to be trusted, and that she should behave towards him like everyone else, not talk to the stupid boy except to tell him what to do or not to do or to reprimand him. But the girl would not listen. She was only a child of twelve or thirteen, but even so she should have known better, as the younger girls in the brothel all understood, certainly after the kindly but firm warnings so generously given.

I turned to Dr. Veraswami to try to understand the boy and his crime. As usual, Dr. Veraswami was pleased to talk to me about this or any other subject, it seemed. Both of us lacked friends and conversational partners in Moulmein. Dr. Veraswami's children by his first marriage were grown and departed, those by his second were old enough to love but not to talk with. And his present wife would run to hide in the kitchen when she saw me approaching their bungalow. She had, the Doctor told me with a gentle smile, "many fine qualities indeed, indeed, but the confidence in conversation of a particularly timid mouse."

Dr. Veraswami was the only person I enjoyed in Moulmein, certainly the only one I felt at all close to since, try as I would, I could never establish any reciprocal warmth of feeling with any of the natives, though I think some of them knew I respected them. My servants would not talk at all of the crime, looking anxiously resentful and falling silent if I mentioned the boy. By contrast, in the Club, it was a subject of unending, energetic, circumlocutiously salacious chatter, the details of which I spared myself by stressing that since the matter was *sub judice* I should not mention it or receive advice about it. This did no good, of course, but it did give me a further excuse to avoid the Club, and confirmed the prevalent view of me there as a posturing outsider, probably a coolie lover.

Dr. Veraswami had, after all, worked in a mental hospital, and he was closer to the Burmese, certainly in their illness, than anyone who was not Burmese. So I turned to him.

The evenings on the porch, the rattan armchairs, the foliage still hanging heavy from the regular late afternoon rainshower, the smells and sounds of the village and the nearby hospital and gaol, the heat abating, and the bottles of Watney's beer with their wired glass stoppers clinking among the few tired lumps of ice in the oval bucket, made an oasis of mind talking to mind profoundly different from the

relentless ritual phrases of the Club. And it was good to have the chance to learn from him about matters my reading had neglected.

"The boy iss, I think, quite retarded, but to what level iss hard to tell." Dr. Veraswami seemed perplexed. "Iss not easy to be sure. After all, my friend, he iss quite illiterate. Unlike you, he and books move in different circles, always have and will. Measuring such a mind iss beyond me, and others also issn't it. But he iss certainly far backward, far backward."

The villagers had made much of the girl's virginity; I wondered about the boy's sexual experience. Dr. Veraswami was again hesitant, but did not doubt my speculation that the violence by the river might have been the boy's first experience of intercourse. He had witnessed much, of course, but the brothel girls would certainly see themselves as superior to and distant from the boy. Chastity, in the sense of absence of congress with a woman, may well have been forced on the boy.

"Is he mad? Was he mad?" I asked the doctor.

"To be sure, I don't know at all. . . . He iss certainly not normal. But given hiss life, dear friend, how would you know what he thinks . . . if he does think, ass you mean it."

"Mad or not, dear doctor, is he likely to do something like this again, or has he learned his lesson?" Surely the swift and brutal punishment for his venery, then the arrest and everyone condemning him, had instructed even his dull mind.

Dr. Veraswami was not so sure. "One would think so, indeed one would. But I must tell you that there are cases like hiss where even after very severe punishment the act iss repeated. You must not, dear friend, underestimate . . ." and here he grasped wildly in the air for an unembarrassing euphemism, and with triumph found it ". . . the power of the gonads! . . . Of course, if you hold him in prisson for twenty years there would then be little risk—these fires do with the years burn less intensely, believe me—but I doubt he would survive so long in prisson."

Dr. Veraswami's resignation in the matter began to annoy me. "Well, if you can't help with why he did it, or whether he's dangerous, what should be done about him."

"He will be hanged, of course."

I protested that we both knew the boy meant no harm, no evil. The more I thought about him and his crime, the less wicked it seemed, though the injury to the girl and her family was obviously extreme; but it was a tragedy, not a sin.

Dr. Veraswami was relentless. "You think him retarded, and he iss. You think him ignorant of what he should and should not do, and he

iss. You think he meant no harm, just like an animal, a reaction to the girl. But don't you see, dear friend, all your English colleagues see him ass just the same ass other Burmese, indistinguishable from all other native boys. All look alike. All are stupid, ignorant, cunning, untrustworthy, dirty, smelly, sexually uncontrolled. All the same. To excuse him because he iss just like the rest would in their minds be madness in you, not in him."

I had no answer. "And," he continued, glancing towards the village. "so I fear iss the view of the Burmese. A brothel boy, yes, but in no other way different. They don't let mind speed worry them. You think he iss different and therefore innocent where others would be guilty, you may be right, probably so, but the villagers don't agree! You must do what your British friends at the Club and the villagers both expect you to do."

My testiness increased. "You seem so content in this, Doctor. The boy is surely *less* responsible than most killers; he meant no harm insofar as he understood what was happening; and you seem so swiftly to accept his hanging. Surely he is *less* worthy of being hanged than most murderers."

Dr. Veraswami was waving his head vigorously from side to side as I spoke. This, I had earlier discovered, was a frequent Indian gesture easily mistaken for dissent, but having the larger meaning of a qualified assent, in effect—you are nearly right but not quite. "The gaol, the prisson, perhaps," he said, waving to the nearby dingy walls. "He could sit there on the other side of the wall with the others until he died perhaps. He will learn nothing there, ass you know. Have even less to do than in the brothel. If anything he will become even more idiot than now. And they will prey on him." Then, after a pause to acknowledge my troubled silence, "Or perhaps the place where we lock up the mad. Have you seen it? . . . Worse, I think, than the prisson. Have you been there?"

I had and it was. No psychiatrist could possibly wish to work in such circumstances and none did. It was indeed the least desirable service for any doctor, Burmese or Indian—and no English doctor has as yet ever drunk enough to find himself posted there.

"But iss it not much the same, . . . even in England?" Dr. Veraswami asked. It was not really a question. He knew, I did not know. What he implied was probably the truth.

"So what, dear police magistrate friend, would you have us do with the boy?" Shall I take him home with me? Keep him here to serve us beer? Iss it not difficult enough for me to live in this dreadful place without taking him ass a son to my bosom? The villagers would indeed then reject me entirely quite. Or iss he to be a part of the police magis-

tracy? You would be more doubted and even less respected—a most unwise move indeed, indeed . . ." And he trailed off to vague head wavings.

"I wonder, Doctor, if one of us could have talked to the girl before she died, what would she have wanted me to do?"

"She would have been more scared of me than of you—Indian doctors, ass you know, bewitch village maidens and turn them into hyenas or other horrible animals; English policemen merely steal them! I doubt either of uss could have made her understand very much about the boy. But what if we could? How could she forgive him? How tell him? Take the money from him, perhaps . . . ? It iss offensive. No, you will get no help from such thoughts, my friend. It could not in any way have been her problem. It iss yours."

Later, reflecting on the realities Dr. Veraswami had held up to me, I found myself dreaming the reformer's dreams, summoning resources of medicine, psychiatry, prisons without brutality, and a political caring ages removed from Burma under the Raj.

Did much change? I was not sure. Certainly, the boy would not be executed, since with the movement towards minimum social decencies the executioner is one of the first functionaries to be retired. But others tend to take his place. A larger self-caring often accompanies a larger caring for others. The boy might well be held until cured. And how would one ever know that? Only by letting him out. And one can't do that until he is cured. So he must be held. The false language of treatment and cure would replace the Burmese bluntness of condign punishment—and who could tell which is to be preferred? If the boy could choose he would choose to avoid the hangman, but there would be other whips and torments waiting for him even in my dream of the all-loving State.

My daydreams of the boy and I being elsewhere and at another time, rather than here and now in Moulmein, were understandable but gave me no comfort. My decision would have been cruelly lonely had not Dr. Veraswami seemed to enjoy our discussions and to wish to help me in my thrashings around to avoid hanging the boy. Sometimes, however, he struck home hurtfully. I was pressing him for his opinion of how the boy felt in killing—caring, cruel, lost, bewildered? I suggested confusion and a sense of isolation. Dr. Veraswami looked incredibly embarrassed. "Did you not tell me, dear friend, of some difficulties you and some of your distinguished young friends . . . ass it were . . . experienced at that fine English preparatory school you attended before Eton? St. Cyprian's, issn't it?" I had no idea what he was talking about and remained silent. He blushed. Indians do blush, though less obviously of course than Englishmen. "Enuresis, issn't it,

I believe . . . Flogged for what you did not know how to avoid, I think you said." And I knew that I too suddenly was blushing, the lobes of my ears scarlet, the guilt of my childhood bed-wetting still upon me. Dr. Veraswami was sure he had offended me; his agitation increased. He got up, fussing about with bottles of beer, now warming as the bits of ice he had somewhere found melted to fragments.

He was, of course, quite right. In a sense I had been where the brothel boy found himself. I had been beaten for my sins, sins which were clearly both wicked and outside my control, yet nevertheless sins, or so they seemed to me and to Bingo and to Sim, who wielded the cane and broke the riding crop on me.

It was possible, therefore, to commit a sin without knowing you committed it and without being able to avoid it. So it had seemed then, and the feeling of guilt undeniably remained, and strong. Sin was thus sometimes something that happened—to me as to the brothel boy. You did not properly speaking *do* the deed; you merely woke up in the morning to find in anguish that the sheets were wringing wet.

I tried to calm Dr. Veraswami, to assure him that he had not offended me, that I appreciated his directness, that I needed his help. This led me to an excessive confession, one I had made to no one else, and probably no one else knew about it, not even Sim. The last time Sim had flogged me for bed-wetting I remember with great pain a further loss of control of my bladder and a warm flow inside my short pants, down the inside of my left knee, onto my long socks and into my left shoe. Sim had me bent over a desk, posterior protruding; but I hoped most desperately and still in misery believe that the desk shielded his eyes from my pants and the pool which may have formed at my feet. The shame, had the puddle been seen and almost surely commented on, would have been beyond bearing. But I still don't know if it was.

Dr. Veraswami's hands were flying about in near frenzy. I tried hurriedly to make the link to the case of the brothel boy, straining thus to calm him. I thought he feared a breach in our friendship, but that is unfair; on reflection I think his only anxiety was that he was troubling me too deeply. Perhaps he was.

Were my feelings then, and the brothel boy's now, at all comparable? Had I become a ponderous, unfeeling mixture of Bingo and Sim, punishing the boy by death because of the harness of the environment into which he had been flung, compared to which my trials at St. Cyprian's were trivial?

Dr. Veraswami would have none of it. "Dear friend, bed-wetting and rape which kills . . . how can you compare them at all? . . . mis-

placed guilt . . . childish fears and adversities loom ever large, but no, not at all, not in any way like the brothel boy's guilt."

Perhaps gallows humor would reassure the Doctor that he had not wounded me. "At all events, Dr. Veraswami, after that beating, when I wet my sock and shoe, I did not wet my bed again. I was cured. Sim cured me. The hangman will surely cure any lack of control our brothel boy may have over his burgeoning sexual instincts!"

But Dr. Veraswami was hardly listening. "No, no, no, dear Sir . . . enuresis while you sleep; sexual attack while awake; nothing similar."

So I pressed the analogy, suggesting that precautions might be taken to empty the bladder. One might arrange to be awakened during the night if others would help. What were the precautions the brothel boy should have taken against copying what he had seen, and seen as acceptable, to be purchased when the flesh engorged? The brothel boy could hardly be justly punished for the desire. Obviously he had had nothing to do with it, less than I had with the springs of enuresis. And whence was he to find the wisdom and control, in unsought and unexpected heat, not to do what probably seemed to him an obvious and acceptable act. He had observed in the brothel apparent gratitude by both parties, simulation and true appreciation being indistinguishable by him. Where were the differences between him and me in sinning? The distinctions seemed to favour him.

Dr. Veraswami's intensity increased. "No, you are very wrong, forgive me contradicting you, but you are off a lot. The boy must have known he wass hurting her, dull though he iss. The girls in the brothel fear and complain of violence, they talk to each other about it often, the boy must have known. Once he came close upon her, he knew, he knew, believe me my friend. The cases are quite different. You do yourself too much injustice. You did not sin, he did, and most grievjously. Your comparison with your bed-wetting misses the essential difference, issn't it—he was conscious of what he wass doing, you were not. And being conscious, backward and confused though he iss, mistreated and bewildered though he wass, he must be held responsible. You must convict him, punish him, hang him! He iss a citizen of Burma, a subject of your Imperial Majesty, but you must treat him ass a responsible adult and punish him. That iss what citizenship iss."

I had never before heard such a lengthy, passionately sibilant speech from Dr. Veraswami. It seemed to have calmed him. Again, it didn't help me.

It seemed to me that the discussion had tilted crazily against the brothel boy. Responsibility . . . citizenship . . . consciousness of what he was doing . . . were these sensible standards for a youth of his

darkly clouded intelligence and blighted situation? And, if not, what standard should be applied, to what end, with what results?

An all-wise God could by definition draw these fine distinctions, but it was hard to think of the brothel boy and an omniscient God as in any way related, hardly an omnibenevolent God to be sure. And I knew that I was no plenipotentiary of such a divinity; a minor agent of the Raj was enough for me. My employers had never distinguished themselves in drawing delicately generous moral distinctions; indeed, they seemed to judge entirely by the results and not by the intentions, which surely must inhibit any fine gradations in attributing responsibility.

Did this mean that there was no room at all in my jurisdiction for mercy, for clemency? I decided to put the question to Dr. Veraswami.

Unlike my fellow members of the Club, Dr. Veraswami enjoyed my skill in rolling cigarettes. He rarely smoked but occasionally would accept one of my home-grown cigarettes. He preferred to moisten the paper himself, I holding the enfolded tobacco out to him; but he also cheerfully accepted those the product of my hands and tongue.

When talking with Dr. Veraswami, I found I sometimes rolled a cigarette to give me time to phrase a point of delicacy or difficulty, as many who smoke a pipe use the ritual of filling, lighting, and tamping as time for meditation. On this occasion, the cigarette rolling was a preamble to an effort to seek Dr. Veraswami's views on the moral aspects of the problem of the brothel boy. And, if he agreed that the boy was less culpable, to press him why he was so adamant about the hanging.

"Do you know a painting by Peter Paul Rubens of the Last Judgment?" I asked Dr. Veraswami. "It is a huge painting with lovely though overweight naked ladies and gentlemen going up to unclothed inactivity above the right hand of Christ. Just below His left hand there is an interesting Prince of Darkness in control of a lecherous team dragging the damned off to unpainted horrors, with a face at the bottom of the Devil's side of the painting screaming in agony."

Dr. Veraswami said he had seen a poor print of it once, he thought, but in any event he plunged ahead of my circumlocution to the heart of the question. "You ask, I suppose, my friend, where will the boy be if the admirable Mr. Rubens paints truth? Of course, I don't know. I am not a Christian but, if I were, I would guess he will not be among those damned."

"Well, then, how can you tell me to hang him?" I asked, pressing Dr. Veraswami for reconciliation of what some would see as conflicting positions.

Dr. Veraswami yielded to no difficulty in the reconciliation. Mercy, a full and forgiving understanding of behaviour, was the prerogative of whoever was God, if there was one, and if he had so little to do that he interested himself in us after we died—which Dr. Veraswami doubted. Nor did he believe, as did some Hindus, that we came back in some other form; but if we did the boy was as likely to ascend as to descend in the hierarchy—whatever it was. All in all, if God had made the boy as he was, and put him where he was, it was hard to see that the boy had behaved any better or worse than God must have expected. But all that, he argued most vigorously, had nothing to do with Assistant Police Magistrate Blair, who, admirably though Dr. Veraswami knew he was, educated and wise beyond his years, could not now help the boy. "Justice, my friend, iss your job. Justice, not mercy." And his gesturing hand fell and was still, simulating the fall of the gallows.

"Surely, Doctor, mercy can be a part of justice. They are hardly in opposition. Cannot mercy infuse justice, shape it, direct it?"

"Sometimes, sometimes, but often it iss beyond our competence." And he launched again into a lengthy speech, his plump white-clad behind balanced against the veranda rail, his black thumb and forefinger nipping at the air as if to capture ideas as they floated by. The tenor of his argument was, so far as I followed it, Freudian. If we knew all we could about any murderer, including the brothel boy, all about his inherited capacities and all his life experiences, we would find more than sufficient explanation for all his actions including the killing. Conduct was apparently "overdetermined," once you included the unconscious and the subconscious. And for most of these pressures, which collectively and massively determine everyone's behaviour, it would seem unfair to hold anyone responsible. "But, my dear friend, fair or not, it iss essential to do so! Within justice there may be room for clemency, for mercy, for human understanding, providing only the essential purposes of punishment under law are not frustrated. Here they would be. He hass killed while deliberately doing what iss a very serious crime. There iss no room for mercy, no room at all." And then as if he thought it would clinch the matter: "Why even the good Viennese doctor himself, Sigismund Freud, said you are responsible for your unconscious. There it iss!"

"But, dear Doctor, if we can assess differences of fault, or think we can, sufficiently to reduce or increase the punishment of the guility, to be merciful or to be severe, why can't we, why can't I, by the same means reduce guilt itself? After all, sometimes we do that—when people kill accidentally we call it manslaughter, if they have been very careless indeed; and if they have not been careless and yet have

killed it is usually no crime and never murder. We may not be very good at judging moral fault; but in a rough and ready way we can. And surely the boy is nearer innocence than guilt."

"No, no, my magistrate friend, you make the same mistake, forgive me please. We are talking only of intentional acts, not of acts of carelessness—they are quite different. That iss what distinguishes the boy's act from your enuresis, issn't it. And for such acts . . ." and here Dr. Veraswami grabbed two handfuls of ideas from the air around him ". . . the boy is either to be treated ass a responsible man or he issn't. There are no half-men for guilt in the eyes of the law. If there were a choice of punishments for what he hass done, perhaps you could be merciful, because he hass been much abused and iss of weak mind. But there issn't, there issn't. It iss circular you see, dear friend."

I didn't see at all, but he pressed on, now almost skipping about with the released energy of uninhibited talk, which I suddenly realised was an even more cherished luxury for him than for me—"Man iss defined by hiss capacity for moral choice. That iss what man iss, nothing else, otherwise an animal." And then, chuckling at the cruel pointedness of the joke: "Dr. Freud and the law agree, you see. For his unconscious mind and for hiss conscious mind, such ass they are, the brothel boy iss twice responsible. Otherwise you would have to excuse everyone, certainly everyone you took the trouble to understand."

Though an elusive conclusion, the point was strong. Justice cannot excuse everyone, obviously. And if our judgment of moral guilt reflects mainly our degree of ignorance of the relevant moral facts, then all we would do in a mercy controlled system of punishment would, in effect, be to excuse or be merciful towards those we know a lot about or decided to find out about—and not the others. To my dismay it seemed to me, therefore, that if Justice stands in opposition to Mercy, we are damned (or, certainly, this Assistant Police Magistrate is); and if Mercy is to infuse Justice, to be a part of it, we probably claim beyond our competence.

Dr. Veraswami understood my difficulty in this whole matter, my search for some principle to guide me. "I think a lot about it, my friend, since it iss such a worry to you. And, if I may please, I hope you agree, here iss my conclusion." And after a pause, a thumb and forefinger, tweezer-like nip in the air to catch his words, "There iss no steady principle to guide you, none at all. You must be a man of principles, not of principle."

Dr. Veraswami seemed to be becoming more elliptic than before, and in anoyance I told him so. "No, you misunderstand me," he

replied, "I mean there iss no moral princple to guide you, moral, moral . . . There are, of course, other guides, other principles. The main one iss that you English should use the executioner ass little ass you can—rarely, if you use him at all. And how to know how little iss ass little ass you can?" Here he paused again, hands still, achieving impressive rhetorical effect. "I have it: if the British do not wish him killed, there iss no problem unless the natives want him killed very much, and the British think they should let them have their way. If it iss a native to be executed they will not care too much. But if the British and the natives *both* want him killed, ass with the brothel boy, unless he iss so very mad ass to be obviously mad to all, natives and British, you can do nothing unless you also wish to leave the service of the Raj and be seen by all ass a treasonable fool."

Hesitantly, regretting the force of "treasonable fool," he added: "I would like to help you, but I can't. Perhaps you should leave here . . . I would miss you. You would be happier in England I think. But iss this the way? Iss this the way to go? And even if you do save the boy what can we do with him? Ass I said, the gaol? the madhouse?

It appalled me to realise that I was in Pilate's role, at least as Pilate may have seen it, though otherwise the comparison made no sense. Nor, increasingly it seemed to me, did I. Perhaps it was me for the madhouse that Dr. Veraswami saw as useless for the boy. No; I understood the issue all too well; it was now clear and I was not confused. Dr. Veraswami was right. As a moral issue, the boy was nearer to innocence than most of us; at the Last Judgment I would back his chances over most. But as a political matter, what a weak reed he had in me to sustain his life.

I recalled another recent occasion in Moulmein when I had failed to stand for the right against public pressures. Was it to become a habit? A recidivist Pilate indeed! A few months ago, very much against my better judgment and every inclination, I had shot a working elephant that had recovered from a period of "must" in which he had damaged some property and killed a native. As soon as I saw the elephant I knew with perfect certainty that I ought not to shoot him; but the natives expected it of me and I had to do it; I could feel their dark, sweaty wills pressing me forward, irresistibly. If I did nothing it was quite probable that some of them would laugh. So I shot the elephant.

I had to contend then only with native opinion; the Europeans would have divided on the question, some holding it to be a damn shame to shoot an elephant for killing a coolie, because an elephant was worth more than any damn Coringhee coolie. Now, with the brothel boy, the forces pressing on me were different and probably

greater. No one would laugh if I did not hang the boy, but both European and native opinion was agreed and vehement: that is what I ought to do, what I must do.

Memories of St. Cypian again swept in. I remembered how Latin was beaten into me and I still doubted that a classical education could be successfully carried on without corporal punishment. Bingo, Sim, and the boys all believed in its efficacy; as in Moulmein, public opinion was unanimous about the value of physical punishment. I recalled Beacham, a boy of dull mind, not as dull as the brothel boy but certainly not bright, whom Sim flogged towards their joint goal of a scholarship for Beacham, as the heartless might flog a floundered horse. And when Beacham was severely beaten yet again for his failure in the scholarship exam, his words of poignant regret came back to me: "I wish I'd had that caning before I went up for the exam."

[Here there are pages missing in the manuscript. It leaps to a few concluding paragraphs.]

As I walked with Dr. Veraswami into the gaol yard I caught sight of him. Six gaurds were getting him ready for the gallows. He stood, surrounded by the gaurds, slim and muscular, with shaven head and vague liquid eyes. He seemed genuinely bewildered, puzzled, uncomprehending though deeply fearful. The gaurds crowded close to him, with their hands always on him in a careful, caressing grip, as though all the while feeling him to make sure he was there. He seemed hardly to notice what was happening. His eye caught mine and paused while it dawned on him that he knew me and that I had been gentle with him. The vague eyes developed a semblance of communication.

By the time he stood by the scaffold no marks remained of the beating. His body had repaired itself, but the intervening weeks had not helped my mind to repair its anguish.

I walked behind him to the gallows. Though his arms were bound, he walked quite steadily. And once, in spite of the men who gripped him by each shoulder, he stepped lightly aside to avoid a puddle on the path. The puddle—and I understood why—brought me back to the unreasoning St. Cyprian guilt. That I should be destroying a healthy conscious man, dull and dangerous though he may be. The unspeakable wrongness of cutting short a life in full tide. The struggle for rational judgment came as a minor anodyne. How can I refashion the world of the just and the unjust, of the forgiving and of the prejudiced, myself an uncertain observer rather than a shaper of justice, a player

without influence on the rules. Only by my own death would I escape the pain of these cruel games. I must leave Burma.

So that when he was dead, and the Superintendent of the gaol asked Dr. Veraswami and me and the rest of the little procession to join him in a drink—"I've got a bottle of whiskey in the car. We could do with it."—I found myself drinking and laughing, perhaps too loudly, with the rest of them, quite amicably, natives and Europeans alike.

Veraswami was right; I must leave Burma.

II

THE DYNAMICS OF INTERSYSTEM PROCESSING

The following four chapters examine the dynamics of intersystem processing, or what Warren and Guttridge (Chapter 5) term "trans-institutionalization." Each of the four illustrates how tampering with one component may have important ramifications for the system as a whole.

Teplin examines the speculation that the mentally ill have been "criminalized" via incarceration as a result of recent changes in mental health public policy. Her study demonstrates that the problematic methodology used in this research precludes any conclusion in regard to the extent of criminalization. Nevertheless, this chapter illustrates how public policy changes in one system (mental health) can have unintended consequences for both health service delivery as well as the criminal justice system.

Leo Schuerman and Solomon Kobrin present fascinating data concerning the treatment of mentally disordered persons who are processed through the criminal justice system. Their data are unique in two respects: First, as Chapter 3 points out, most investigations in the area have used extremely biased samples, restricting their studies to persons previously hospitalized in a public psychiatric hospital. In contrast, Professors Schuerman and Kobrin used persons who had been treated within community mental health centers (both inpatients and outpatients) as their sample. Second, the bulk of investigations have focused on arrest rates and have not examined subsequent criminal justice processing. Schuerman and Kobrin provide data at each

level of the criminal justice system. Their findings are striking. They found that persons utilizing services of community mental health centers were found to have a higher rate of arrest than the general population.

Chapter 3

THE CRIMINALIZATION OF THE MENTALLY ILL
Speculation in Search of Data

LINDA A. TEPLIN

A number of mental health professionals have commented on what has been termed the "criminalization of mentally disordered behavior" (Abramson, 1972).[1] It is thought that a number of persons who had heretofore been treated within the mental health system are now being shunted into the criminal justice system, both in the United States (Abramson, 1972; Rachlin et al., 1975; Stone, 1975; Kirk and Therrein, 1975; Swank and Winer, 1976; Whitmer, 1980; Morgan, 1978, 1981; Lamb and Grant, 1982) and in Great Britain (Orr, 1978; Bowden, 1978). However, it is unclear the extent to which this thesis is substantiated by the research literature. This chapter shall examine the empirical evidence bearing on the alleged criminalization of the mentally ill.

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BACKGROUND

Three major factors underly the speculation that the mentally disordered are being criminalized:

The Increase in Mentally Ill Persons Residing within the Community

There are many more mentally disordered persons living in the community than ever before (Whitmer, 1980). This increase may be traced to three major developments in the mental health system. First, deinstitutionalization has resulted in greater numbers of persons who would have formerly been hospitalized being given outpatient treatment within the community setting. Second, the legal context regarding patient rights has resulted in specific restrictions regarding psychiatric treatment. For example, more stringent mental health codes have placed greater restrictions on commitment (Curran and Hyg, 1978; Singer, 1981; Urmer, 1973). Another example is the concept of the right of the patient to refuse treatment (see O'Connor v. Donaldson, 1975; Bowden, 1978; Whitmer, 1980). These restrictions have resulted in an unknown number of mentally ill persons who have chosen to live in the community without the assistance of psychiatric treatment.

Finally, fiscal reductions in mental health programs have resulted in an increasing number of mentally ill persons who, because of a lack of available programs and/or a paucity of individual financial resources, are denied treatment. These factors have had the effect of increasing the number of mentally ill persons residing within the community. Unfortunately, there is a limit to society's tolerance of such persons, particularly give the stereotype of the mentally ill as "dangerous" (Shah, 1975; Rabkin, 1974; Fracchia et al., 1976; Olmstead and Durham, 1976; Mechanic, 1969; Nunnally, 1961; Steadman and Cocozza, 1978), as well as the bizarre quality of some symptoms of mental disorder. The community may attempt to invoke the criminal justice system when situations arise that involve mentally disordered persons (Abramson, 1972; Swank and Winer, 1976). As a consequence, mentally disordered persons may be arrested in order to remove them from the community.

Police Handling of the Mentally Ill

Although the police have been recognized as a major mental health resource within the community (Rock et al., 1968; Bittner, 1967; Bunoz et al., 1969; Liberman, 1969; Warren, 1977; Teplin et al., 1980; Sheridan and Teplin, 1981), the police are often limited by the bureaucratic difficulties inherent in initiating an emergency hospitalization (Matthews, 1970). More recently, police action has been limited further by the aforementioned stringent criteria governing commitment and treatment (Abramson, 1972), as well as the limited psychiatric placements available to them (Teplin, this volume). Given the potential bureaucratic snarls in making mental health referrals, the police might consider arrest to be a less cumbersome and more reliable way of handling situations involving mentally disordered persons.

The "Borderline" Client

There is some evidence that persons with numerous previous hospitalizations (Kirk and Therrein, 1976), or persons thought to be "dangerous" (Bowden, 1978), are among the most unwanted clients of mental health agencies. Clearly, such persons fall into the "cracks" of the system in that they are thought to be too "dangerous" to be accepted for treatment but not dangerous enough to be committed (Bowden, 1978). In a sense, the criminal justice system becomes the system that can't say "no." Persons rejected as inappropriate for the mental health system are readily accepted by the criminal justice system. Thus the jails and prisons may have become the new long-term repository for mentally ill individuals who, in a previous era, would have been institutionalized within a psychiatric facility.

There are a number of structural factors that would seem to indicate that the mentally ill may indeed be criminalized. However, the empirical evidence for the processing of mentally disordered persons through the criminal justice system is problematic at best, as outlined in the following sections.

THE RESEARCH LITERATURE

Empirical evidence for the criminalization of the mentally ill can be found in three separate but related types of research: (1) archival

studies; (2) investigations of police decision making in relation to mentally disordered persons; and (3) studies of the prevalence of mental disorder among jail detainees.

Archival Studies

A few archival studies provide data that appear to offer some tentative evidence consistent with the criminalization thesis. Modlin (1979) cites a study conducted by Blair (1973) which found that the closing of one California state hospital precipitated a 300% increase in the Santa Clara County Jail population. Similarly, Abramson (1972) reports that in the year after the passage of the Langerman-Petris-Short Act (LPS) in California (a law intended to increase the legal rights and reduce the legal disabilities of mentally ill persons involuntarily treated in mental hospitals), the number of arrests increased by 36%. More important, the number of incompetent-to-stand-trial pleas doubled. More recently, Bonovitz and Bonovitz (1981) found that mental-health-related incidents coming to the attention of the police increased 227.6% from 1975 to 1979.

In constrast, a study reported by Steadman and Ribner (1980) does not support this trend. They examined two cohorts (prison and jail) at two different points in time (1968 and 1975) and found no increase in the proportion of persons in prison with prior psychiatric hospitalizations, and only a 3% increase among jail detainees. However, they did find that among those persons with any psychiatric inpatient history, the number of previous psychiatric admissions increased from 1.9 admissions in 1968 to 4.1 admissions in 1975. Overall, Steadman and Ribner concluded that there was no evidence for the criminalization hypothesis from their prison data, and only modest empirical support for the alleged increase in mentally disordered offenders in jail. They hypothesized that changes may have occurred more in the perceptions and expectations of the correctional staff than in the characteristics of the inmates.

The Steadman and Ribner (1980) study, while representing an important first step in this area, utilized only one measure of psychiatric illness—previous hospitalization. There are at least two potential problems with using hospitalization as the sole indicator of mental disorder.

First, a recent study reported by Bonovitz and Guy (1979) indicates that findings regarding previous hospitalization are not necessarily consistent with other measures of mental illness. They examined the

extent to which a prison population in Philadelphia changed as a function of the new Mental Health Procedures Act (MHPA) in Pennsylvania. Although Bonovitz and Guy did not find that persons admitted after the MHPA were more likely to have a history of psychiatric hospitalizations than persons admitted before the act (results similar to those of Steadman and Ribner, 1980), their other findings supported the criminalization hypothesis. Specifically, they found that the number of requests from prison staff for psychiatric consultation rose substantially subsequent to implementation of the MHPA. More important, the criminological characteristics of the pre-MHPA group were significantly different from those of the post-MHPA cohorts. Specifically, persons hospitalized in the prison psychiatric unit after implementation of the act tended to have committed fewer offenses in the past and were arrested for less serious offenses (disorderly conduct, trespassing, and so on) than persons referred to the psychiatric service before the passage of the MHPA.

Bonovitz and Guy (1979) discovered from examining the case records that a number of these persons were considered to be mentally ill by the arresting officer but either refused voluntary treatment or were thought not to meet the criteria for civil commitment. These findings were interpreted to be evidence that the police, when faced with complaints concerning deviant citizens, might feel that their only alternative was to arrest the person in order to remove him or her from the community (Bonovitz and Guy, 1979). The investigators concluded that the criminal justice system appeared to be used as a mental health resource and that this state of affairs appeared to be a function of the more stringent "protections" of the new mental health code.

Second, by utilizing prior hospitalization as the sole indicator of mental disorder, the Steadman and Ribner (1980) study may underestimate the number of mentally disordered persons. Such a conceptualization does not, by definition, include those mentally disordered persons who, because of a lack of sophistication or resources, or pure happenstance, are initially channeled into the criminal justice rather than the mental health system; as a consequence, such persons would have no history of psychiatric hospitalization. Thus, using prior hospitalization as the sole criterion variable enhances the probability of a finding consistent with that of the Steadman and Ribner study; that is, that the mentally ill are not being criminalized. However, it is unclear whether this result would obtain if the operationalization of mental disorder were not restricted to a history of prior psychiatric inpatient treatment.

Another group of archival studies that provide data relevant to the criminalization issue are investigations comparing the arrest rates of former mental patients with those of the general population. Although the primary goal of this research has been to assess the relative dangerousness of ex-mental patients, the research findings are also applicable to the criminalization issue. If the mentally ill were being criminalized, one would expect a higher arrest rate among mentally disordered persons than among the non-mentally disordered, particularly for minor crimes. In short, a higher arrest rate among mental patients is necessary but not sufficient evidence of criminalization.

The higher arrest rate among formerly hospitalized persons has been confirmed in the literature, at least in the more recent research (Rappeport and Lassen, 1965, 1966; Giovannoni and Gurel, 1967; Zitrin et al., 1976; Durbin et al., 1977; Steadman, Cocozza, et al., 1978; Steadman, Vanderwyst, et al., 1978; in contrast, see Ashley, 1922; Pollock, 1938; Cohen and Freeman, 1945; Brill and Malzberg, 1954). However, this finding is not necessarily an indication that the mentally ill are being criminalized, since this data pattern may indicate that they are simply more prone to crime. An alternative explanation has been offered by Steadman and his associates. They found that the number of mental patients with prior arrests has substantially increased over the years, and posited that the apparently higher arrest rate for mental patients is a result of this marked change in the clientele of state hospitals. Steadman, Vanderwyst, et al. (1978) investigated this thesis by comparing the rearrest rates of patients with and without prior criminal records. They found that those patients without arrest records (approximately three-quarters of their sample) were arrested infrequently; that is, at about the same rate as the general population. In contrast, it was the "multiply-arrested patient" who was more likely to be rearrested upon release. Since prior arrests tend to be associated with subsequent arrest, the investigators concluded that it is not the prior criminality of mental patients that results in their being arrested more often than before, but rather the increased number of mental patients with arrest records.

At first glance, the results of this latter study appear to be at odds with the criminalization hypothesis, since the greater propensity of former mental patients to be arrested is explained by factors other than the prior psychiatric hospitalization of the patient. While the study provides important data, it is somewhat limited by the sampling criteria. Again, the study focuses only on previously hospitalized patients; it is questionable whether this finding would be replicated among persons who are mentally ill but have never been treated as mental patients (that is, hospitalized). Labeling theorists suggest that

initially bestowed definitions such as "mental patient" become a type of master status that substantially affects the ways in which a person's subsequent behavior is defined and interpreted (see Schur, 1971; Becker, 19763; Rosenhan, 1973). It is possible that unlabeled persons (that is, individuals who are mentally disordered but never hospitalized) have a greater chance of being arrested for minor offenses than persons who have been labeled as mental patients via hospitalization. Moreover, once arrested, the former may be prone to be rearrested (that is, relabeled as a criminal) again and again. In short, by focusing on previously hospitalized persons, research in this area misses those mentally disordered persons who are arrested for minor offenses and then continually (re)channeled through the criminal justice system. One wonders about the extent to which the jail has become the poor man's mental health facility, particularly in light of the decreasing availability of psychiatric services.

Given the potential import of a prior label on subsequent processing, the results of another study conducted by Steadman and Ribner (1980) are particularly interesting. They investigated the extent to which prior hospitalization affected the rearrest rates of a group of offenders. The investigators found no relationship between the existence of a prior mental hospitalization and subsequent arrests within eighteen months after the offenders were released. Although this finding appears to fly in the face of the criminalization hypothesis, there are at least two other mitigating factors.

First, since again prior hospitalization was the sole criterion variable, it is likely that at least some of the offenders in the Steadman and Ribner study may have been mentally ill but were never treated via hospitalization. Such persons would be assigned to the "no prior hospitalization" group. A high arrest rate among these persons would tend to make the arrest-rate data even out across the independent variable, thus enhancing the probability of a "no difference" finding.

Second, since only offenders were studied, the findings may be specific to this type of sample. Thus, the results of this study may be less an indication of the noncriminalization of the mentally ill than of the relative import of the "offender" label in subsequent processing. Again, the labeling perspective is most instructive. Since those offenders who have been hospitalized possess two potential labels, that of offender and mental patient, it is possible that one may take precedence over the other. This is a particularly interesting question given the inherently grey area of behavior which, depending on cultural value and administrative practice, might be labeled either criminal or psychiatric (Stone, 1975). For example, similar behaviors can be defined as either "disordered" or "disorderly," depending on the

sociopsychological/sociostructural context. It seems likely, particularly in the absence of abundant clinical services, that persons who possess both identities may be defined and processed as offenders rather than mental patients. This interpretation is consistent with the data pattern of the Steadman and Ribner (1980) study, as well as that of the aforementioned investigations by Steadman and his associates.

The most recent archival study in this area tested the hydraulic model. Simply stated, this theory, originally set forth by Penrose (Steadman et al., 1983), postulates that a change in the population of one institutional system (for example, the mental hospital) will force an inverse change of equal magnitude in the population of the other (the prison). Steadman et al. (1983) attempted to verify the hydraulic model by comparing the proportion of prisoners with any prior hospitalization in 1978 to that in 1968 for six states: New York, Arizona, Massachusetts, California, Iowa, and Texas. For each state, they compared the 1978 figures to expected values based on the increase in prison admissions while holding constant the proportion of inmates with prior hospitalizations found in the 1968 group. They found that in New York, Arizona, and Massachusetts, the number of prisoners found in 1978 to have a history of prior hospitalization was smaller than would have been expected. In contrast, the California, Iowa, and Texas data showed that the actual number of 1978 prison admissions with prior hospitalizations exceeded the expected values. However, the growth in prison populations during this period could not be attributed solely to the admission of prior mental patients who, in the previous era, might have remained hospitalized. In sum, Steadman et al. (1983) concluded that it is unlikely that the rapid growth in state prison populations between 1968 and 1978 is attributable to the shift of persons from state mental hospitals to state prisons.

This finding does not necessarily mean that the mentally ill in these states are not being criminalized. Steadman et al. (1983) speculate that, given the preponderance of criminal records among ex-mental patients, it may be the jail that has become the repository for the mentally ill. Still another hypothesis is that mentally disordered persons who are arrested may be diverted to the mental health system at some point prior to final adjudication of their case. Unfortunately, there has been no research effort to date that provides evidence for either of these possibilities.

In sum, the archival research findings are somewhat problematic at best. Investigations of arrest rates appear to indicate that the apparently high arrest rates among previously hospitalized mental patients can be explained by the high proportion of persons with criminal

records now present in psychiatric hospitals. Those former mental patients without criminal records have arrest rates comparable to those of the general population. Unfortunately, the literature is inconclusive as to the extent to which mentally disordered (albeit never hospitalized) persons are now being processed through the criminal justice system. On the other hand, the hydraulic model has not been supported, at least when using data from prisons. Studying the prison system provides only limited data in relation to the criminalization thesis, since the jail may have become the new mental health repository. Conclusions concerning the criminalization thesis are further complicated by the results of the archival studies reviewed in the first part of this section. Although somewhat weak methodologically, these studies provide results inconsistent with both the arrest-rate research and the hydraulic model study. Clearly, what is needed are investigations of a variety of research settings (such as prisons, jails, and mental health facilities) using a number of criteria vis-à-vis the presence of mental illness. The complexity inherent in the criminalization hypothesis requires such a multidimensional approach.

Investigations of Police Decision Making

Although a number of studies have investigated or commented on the involvement between the police and the mentally ill (Cumming et al., 1965; Matthews, 1970; Liberman, 1969; Sims and Symonds, 1975; Fox and Erickson, 1972; Teplin et al., 1980), there has been relatively little research examining the police officer's decision in choosing a criminal versus a psychiatric disposition. Nevertheless, a few studies offer some tentative evidence that mentally ill persons may be processed through the criminal justice system.

Although Bittner (1967) found that police tend to utilize informal means (that is, neither arrest nor hospitalization) to bring mental-health-related situations under control, two other investigators (Rock et al., 1968; Matthews, 1970) have noted that the standard operating procedure for dealing with mentally ill persons is to use arrest as the initial "intake" procedure. This practice apparently resulted from the fact that emergency provisions for psychiatric intervention did not provide sufficient authority for a workable procedure. The police turned to the more familiar device of criminal arrest to imbue the intervention with legal authority (Rock et al., 1968). Matthews (1970) has also noted that a lack of consistent policies in relation to hospital admissions resulted in police arresting mentally disordered persons in order to simplify the process. In a similar vein, Urmer (1973), in a study in California, discovered that a number of mentally disordered

persons were processed through the penal system. He feels that mental health services resist accepting aggressive persons for treatment, a practice which results in their being arrested for lack of an alternative procedures. Urmer observed that it is the "non-dangerous" and somewhat aggressive mentally disordered person who, because he or she does not fulfill the commitment criterion, may be cycled through the penal system.

More recently, in an observational study of nearly 1400 police-citizen encounters, Teplin (1982, 1984) found that incidents involving mentally disordered suspects produced a significantly higher arrest rate (46.7%) than incidents not involving mentally disordered persons (27.9%). Moreover, the higher arrest rate was not simply a function of mentally disordered persons being more frequently involved in serious crimes that tend to have a higher arrest rate. Rather, the difference in arrest rates was evident irrespective of the type and seriousness of the incident (for example, both disorderly conduct and assault). Teplin (1982, 1984) concluded that, other things being equal, a mental disorder appears to enhance the probability of arrest. Given the higher arrest rate of mentally disordered offenders presented in the previous section (Steadman, Cocozza, et al., 1978; Steadman, Vanderwyst, et al., 1978), it is possible that it is not simply the prior criminal record of the mentally ill offender that seems to increase the likelihood of arrest; rather, evidence of a mental disorder may be used as input into the police officer's definition of the situation and subsequent disposition of the incident.

Several other studies that have utilized direct observation of police practices have found that the seriousness of the incident determined the type of disposition (criminal or psychiatric) (Schag, 1977; Teplin, this volume). Cases defined as "serious" by police nearly always resulted in a criminal disposition. Moreover, the definition of a case as serious was not always correlated with the severity of the offense; a number of sociopsychological and sociostructural contingencies determined whether or not the "serious" criterion would be invoked. For example, situations in which a citizen was disrespectful of a police officer were nearly always thought to be serious (Teplin, this volume). Even if the offender displayed evidence of a mental disorder, he or she was nevertheless arrested. Apparently, the police assume that since the court routinely evaluates both criminal negligence and the need for psychiatric help, a mental health diversion could be easily initiated within the criminal justice system (Schag, 1977). A complicating factor is that in certain jurisdictions, mental hospitals will not accept a patient who has any criminal charge pending against them, no matter how minor (Teplin, this volume). In such cases, arrest becomes the only viable option for handling the situation.

In contrast, the disposition of less serious cases is far more problematic. Schag (1977) feels that emergency apprehension may be invoked when a criminal arrest would be preferable but cannot be accomplished (for example, when a victim refuses to sign a complaint). Teplin (this volume) found that a number of contingencies may determine the dispositional decision, such as the "publicness" of the behavior, whether or not the offender is a known neighborhood character, the degree to which a person is thought to become a behavior problem during the disposition, and whether or not the person fulfills a hospital's requirements (as perceived by the officer) for treatment.

Three other studies that examined police decision making utilized post hoc data collection procedures (Jacobson et al., 1973; Monahan et al., 1979; Bonovitz and Bonovitz, 1981). Jacobson et al. (1973) queried those police officers who made psychiatric apprehensions about their choice of disposition, both generally and in specific cases. They found that 51% of the officers said that if a crime had been committed, they would "sometimes" arrest an allegedly mentally ill person. An additional 14% reported that they would "always" arrest a mentally ill individual if there had been a violation of the law. Jacobson et al. (1973) noted, however, that the actions of the police officers in the specific cases were not consistent with their expressed attitudes; there was much less inclination to arrest than was suggested by the officers' responses to the hypothetical questions. However, this interpretation of the findings is somewhat problematic for two reasons: First, the apparent disinclination to arrest may apply only to those officers who habitually utilized mental health resources as a dispositional alternative, since the investigators did not interview police who chose the option of arrest. Second, the fact that a total of 65% of the officers indicated that mentally disordered persons *might* be given a criminal disposition provides further support for the criminalization thesis.

In a somewhat similar study, Monahan et al. (1979) found little evidence that mentally ill persons were being criminalized via placement in jail. Questioning police officers subsequent to the dispositional decision (both arrest and emergency psychiatric apprehension), Monahan et al. (1979) discovered that two-thirds of all cases entering either system (criminal or psychiatric) were perceived by the police as being totally inappropriate for referral to the other. Moreover, in the remaining one-third of the cases, the choice was felt to be more of a legal technicality than a behavioral option; in only 6% of the committed cases were the police sufficiently concerned to voice the desire to make an arrest should commitment be denied.

Although the findings of the Monahan et al. (1979) study differ from those reviewed earlier in this section (see Teplin, 1982, 1984,

this volume; Schag, 1977; Rock et al., 1968; Matthews, 1970), the discrepancy may be due to the point at which the data were collected. Specifically, Monahan et al. (1979) interviewed officers post hoc; that is, after they had made the criminal versus psychiatric decision. This methodology is problematic for at least two reasons: First, the officers may have hesitated to offer evidence that they had made an error in their choice of disposition. Second, having already constructed a definition of the situation, the officers' responses may have served as postdecision dissonance reduction (Festinger, 1975; Brehm and Cohen, 1962). In other words, it is likely that the officers attributed a decision to the exigencies of the situation and subsequently redefined those exigencies to be consistent with the decision already made.

Bonovitz and Bonovitz (1981), in a study of 248 mental-health-related incidents, found that only 13% resulted in arrest. Although the investigators interpreted this finding as evidence that mentally disordered persons are not being processed through the criminal justice system, their sampling strategy renders this interpretation questionable for at least two reasons: First, as in the Jacobson et al. (1973) study, Bonovitz and Bonovitz studied only mental-health-related incidents, the definition of which is never operationalized. By whose definition is a situation "mental-health-related?" The family's? The offender's? The police officer's? This issue is particularly crucial since, if the police officer's definition is used, the investigators have studied only those situations least likely to result in arrest; such incidents, by definition, would be recognized as being mental-health-related by the officer. Second, the 13% arrest rate, while interpreted as being low, may not be any lower than the arrest for non-mental-health-related cases. Police commonly utilize a number of peacekeeping techniques, and arrest is a relatively rare event (Reiss, 1971; Manning, 1977). Thus, the obvious question is whether or not a "low" rate of 13% is any lower than arrest rates in non-mental-health-related incidents. Unfortunately, the design precludes our comparing the disposition of mental-health-related incidents with other incident types. The validity of Bonovitz and Bonovitz's (1981) conclusions is further compromised by the fact that, upon close inspection, their data provide tentative evidence in support of the criminalization hypothesis. Specifically, they found an 82% increase in disorderly conduct cases from 1976 to 1979. It is possible that this dramatic increase in "disorderlies" was a result of the arrest of mentally disordered persons, which, as a result of the above-mentioned sampling bias, is not evident in the Bonovitz and Bonovitz (1981) data.

In sum, most studies of police decision making, while somewhat mixed, provide evidence that mentally disordered persons may be processed within the criminal justice system.

Studies of the Prevalence of Mental Disorder in Jail Populations

Table 3.1 summarizes the findings of the more recent studies of the prevalence of mental disorder in jails.[2] As seen in the table, the rates of mental illness range from a low 3% (Petrich, 1976a) to 50% (Schuckit et al., 1977; Kal, 1977) for unselected samples; studies that tabulated the prevalence of mental disorders by looking only at those persons referred for psychiatric evaluation found that between 24% (Nielsen, 1979) and 75% (Lamb and Grant, 1982) suffered from a psychosis. Unfortunately, the findings have virtually no discernible historical pattern to enable a valid test of the criminalization thesis.

The diversity of these findings may be explained in part by several methodological inconsistencies:

Sample Section. Although random samples of jail populations are the only precise way to ascertain prevalence, this type of study is exceedingly rare. The more common type of study, in which persons who are referred for psychiatric evaluation are tabulated by the type of mental disorder exhibited, is meaningless unless we know the criteria for referral to the examining psychologist. One wonders, for example, if prior hospitalization was used as the primary criterion for referral in the Lamb and Grant (1982) study, since 90% of their sample had been previously hospitalized. Moreover, the decision to refer a prisoner for treatment is dependent on a number of factors other than the degree of illness per se. For example, it is likely that in order to be diagnosed as mentally disordered within an inherently "disorderly" social setting (the jail), one must act extremely disturbed to get noticed. Becoming a behavior problem (being loud, aggressive, threatening, or loudly proclaiming suicidal ideation) may enhance the probability of being treated for mental disorder. In contrast, quiet compliance, while potentially indicative of depression, is likely to be encouraged by the custodial staff. Thus, it is likely that only a certain type of mental disorder will get detected and treated within the jail setting, particularly if the diagnosis is made on the basis of subjective instrumentation and/or clinical inference. Petrich's (1976a) finding that only 10% of his sample were diagnosed as depressed lends some support for this.

In a similar vein, the definition of the need for evaluation may coincide with the availability of services. Morgan's (1978, 1981) work, contrasting the perceptions of sheriffs in various jails, lends some limited support for this thesis. She found that in Alabama (a state not noted for its mental health services in jails), sheriffs estimated

Table 3.1 The Prevalence of Mentally Disordered Persons in Jails: Recent Research

Study	*Type of Sample*	*Findings*
Bolton, 1976 (cited in Lamb & Grant, 1982)	5-county combined sample of 1084 adults	6.7% psychotics. 9.3% nonpsychotic mental disorders
Petrich, 1976a	n = 539 persons referred for evaluation 56.5% misdemeanors 54.9% felonies	49% psychotic 27% antisocial 43% alcohol/drugs 10% depression overall 3% of total jail population were referred
Petrich, 1976b	n = 122 persons referred for evaluation	12% depression 6% mania 17% secondary depression 29% schizophrenia 2% anxiety neurosis 43% antisocial personality 70% drug/alcohol 4.3% approximate psychiatric morbidity
Pasewski et al., 1976	n = 50, selected from those referred for pretrial psychiatric evaluation	Bipolar affective, 10% Schiz., 22% OBS, 4%
Swank and Winer, 1976	n = 545; 445 referred for psychiatric evaluation, 100 randomly selected	*Referred (%) Random (%)* psychosis 26.3 5.0 pers. disorder 34.8 29.0 neurosis 2.5 2.0
Kal, 1977	Random	50% DSM III diagnoses among females, 63% among males
Schuckit et al., 1977	n = 199; random, no prior felony convictions	48% fulfilled some diagnostic criterion most frequent diagnosis = antisocial 5% acutely ill
Morgan, 1978, 1981	Surveyed sheriff's perceptions of extent of mental illness	Estimates ranged from 4% (Alabama) to 25%–50% (California)
Nielson, 1979	No sample size given; data based on 9 of those referred	24% psychosis, 4% OBS 47% narcissistic pers. disorder, 25% other
Monahan and McDonough, 1980	n = 632; nonrandom, all inmates selected for mental health services	31.6% schiz., 22% char disorder psy. disorder; 55% were misdemeanants, race and sex differences
Whitmer, 1980	n = 500; apparently nonrandom, persons defined to be "in need" of treatment. ½ felonies, ½ misdemeanors	averaged three prior psychiatric hospitalizations

(continued)

Table 3.1 Continued

Study	*Type of Sample*	*Findings*
Lamb and Grant, 1982	n = 102, randomly selected from those persons referred for evaluation; Drug/Alcohol excluded: 53% felonies, 41% misdemeanors, 7% outstanding bench warrants	75% schizophrenics 22% major affective 2% OBS 2% adjustment disorders

the prevalence of mental illness to be only 4%, a rate far below that of the other data collection sites. In short, it is likely that the criteria for referral are inconsistent across samples; this inconsistency would then result in different rates regarding the prevalence of mental disorder, since the samples, by definition of the "target group," would exhibit different rates and types of disorder. This problem, of course, could be avoided by using randomly selected samples, a procedure which, while more costly, allows researchers to accurately assess the prevalence question.

Sample Size. In the few studies in which random samples have been used, the sample sizes have been, without exception, insufficient to reliably ascertain the prevalence of a statistically rare event such as serious mental disorder. The minimum sample size necessary to be able to detect a rare trait (with a "true" prevalence in the population of, say, 2%) 95 times out of 100 would be 200 for each subpopulation of interest, controlling the offense category, race, and so on (see Lazerwitz, 1968).[3] For example, a study that wished to accurately assess the prevalence of mental disorder among felons and misdemeanants would require a total sample size of at least 400 (200 felons and 200 misdemeanants), and more if other variables were to be included in the analysis. The few studies that have been done have used sample sizes far below the 200 required for each subgroup. Swank and Winer (1976) had a randomly chosen "comparison group" of 100. Schuckit et al. (1977), while somewhat better (N = 199), nevertheless utilized a sample size insufficient for the type of analyses performed. They attempted to relate the prevalence and type of mental disorder to fifteen other variables of interest, an endeavor clearly inappropriate for a sample of 199.

Measurement. The diagnostic process in a number of studies is rendered problematic by the use of unspecified criteria and instru-

ments (see Swank and Winer, 1976; Nielsen, 1979; Whitmer, 1980; Monahan and McDonough, 1980). The lack of purely objective criteria may result in a number of problems. For example, since the diagnosis of mental disorder is less an objective identification of symptoms than a subjective definition of a set of problematic characteristics within a specific social setting, it is likely that the diagnostic process is not consistent across samples. Moreover, if the diagnostic process is not completely objective, the social milieu may intrude on the clinician's definition of the situation. One wonders, for example, if the large proportion of "antisocial" personality diagnoses in the literature (see Petrich, 1976b; Schuckit et al., 1977) is solely a function of the offenders' pathology, or if the apparent epidemic of this diagnostic group is, at least in part, a result of the clinician's using an offenders' presence in the jail setting as evidence of his or her antisocial nature.

Similarly, it is likely that a psychologist who is a regular staff member of a jail will find substantially less "disorder" (in the psychiatric sense) than an outsider who, unaccustomed to the chaos and cacophony of the jail setting, sees pathology as a ubiquitous phenomenon. Still another problem resulting from the inadequate specification of diagnostic criteria is that investigators have not differentiated between jail detainees who exhibit signs of mental disorder resulting from the stresses of the jail experience and those who have exhibited symptoms of mental illness prior to their appearance in jail. Although the state-of-the-art of the diagnostic process makes this sort of differentiation at least somewhat problematic, there are several diagnostic systems—for example, the NIMH Diagnostic Interview Schedule (Robins et al., 1981)—that provide both "current" and "past" (that is, previous month, six months, and "lifetime") diagnoses of mental disorder.

Lack of Baseline Comparisons. The extent to which mental disorder is a severe problem among jail populations is unknown due to the lack of studies comparing jail rates with available baseline data from nonjail samples. The lack of such comparative studies is particularly problematic given that without such comparisons, one cannot ascertain the extent to which jail rates differ significantly from rates in the general population. Clearly, what is needed is a study that contrasts in-jail rates of mental disorder with available epidemiological data from the general population.

In sum, investigations of prevalence have been plagued by four problems that preclude a definitive statement vis-à-vis the presence of mentally disordered persons among jail populations: (1) most

studies have focused on characterizing those persons referred for treatment rather than studying the prevalence of mental disorder among the jail population as a whole; (2) sample sizes have been, without exception, insufficient to detect a statistically rare event such as serious mental illness; (3) the assessment process has been plagued by imprecise and/or insufficient instrumentation; and (4) investigators have not used baseline data for comparison. What is needed is an investigation of the prevalence of mental disorder in jails that is designed in such a way so as to avoid these methodological problems.

A final cautionary note is in order. Although prevalence studies provide data central to the criminalization thesis, this type of research may seriously underestimate the magnitude of criminalization. Samples obtained at this point in the criminal justice process (the jail) omit all persons who are arrested but not incarcerated. This bias may result in an underrepresentation of the actual number of mentally ill persons who are being criminalized since the sample, by definition, does not include mentally disordered persons who are arrested but either make bail or are diverted to a mental health facility during their pretrial hearing.

DIRECTIONS FOR FUTURE RESEARCH

This review indicates that the available empirical evidence provides only tentative support for the speculation that the mentally ill are being criminalized. Clearly, futher research must be undertaken in order to provide a database that will adequately test the criminalization thesis. The following directions are suggested.

First, a variety of measures regarding the presence of a mental disorder must be utilized. Criteria such as prior hospitalization are but one indicator of psychiatric illness. This is particularly crucial given that mentally disordered persons in this day and age are less likely to be hospitalized than were those in a previous era. Thus, a major goal must be to ascertain how persons exhibiting psychiatric symptomatology are handled in the absence of long-term psychiatric institutionalization.

Second, official records, while providing a global view of the problem under study, reflect only one aspect of the dispositional process. What is needed are more observational studies examining how mental health professionals view the law-violative acts of their patients, and how criminal justice officials deal with the psychiatric symptomatology of offenders. In addition, more longitudinal work is required concerning intersystem processing. For example, studies of the adjudication

process of mentally disordered person would provide needed data concerning the handling of such individuals by the criminal courts. Such research is necessary in order to ascertain the extent to which arrest may have replaced commitment as the major mode of entry into the mental health system. Moreover, studies of intersystem processing could provide important information needed to understand those circumstances under which persons may be differentially defined as either "crazy" or "criminal" and subsequently transferred back and forth between the mental health and criminal justice systems.

Third, replication is needed of some of the more micro-type studies (such as research on police decision making) to see if police response is relatively universal or, at least in part, determined by the sociolegal structure of a particular jurisdiction. Such research will indicate whether reeducation is required for the police, or if structural change is needed within the mental health and legal systems.

Fourth, systematic studies of the prevalence of mental disorder among jail populations must be undertaken using appropriate sampling techniques, reliable measures, and baseline data as a comparison. Research conducted less stringently is of marginal utility at best.

Finally, investigators must capitalize on changes in policy, utilizing prospective versus retrospective data indicate that researchers must anticipate policy changes so as to implement natural experiments. In this way, we may provide data necessary to the evaluation of alternative procedures regarding the mentally ill.

In conclusion, innovative policy change must be based on empirical evidence, not intuition or speculation. Thus, research in this area is absolutely imperative in order to formulate policies whereby the mentally disordered person may be treated in a appropriate and humane manner.

NOTES

1. Alternatively, a number of researchers have studied what has been termed the "psychiatrization of the criminal" (Monahan, 1973) and feel that persons who would formerly have been caught in a revolving cell door are now bouncing back and forth between state hospitals and jails (Cocozza et al., 1978) or being kept within the confinement system via diversion (Gottheil, 1979). This thesis is given further support from research conducted by Steadman et al. (1978a), who found that mental hospitals are increasingly populated by persons with a record of prior arrests (see also Cocozza et al., 1978). However, while this interface is important, the scope of this chapter precludes examining this research, and it will focus only on that literature relevant to the criminalization of the mentally ill.

2. Since it is likely that a number of offenders would have been diverted to mental health facilities at some point during the adjudication process, the results of studies in prisons are not readily comparable to those using jail samples. Thus, Table 3.1 and the accompanying discussion do not deal with research conducted using nonjail samples (for example, Guze, Tuason, et al., 1962; Guze, Woodruff, et al., 1974; Sutker and Moan, 1973).

In order to simplify the foregoing discussion, studies of suicide rates in jails have been omitted. However, it should be noted that most studies of suicide in jails have found rates that are substantially higher than those in the general population (see Henden, 1967; Esparza, 1973; Fawcett and Mars, 1973; for an opposite result, see Heilig, 1973). These findings provide further support for the existence of mental disorder in jail populations (see Singer, 1978, 1981, and Danto, 1973, for a more detailed discussion of jail suicide).

3. The 2% figure is an approximation, based on available epidemiological data indicating that less than 5% of the population will have any disorder, but for many disorders the point prevalence is closer to 1% (Weissman et al., 1978; Eaton et al., 1981).

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Chapter 4

EXPOSURE OF COMMUNITY MENTAL HEALTH CLIENTS TO THE CRIMINAL JUSTICE SYSTEM
Client/Criminal or Patient/Prisoner

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The question addressed in this chapter is the degree to which the presence in the community of substantial numbers of the mentally ill has affected the operations of the criminal justice system. The issue has arisen in recent years as a result of two large-scale developments. The first has been the movement, initiated during the 1960s, to reduce the use of hospital confinement in the treatment of the mentally ill, with a shift to community-based mental health treatment programs. Sosowsky (1978: 33) noted, for example, that nationwide state hospital patient loads peaked in 1955 at approximately 560,000 patients but then declined to about 428,000 by 1969. By 1974, the total patient load was only approximately 238,000.

The second and concurrent movement during this period was a substantial increase in the prison population in the United States. According to Gottfredson et al. (1978), prison populations increased from approximately 186,000 in 1955 to roughly 300,000 inmates by

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1978. The question raised by the decline in the mental hospital population and the increase in the prison population during the same period is whether the former, now present in the community in large numbers, account in some part for the rise in the prison population.

To assess the extent to which the two developments were related, two levels of analysis were made. The first examined a sample of clients of the Los Angeles County Department of Mental Health who were arrested for felony and misdemeanor offenses. The sample consisted of all adult mental health patients admitted as clients during 1978. This sample included individuals who may or may not have been clients in previous years. In this initial analysis, the frequency of their arrests over the four-year period, 1976–1979, was examined by sex, age, ethnicity, and type of charge, with the frequency and rate for each category compared to those for the entire arrest population of Los Angeles County during the same period, exclusive of mental health clients.

In a second analysis, only first admissions as mental health clients in 1978 were used. With this cohort, an identifiable date of entry into the County Community Mental Health System was established. In turn, this provided a way of establishing arrest rates during the 24-month period prior to their identification as clients of the Department of Mental Health and during the 24 months subsequent to their identification. These prior and later period rates were compared to the entire arrested population during 1977 and 1979, respectively. Whatever the contribution to the police workload, it was considered possible that a population of mental health clients in community treatment may have constituted a differentially greater burden in the course of court processing. Consequently, the comparative charge and disposition distribution of the 1978 cohort of first admissions to the Department of Mental Health, who were moved from the arrest through the Municipal and/or Superior Court, was then examined. Again, patterns of frequency and disposition were distinguished prior and subsequent to cohort members' identification as mental health patients.

Only in the first analysis, however, which covered the arrest records of all admissions of the 1978 cohort for the four-year period, 1976–1979, were both misdemeanor and felony arrests included. In the analysis restricted to the 1978 first-admission cohort, only felony arrests were included. This restriction was imposed because a complete tracking from arrest to a court disposition is available only when the initial charge is a felony arrest.

The study population frame included approximately 285,000 unique individuals who generated over 500,000 admissions to the Los Angeles

County Department of Mental Health during the four year period, 1976–1979. From this universe a sample was drawn consisting of 65,599 separate adult admissions for 1978. This sample constituted the population of the first analysis. Through the use of a records-matching computer program, all clients for whom a record of arrest on misdemeanor and felony charges existed in the Arrest and Citation file maintained by the California Bureau of Criminal Statistics were "statistically" identified for the four-year period, 1976–1979. The arrest file contained over 4,644,000 adult arrests. In order to obtain the fewest false positive matches and at the same time preserve the anonymity of clients, the linkage criteria were restricted to achieve an absolute match on the following fields of information:

(1) second through sixth character of the surname
(2) first initial of the first name
(3) complete birth date
(4) race/ethnic identification
(5) sex

It should be emphasized that these restrictions on the matching procedure produced a very conservative estimate of the frequency of appearance of mental health clients in the arrest file. In essence, matches were obtained only on those individuals for whom the information was most likely to be consistent, accurate, and reliable when their basic demographic characteristics were recorded by each agency. Since follow-up studies by the California Bureau of Criminal Statistics (including the use of finger print search) have shown for the arrest registry at least a 10% error on surname alone, it might be expected that the slippage is higher in the mental health files, where there is less need to assure accurate identification in order to protect against false arrest. This means that the rate of false negatives, although indeterminable, may well be substantial. Differences between the arrest rate for the mental health sample and that for the general population (which for some population and offense categories was found to be consistently higher), were thus minimized.

Two additional features of the matching procedure had the effect of increasing the conservatism of the estimated frequency with which mental health patients appeared in the arrest file. First, the 18- and 19-year-old individuals in the 1978 cohort were juveniles in 1976 and 1977. Since juvenile offenders were excluded from the adult arrest files, no record of arrest was available for these criminally active age groups in the arrest records. And since these two age groups account for almost 6% of all arrests and over 10% of felony arrests, it would be

expected that additional years at risk would be reflected in higher arrest rates for the mental health cohort. Second, the mental health cohort was subtracted out of both the numerator and the denominator numbers when calculating the arrest rate for the general population. Given the potential for an increased number of mental health client arrests, and thus contracting the size of the numerator in the general population, it is evident that this will produce a smaller arrest rate for the general population, thus maximizing the differential estimated rates for the two groups.

ANALYSIS AND FINDINGS

Arrest Rates

Bearing in mind the fact that the sample is only for 1978 admissions to the Department of Mental Health (these individuals may also have entered and/or exited the system in other calendar years), and despite the precautions taken to obtain a conservative differential arrest rate for the mental health cohort, the data of Table 4.1 show them to have a consistently higher arrest rate pattern. This is true for all arrest charges, as well as separately for misdemeanors and felonies. For all Part I crimes, the rates are almost double those of the general population. The same differential is seen in the arrest rates for specific categories of the more serious property and personal offenses.

Perhaps the most notable feature of these arrest data is the similarity of distribution for both the mental health cohort and the general population. Strongly suggested is the possibility that the social and cultural controls on types of offense behavior prevalent in the general population operate as well in an identified mentally ill population. But without disturbing the pattern of distribution, in the case of each type of offense the arrest rates are consistently higher for the mental health cohort.

Alcohol-related offenses have been treated separately in order to highlight the fact that, as a single type of offense, it shows by far the highest arrest rate both in the mental health cohort and in the general population, although it remains substantially higher in the former than in the latter. This can only mean that a large proportion of the mental health cohort has come to consist of patients with an added problem of alcoholism. It is possible that these are patients who in an earlier period constituted the "revolving door" clientele of our city and county jails, now transferred into our public mental health organizations.

Table 4.1 1976-1979 Arrests and Rates for Uniquely Identified Adult Community Mental Health Clients for 1978 and the General Population: Los Angeles County

	Adult Mental Health Clients		*Adult County Population*	
	Number	*Rate*	*Number*[a]	*Rate*
All arrests	30,090	45.9	1,707,254	34.7
Misdemeanor	22,450	34.2	1,292,961	26.3
Alcohol-related	11,357	17.3	657,972	13.4
Other	11,093	16.9	634,989	12.9
Felony	7,640	11.7	414,293	8.4
Part I	5,050	7.7	235,367	4.8
Property	2,843	4.3	137,879	2.8
Burglary	1,498	2.3	67,058	1.4
Grand theft	615	.9	35,861	.7
Vehicle theft	730	1.1	34,960	.7
Personal	2,207	3.4	97,488	2.0
Homicide	66	.1	4,698	.1
Forcible rape	99	.2	4,966	.1
Robbery	535	.8	31,349	.6
Assault	1,507	2.3	56,475	1.1
Population at risk	65,599		4,919,000[b]	

a. All counts are adjusted to remove mental health population.
b. Estimate of 1978 general population.

One of the best-documented differences in criminal behavior is that between males and females. The data of Table 4.2 show that these differences are preserved in the mental health cohort. The drastically lower arrest rate for females in the general population is reproduced in the study population. There are, however, a number of distinctions worth noting. The differences in the arrest rate of females for misdemeanor offenses, as compared with the general population and the mental health cohort, are much larger than the corresponding differences for males. However, of the misdemeanor offenses occasioning arrest, alcohol-related problems in the mental health cohort loom much larger for males than for females, as they do as well in the general population. For all felony arrests, as well as for property and personal offenses, male-female differences in the mental health cohort largely reproduce those found in the general population.

In contrast, when sex is controlled for, some differences of possible significance between the mental health cohort and the general population emerge when age is taken into account. As seen in Table 4.3, clients of the Department of Mental Health between 18 and 25 years

Table 4.2 1976-1979 Arrests and Rates for Uniquely Identified Mental Mental Health Clients for 1978 and the General Population by Sex: Los Angeles County

	Adult Mental Health Clients		*Adult County Population*	
	Number	*Rate*	*Number*[a]	*Rate*
Males				
All arrests	25,358	77.0	1,501,262	64.6
Misdemeanor	18,894	57.4	1,410,338	49.0
Alcohol related	9,810	29.8	609,405	26.2
Other	9,084	27.6	531,333	22.9
Felony	6,464	19.6	360,924	15.5
Part I	4,365	13.2	210,243	9.0
Property	2,514	7.6	123,403	5.3
Personal	1,851	5.6	86,840	3.7
Population at risk	32,941		2,325,000[b]	
Female				
All arrests	4,732	14.5	205,992	7.9
Misdemeanor	3,556	10.9	152,623	5.9
Alcohol-related	1,567	4.8	48,947	1.9
Other	1,989	6.1	103,676	4.0
Felony	1,176	3.6	53,369	2.1
Part I	685	2.1	25,124	1.0
Property	329	1.0	14,476	.6
Personal	356	1.1	10,648	.4
Population at risk	32,658		2,594,000[b]	

a. All counts are adjusted to remove mental health population.
b. Estimate of 1978 general population

of age show lower overall arrest rates than does the same group in the general population. However, this is reversed for those over 25 years of age; the mental health cohort has an arrest rate substantially above that for this age group in the general population. This is true as well for all misdemeanor and felony arrests. In terms of average age, too, arrests on felony charges are more prevalent among the young than are misdemeanors. The median age for felony arrests among mental health clients was 24. For misdemeanors, and specifically alcohol-related arrests, the median ages were 28 and 31, respectively. However, a decided shift occurs for the younger groups in arrest charges for Part I felony offenses, including both property and personal crimes: Their rates are consistently higher than for their counterparts in the general population.

Particular note should be taken of the differences in comparative arrest rates for the younger and the older segments of the mental health cohort. While arrest rates on both misdemeanor and felony charges for the younger group are below those for the same age group in the general population, for the older group they are higher. This

Table 4.3 1976-1979 Arrests and Rates for Uniquely Identified Mental Health Clients for 1978 and the General Population by Age: Los Angeles County

	Adult Mental Health Clients		*Adult County Population*	
	Number	*Rate*	*Number*[a]	*Rate*
Population 18–25 Years Old				
All arrests	12,463	64.8	747,036	78.7
Misdemeanor	8,196	42.6	515,638	54.3
Alcohol-related	3,012	17.7	179,332	18.9
Other	5,909	30.7	336,306	35.4
Felony	4,267	22.2	231,398	24.4
Part I	2,881	15.0	94,529	10.0
Property	1,762	9.2	49,861	5.3
Personal	1,119	5.8	44,668	4.7
Population at risk	19,239		949,000[b]	
Population Over 25 Years Old				
All arrests	17,627	38.0	960,218	24.2
Misdemeanor	14,254	30.7	777,323	19.6
Alcohol-related	8,345	18.0	481-652	12.1
Other	5,909	12.7	295,671	7.4
Felony	3,373	7.3	182,895	4.6
Part I	2,169	4.7	140,838	3.5
Personal	1,081	2.3	88,018	2.2
Property	1,088	2.3	52,820	1.3
Population at risk	46,365		3,970,000[b]	

a. All counts are adjusted to remove mental health population
b. Estimate of 1978 general population

trend differs sharply from the usual declining trend in arrest rates as persons age. Suggested, then, is that the expected aging effect on offense behavior does not occur in the mental health cohort. Their arrest rates remain differentially higher as they grow older. This may indicate that one possible effect of identified mental illness is a tendency for patterns of deviant behavior to persist into older age levels.

As may be seen in Table 4.4, ethnicity as well as age is a source of variation in differential arrest patterns. The first and perhaps most striking finding is the sharp contrast in the total arrest rate between the Anglo group, the Hispanics (principally Mexican-American), and the Blacks. The latter two groups constitute the two largest minority populations in Los Angeles County. Among Anglos in the mental health cohort, arrest rates in every category of charged offense are much higher than for Anglos in the general population. But for

Table 4.4 1976-1979 Arrests and Rates for Uniquely Identified Mental Health Clients for 1978 and the General Population by Race/Ethnicity: Los Angeles County

	Adult Mental Health Clients		*Adult County Population*	
	Number	*Rate*	*Number*[a]	*Rate*
Anglo Population				
All arrests	16,142	43.1	672,737	19.1
Misdemeanor	12,254	34.6	539,146	15.3
Alcohol-related	7,308	19.5	296,509	8.4
Other	5,646	15.1	242,637	6.9
Felony	3,388	8.5	133,591	3.8
Part I	2,096	5.6	69,922	2.0
Property	1,207	3.2	44,611	1.3
Personal	889	2.4	25,311	9.7
Population at risk	37,454		3,517,000[b]	
Spanish Population				
All arrests	4,557	47.4	514,669	67.9
Misdemeanor	3,371	35.1	398,573	52.6
Alcohol-related	1,772	18.5	231,461	30.5
Other	1,594	16.6	167,112	22.0
Felony	1,186	12.3	116,096	15.3
Part I	818	8.5	65,990	8.7
Property	444	4.6	36,960	4.9
Personal	374	3.9	29,030	3.8
Population at risk	9,615		758,000[b]	
Black Population				
All arrests	9,273	55.8	482,792	104.1
Misdemeanor	6,039	36.3	324,307	69.9
Alcohol-related	2,252	13.6	111,276	24.0
Other	3,787	22.8	213,031	45.9
Felony	3,234	19.5	158,485	34.2
Part I	2,111	12.7	95,825	20.7
Property	1,175	7.1	54,497	11.7
Personal	936	5.6	41,328	8.9
Population at risk	16,617		464,000[b]	
All Other Populations				
All arrests	118	6.2	37,056	20.6
Misdemeanor	86	4.5	30,935	17.2
Alcohol-related	40	2.1	18,706	10.4
Other	46	2.4	12,229	6.8
Felony	32	1.7	6,121	3.4
Part I	25	1.3	3,630	2.0
Property	17	.9	1,811	1.0
Personal	8	.4	1,819	1.0
Population at risk	1,893		180,000[b]	

a. All counts are adjusted to remove mental health population.
b. Estimate of 1978 general population.

both the Hispanics and the Blacks, the reverse is the case. Rates for all arrests, for misdemeanors, and for all felonies are consistently higher in the Hispanic and Black general population than for the Anglo general population. Within the two minority groups, such differences are larger for the Black than for the Hispanic group in the mental health cohort. In the Black group, rates for all arrests, and for misdemeanors that are both alcohol- and non-alcohol-related, are twice as high among their counterparts in the general population as in the mental health cohort. This discrepancy persists in the Black group for felony arrests, declining only slightly for the Part I felonies.

As for differences in arrest rates among ethnic groups in the mental health cohort, these are entirely similar to differences among ethnic groups in the general population. Within the mental health cohort, Blacks had the highest arrest rates, followed in descending order by Hispanics, then Anglos, and the "all other" group. The latter consists principally of Orientals and, among them, of Japanese-Americans. The latter group deserves special comment. Note that while the rate of all arrests for the "all other" group in the general population is virtually identical with that of the Anglos in the general population, the rate of arrests for the "all other" members of the mental health cohort is drastically lower than for the Anglo members (6.2 versus 43.1).

There are additional unstable differences by ethnicity. Felony arrest rates escalate much more rapidly across ethnic groups in the general population than they do across the corresponding groups in the mental health cohort. While this rate is about ten times higher for Blacks than for Anglos in the general population (3.8 versus 34.2), it is only twice as high in the mental health cohort (8.5 versus 19.5). The same differences hold for both property and personal arrest charges. The differences between Anglos and Blacks in the general population are much greater than they are in the mental health cohort.

Thus far, attention has been confined to the issue of proportionality; that is, the extent to which rates of arrest in the mental health cohort—and in the age, sex, and ethnic subgroups of the cohort—vary in a pattern similar to that found in the corresponding categories in the general population. These comparisons are summarized in Table 4.5, illustrating the fact that the proportion of each of the subcategories defined for this analysis varies in striking ways in comparison to their proportion in the general population. While the two sexes are proportionally represented, as are the Hispanic and the "all other" ethnic groups, heavily overrepresented in the cohort are the 18- to 25-year-old group and the Black group. Underrepresented are the group over 25 years of age and the Anglos. This finding

Table 4.5 1976-1979 Arrests, Activity Rates, and Client Rates for Uniquely Identified Adults: Los Angeles County Community Mental Health Clients for 1978

	With at Least One Arrest for One Client		*Total Arrests*		*Maximum Arrests for at Least One Client*
	Number	*Rate*	*Number*	*Rate*	*Number*
All arrests	10,859	16.6	30,090	45.9	118
Misdemeanor	8,941	13.6	22,450	34.2	116
Felony	4,690	7.1	7,640	11.6	12
Males	3,793	11.5	6,464	19.6	12
Females	897	2.7	1,176	3.6	8
Males, Part I					
18 to 25 years					
Anglo	634	11.9	818	15.4	8
Spanish	205	11.4	296	16.4	7
Black	422	12.0	610	17.3	8
Other	7	2.4	8	2.7	2
26 years and older					
Anglo	570	4.4	864	6.6	8
Spanish	223	7.1	381	12.1	9
Black	676	12.9	1,152	21.9	9
Other	6	1.0	11	1.9	5
Males, Felony Property					
18 to 25 years					
Anglo	356	6.7	457	8.6	8
Spanish	123	6.8	166	9.2	5
Black	231	6.6	320	9.0	8
Other	3	1.0	4	1.4	2
26 years and older					
Anglo	404	3.1	598	4.6	8
Spanish	145	4.6	224	7.1	7
Black	472	9.0	735	14.0	8
Other	5	.8	10	1.7	5
Males, Felony Personal					
18 to 25 years					
Anglo	318	6.0	361	6.8	4
Spanish	103	5.7	130	7.2	5
Black	239	6.8	290	8.2	5
Other	4	1.4	4	1.4	1
26 years and older					
Anglo	225	1.7	266	2.0	4
Spanish	123	3.9	157	5.0	4
Black	332	6.3	417	7.9	4
Other	1	.2	1	.2	1

Table 4.6 General Percentage Distribution of Ascribed Characteristics in 1978 for Uniquely Identified Adult Community Mental Health Client and the Adult General Population: Los Angeles County

	Community Mental Health		*County Population*[a]	
	Number	*Percentage*	*Number*	*Percentage*
Total Population	65,599	100.0	4,919,000	100.0
Sex				
Males	32,941	50.2	2,325,000	47.3
Females	32,658	49.8	2,594,000	52.7
Age				
Age 18-25	19,234	29.3	949,000	19.3
Age Over 25	46,365	70.7	3,970,000	80.7
Race/Ethnicity				
Anglo	37,474	57.1	3,517,000	71.5
Spanish	9,615	14.7	758,000	15.4
Black	16,617	25.3	464,000	9.4
Other (e.g., Asian)	1,893	2.9	180,000	3.7

a. All counts are adjusted to remove mental health populations and are estimates of the 1978 general population.

qualifies the case often argued that minority groups are inadequately served by public mental health agencies. Among the offender subset of the mental health cohort, the Anglo population was the most sharply underrepresented, though constituting some 57% of all clients of the Department.

Finally, the mental health cohort data were examined for differences in cumulative arrest rates, as well as rates for those with at least one arrest for one client, including both males and females and, among males, for the older and younger segments in each of the ethnic categories (Table 4.6). The data provide some indication of rearrest rates for this population. No comparison was possible with the general population. The rearrest rates of those in the general population ever arrested are essentially unknown, although efforts have been made to estimate them indirectly (Blumstein and Larson, 1969; Greenberg, 1975).

To be noted is the very large difference between rates of those ever arrested and cumulative arrest rates for both misdemeanor and felony offenses for the entire cohort, including males and females. Misdemeanors are by far the most frequent type of offense for which an arrest is recorded. Each client accumulated on the average approximately three misdemeanor arrest charges over the four-year period, in contrast to an average of about one and a half felony arrest charges.

However, males averaged almost two such charges in the course of the four years. Arrest rates for Part I offenses for younger and older males in the several ethnic categories reveal striking differences. Among Anglo and Hispanic males, both the ever arrested and the cumulative arrest rates show sharp declines with advancing age. This is not true, however, for Black males, where the high rates for the young hold as well for the older group. Indeed, the rates of arrest for felony property offenses for Black males rise with advancing age, in contrast to their decline among all other ethnic groups. In addition, arrest rates for felony personal offenses among Black males exhibit substantially less decline with advancing age than is true for either Anglo or Hispanic males. For Anglo males in the cohort, the cumulative arrest rate for person offenses declines from 6.8 to 2.0, for Hispanic males from 7.2 to 5.0, and for the Black males from 8.2 for the younger group to 7.9 for the older.

Finally, the pattern of rearrest frequency is striking and possibly instructive. The least serious misdemeanor offenses generate the highest frequency of rearrest, reaching 118 in one individual. But as the seriousness of offense increases, the frequency of arrest is sharply reduced, averaging four per client in crimes against persons. This pattern holds for both the younger and the older groups, as well as for all ethnic categories. Apparently the societal response to offense behavior as represented by arrests reflects the level of tolerance for deviant acts without respect to the mental health status of the offender. As may be the case for "normal" offenders, the reduced frequency with which mental health clients are arrested for the more serious offenses is a function not necessarily of reduced proneness to commit such offenses but of their more frequent incapacitation by the criminal justice system. It is thus possible that as regards the more serious offenses, the criminal justice system may well have been under increasing pressure during the period of the rise of the community treatment movement to imprison substantial numbers of the mentally ill.

Disposition of Part I Arrests

Whether arrests of the clients of the Department of Mental Health are dealt with by the criminal justice system differently from general population arrests was examined in a series of analyses based on California's Offender-Based Transaction Statistics files (1976–1980), which record only the disposition of those arrested on a felony charge. Dispositions of total Part 1 arrests at the police, lower court, and

Superior Court stages were compared with the dispositions of arrests among 47,995 first admissions to the Department of Mental Health in 1978. It should be noted, again, that this cohort differs from the sample used thus far in that it excludes all individuals who had a prior admission in 1976 and 1977. Also excluded so as not to bias the results were 5667 individuals classified as alcoholics, drug addicts, or mentally disordered offenders.

Dispositions for the mental health cohort arrested within a 24-month period prior to each client's first admission date in 1978 (that is, in 1976–1977) were compared with dispositions of the total arrested adult population in 1977. Dispositions of the cohort of clients arrested during the 24 months (that is, in 1979–1980) after being admitted as clients of the Mental Health Department were compared with the total arrested in 1979. For both total arrests and arrests of mental health clients, data were obtained for the seven major offenses (homicide, rape, assault, robbery, burglary, theft, and vehicle theft) commonly referred to as Part I crimes. For purposes of analysis, arrest charges were treated as falling into two classes: personal and property offenses. Included in personal offenses were homicide, rape, assault, and robbery; burglary, theft, and vehicle theft constituted the property offense category.

The extent to which dispositions accorded arrested mental health clients at each stage of the criminal justice process differed from those for the total arrested population was measured by using two forms of Z statistics for testing proportions. First, a one-sample difference-of-proportions test was applied in which each type of disposition in the total arrested population was treated as the standard for comparison. Using a Z-score transformation, the difference between the standard and the proportion for the same disposition in the mental health client sample was measured in standard score units. This measure is presented mainly for descriptive purposes. For each category of disposition, it indicates the extent and direction of the difference in the way criminal justice agencies processed mental health clients both before and after their admission to the Department of Mental Health in comparison with dispositions generally accorded those arrested for felony offenses.

To assess trends in justice agency responses to mental health clients, comparative changes in dispositions during the 1976—1980 period for the total arrested population and arrested mental health clients, comparative changes in dispositions during the 1976-1980 test. To determine shifts in police and court treatment of mental health clients, it is clearly necessary to view such changes in relation to ongoing changes in dispositional practices affecting the total arrested population.

Table 4.7 Disposition of Felony Arrests by Police, Personal Offenses,[a] Total Arrests 1977 and 1976–1977 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.1 (15,371)	100.0 (399)	
Released	18.4 (2,834)	16.5 (66)	.98
Complaints denied	21.3 (3,280)	14.5 (58)	3.32[b]
Misdemeanor filed	33.2 (5,107)	36.1 (144)	1.65
Felony filed	27.0 (4,150)	29.3 (117)	.90
Transferred other jurisdictions		3.5 (14)	—

a. Homicide, rape, assault, and robbery.
b. Significant at .05, two tailed test.

Table 4.8 Disposition of Felony Arrests by Police, Personal Offenses,[a] Total Arrests 1979 and 1979–1980 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (18,869)	100.0 (716)	
Released	21.4 (4,044)	15.4 (110)	3.91[b]
Complaints denied	16.4 (3,089)	14.9 (107)	1.08
Misdemeanor filed	31.9 (6,028)	36.2 (259)	-2.47[b]
Felony filed	30.3 (5,708)	28.5 (204)	1.05
Transferred other jurisdictions		5.0 (36)	

a. Homicide, rape, assault, and robbery.
b. Significant at .05, two tailed test.

POLICE DISPOSITIONS OF ARRESTS

One-sample test of proportions. Tables 4.7–4.10 present comparative dispositions of arrests at two time periods for offenses against persons and property offenses. With respect to the disposition of mental health clients arrested for personal offenses (Tables 4.7 and 4.8), the only uniform pattern appears to have been a tendency for complaints filed to be denied by the prosecutor's office with differentially greater frequency ($Z = 3.32$ and 1.08), and for police to file misdemeanor rather than felony charges with differentially reduced

Table 4.9 Disposition of Felony Arrests by Police, Property Offenses,[a] Total Arrests 1977 and 1976–1977 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (20,450)	100.0 (613)	
Released	20.8 (4,262)	12.4 (76)	5.18[b]
Complaints denied	14.2 (2,895)	10.4 (64)	2.70[b]
Misdemeanor filed	39.3 (8,045)	39.0 (239)	.20
Felony filed	25.7 (5,248)	33.1 (203)	4.19[b]
Transferred other jurisdictions		5.1 (31)	

a. Burglary, theft, and vehicle theft
b. Significant at .05, two-tailed test.

Table 4.10 Disposition of Felony Arrests by Police, Property Offenses,[a] Total Arrests 1979 and 1979–1980 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (25,276)	100.0 (973)	
Released	22.2 (5,603)	17.4 (169)	3.60[b]
Complaints denied	11.0 (2,769)	12.1 (118)	-1.00
Misdemeanor filed	43.3 (10,954)	36.8 (358)	-4.10[b]
Felony filed	23.5 (5,950)	27.4 (272)	3.31[b]
Transferred other jurisdictions		5.8 (56)	

a. Burglary, theft, and vehicle theft
b. Significant at .05, two-tailed test

frequency ($Z = -1.65$ and -2.47). On the other hand, among mental health clients arrested for property offenses (Tables 4.9 and 4.10), releases by the police were more frequent ($Z = 5.18$ and 3.60) and there was a reduced tendency to file felony charges ($Z = -4.19$ and -3.31).

Difference of proportions. Tables 4.11 and 4.12 present differential changes in patterns of police disposition for arrested mental health clients over the last half of the 1970s in Los Angeles County. It should be borne in mind here that the initial period, 1976–1977, involved clients of the Department of Mental Health prior to their

Table 4.11 Two-Sample Test of Difference of Proportions, Police Dispositions of Arrests for Felony Person Offenses,[a] Total Arrests and Arrests of 1978 Cohort Prior and Subsequent to 1978 First Admission to Department of Mental Health, Los Angeles County

	County		*Mental Health Cohort*		*Difference of*	
	1977	*1979*	*1976-77*	*1979-80*	*Proportion*	*Z-Score*
Arrests	15,371	18,869	399	716	.09	
Released	2,834	4,044	66	110	.04	.97
Complaints denied	3,280	3,089	58	107	.16	4.18[b]
Misdemeanor filed	5,107	6,028	144	259	.10	4.08[b]
Felony filed	4,150	5,708	117	204	.06	2.04[b]

a. Homicide, rape, assault, and robbery.
b. Significant at .05, two-tailed test.

Table 4.12 Two-Sample Test of Difference of Proportions, Police Dispositions of Arrests for Felony Property Offenses,[a] Total Arrests and Arrests of 1978 Cohort Prior and Subsequent to 1978 First Admission to Department of Mental Health, Los Angeles County

	County		*Mental Health Cohort*		*Difference of*	
	1977	*1979*	*1976-77*	*1979-80*	*Proportion*	*Z-Score*
Arrests	20,450	25,276	613	973	06	
Released	4,262	5,603	76	169	12	3.81[b]
Complaints denied	2,895	2,769	64	118	16	4.18[b]
Misdemeanor filed	8,045	10,954	239	358	02	1.10
Felony filed	5,248	5,950	203	272	04	1.75

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

Table 4.13 Disposition of Felony Arrests in Lower Court, Personal Offenses,[a] Total Arrests 1977 and 1976–1977 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (15,371)	100.0 (399)	
Convictions	28.5 (3,918)	34.6 (138)	4.14[b]
Probation	42.1 (1,651)	36.2 (50)	1.40
Probation and jail	33.2 (1,302)	43.5 (60)	2.64[b]
Jail	16.4 (644)	17.4 (24)	.32
Other	8.2 (321)	2.9 (4)	2.27[b]

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

entry as patients, and that in the later (1979–1980) period, having been admitted to the Department in 1978, they were already identified as patients. We have assumed that there would have been little difference in the response of the criminal justice system with reference to their law violations before and after admission as clients of the department. Z-score values presented in Tables 4.11 and 4.12 measure the extent to which changes in the disposition of arrested mental health clients exceeded, were similar to, or fell below changes in dispositions accorded the total arrested population.

The data generally indicate not only a differentially larger increase in arrests of mental health clients, but a differentially larger increase in every one of the disposition categories for both personal and property offenses, with the single exception of releases on arrests for offenses against persons. Two developments are to be noted in particular. On the one hand, there was a trend for proportionately more police complaints lodged against members of the mental health cohort to be denied by the prosecutor's office. On the other hand, this trend was accompanied by a differential increase in both misdemeanor and felony filings initiated by the police. Thus, the differential increase in arrests of mental health clients imposed a growing burden on both the prosecutor's office and the police.

It is apparent as well that the enforcement arm of the criminal justice system has come increasingly to function as a primary filter in dealing with the offenses of mental health patients as their number in treatment in the community has grown. In the more recent (1979–1980) period, proportionately more mental health clients than "normal" offenders were subjected to arrest, with proportionately more released (excepting those arrested for person offenses), more complaints denied, and more processed further on misdemeanor and felony charges.

In general, then, the trend has been for mental health clients arrested for violent offenses to be more frequently accorded dispositions quite different from those given "normals" arrested for the same offenses, while this was not the case in arrests for property offenses. The specific differences are indicated in Tables 4.7–4.12. A summary comparison of the percentage distribution in Tables 4.7–4.10 reveals that after admission as clients, police disposition differences between clients and the general population declined. That is, police disposition of mental health clients resembled that for the total arrested population more closely after the former's admission to the Department of Mental Health. This trend is consistent even though there is a relative greater increase in arrests of clients after their first-admission status.

Diminishing differences were further suggested in Tables 4.11 and 4.12. Relative to changes in disposition for the total arrested population, mental health clients arrested for property offenses came to be released more frequently than were mental health clients arrested for violent offenses ($Z = 3.81$ versus .97). And while Z scores indicating a comparative change for complaints denied were both much higher than for the total arrested population and identical ($Z = 4.18$) for both property and personal offenses, there occurred a comparatively greater increase in misdemeanor and felony filings on arrests of mental health clients for personal than for property offenses.

LOWER COURT DISPOSITIONS

Virtually all arrests in which police complaints are accepted for further processing by the prosecutor's office are subjected to an initial hearing in the lower, or municipal, court in Los Angeles County. The police disposition data of Tables 4.7–4.10 indicate that approximately one-third of police arrests based on a Part I felony charge are subsequently reduced to a misdemeanor charge for disposition in the lower court. A small number of felony charges for which the possible penalty on conviction is incarceration for less than one year are tried and disposed of in the lower courts, but the bulk of cases tried in these courts are on misdemeanor charges. Felony charges carrying a possibly longer period of incarceration as the penalty on conviction are given an initial hearing in the lower courts as to the substantiality of the evidence and, if accepted, are heard in Superior Court.

One-sample test of proportions. On conviction in the lower courts for either personal or property offenses, mental health clients were consistently placed on probation in proportions lower than those for the local convicted group (Tables 4.13–4.15). However, they were also consistently given a sentence of jail plus probation in proportions exceeding those for the total convicted group. Differences between the two groups in all other dispositions varied in apparently random fashion, suggesting the operation of unknown local and idiosyncratic factors.

It would seem, then, that the lower courts tended generally to regard straight probation as a relatively unsuitable disposition for convicted mental health clients. And, while jail plus probation for all convicted offenders (ranging from 33.2% to 46.0% of all dispositions)

Table 4.14 Disposition of Felony Arrests in Lower Court, Personal Offenses,[a] Total Arrests 1979 and 1979–1980 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (18,869)	100.0 (716)	
Convictions	35.1 (6,632)	33.5 (240)	.89
Probation	38.7 (1,879)	26.7 (64)	3.82[b]
Probation and jail	41.1 (1,993)	55.4 (133)	4.50[b]
Jail	15.1 (735)	17.5 (42)	1.04
Other	5.1 (246)	.9 (1)	-3.31[b]

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

Table 4.15 Disposition of Felony Arrests in Lower Court, Property Offenses,[a] Total Arrests 1977 and 1976–1977 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (20,450)	100.0 (614)	
Convictions	34.1 (6,982)	38.4 (236)	2.15[b]
Probation	34.0 (2,373)	29.7 (70)	-1.39
Probation and jail	39.7 (2,782)	47.0 (111)	2.26[b]
Jail	21.1 (1,473)	17.4 (41)	-1.39
Other	5.1 (354)	5.9 (14)	.56

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

was the favored disposition, it was invoked proportionately more for convicted mental health clients. This would be likely to have the effect of increasing the number of mental health clients incarcerated in the country jail, whether or not they were recognized as having been, or were potentially subject to being, so identified.

Difference of proportions. Examined here, again, are comparative shifts between 1976 and 1980 in the proportionate use of the several dispositions in the lower courts for the mental health cohort. As seen in Table 4.17, while all arrests for personal crimes underwent an increase during this period, the rise in arrests for mental health clients was even more precipitous ($Z = 6.07$). Moreover, the same differentially greater increase occurred in mental health clients convicted for

Table 4.16 Disposition of Felony Arrests in Lower Court, Property Offenses,[a] Total Arrests 1979 and 1979–1980 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion (Z Score)*
Arrests	100.0 (25,276)	100.0 (974)	
Convictions	39.3 (9,925)	40.1 (391)	.57
Probation	28.7 (2,844)	18.7 (73)	4.37[b]
Probation and jail	46.0 (4,570)	52.2 (204)	2.46[b]
Jail	22.0 (2,183)	27.3 (107)	2.58[b]
Other	3.3 (328)	1.7 (7)	−1.66

a Burglary, theft, and vehicle theft
b Significant at .05, two-tailed test

Table 4.17 Two-Sample Test of Difference of Proportions, Lower Court Dispositions of Arrests for Felony Personal Offenses,[a] Total Arrests and Arrest of 1978 Cohort Prior and Subsequent to First Admission to Department of Mental Health, Los Angeles County

	County		*Mental Health Cohort*			*Difference*
	1977	*1979*	*1976-77*	*1979-80*	*Proportions*	*of Z-Score*
Arrests	15,371	18,869	399	716	.09	
Convictions	3,918	6,632	138	499	.15	7.00[b]
Probation	1,651	1,879	50	64	.03	.62
Probation and jail	1,302	1,993	60	133	.03	2.47[b]
Jail	644	735	24	42	06	1.69

a Burglary, theft, and vehicle theft
b. Significant at .05, two-tailed test

personal crimes (Z = 7.00). Respecting sentence on conviction, with the exception of the sentence of probation, there occurred a larger increase in the sentences of probation plus jail and of jail alone for convicted mental health clients than for the total convicted group (Z = 2.47 and 1.69, respectively).

With two exceptions, similar trends are seen for property offenses (Table 4.18). With a differentially greater increase in arrests of mental health clients for property offenses (Z = 4.31), the lower courts convicted proportionately larger numbers over time (Z = 5.36) and came to make relatively greater use of the jail sentence (Z = 3.07). As in the case of personal crimes, however, the sentence of probation for mental health clients showed about the same increase as was true for the total convicted group (Z = .83). But unlike the

Table 4.18 Two-Sample Test of Difference of Proportions, Lower Court Dispositions of Arrests for Felony Property Offenses,[a] Total Arrests and Arrests of 1978 Cohort Prior and Subsequent to First Admission to Department of Mental Health, Los Angeles County

	County		*Mental Health Cohort*			*Difference of Z-Score*
	1977	*1979*	*1976-77*	*1979-80*	*Proportions*	
Arrests	20,450	25,276	613	973	.06	
Convictions	6,982	9,925	236	391	.007	5.36[b]
Probation	2,373	2,844	70	73	.04	.83
Probation and jail	2,782	4,570	111	204	.03	.03
Jail	1,473	2,183	41	107	.13	3.07[b]

a. Burglary, theft, and vehicle theft
b. Significant at .05, two-tailed test

substantial differential rise in jail plus probation sentences for mental health clients convicted of personal offenses, the increase in the use of this sentence for those convicted of property offenses showed no rise relative to its increased use for the total convicted group ($Z = .03$). Thus, the five-year trend shows convictions of mental health clients to have increased in the lower courts proportionately more than they did for the total group convicted in these courts. Of sentences received, mental health clients tended disproportionately to be accorded the incarceration dispositions of probation plus jail and straight jail. It should be noted that convictions obtained in the lower courts are generally on a misdemeanor charge with commitment to the county jail. Again, as suggested by the difference-of-proportion measure, the trend toward a growing differential use of incarceration sentences for mental health clients indicates that they were likely to become a larger proportion of local jail inmates.

SUPERIOR COURT DISPOSITIONS

Approximately one-fifth of all felony arrests reach the Superior Court and result in a conviction there. With minor variations, this ratio holds for the total arrested population as well as for arrested mental health clients. Attention is here given, first, to differences in the proportion of dispositions this court accorded the two groups and, second, to comparative changes in disposition for the mental health cohort over the five-year period, 1976–1980.

One-sample test of proportion. Differential dispositions of mental health clients in the Superior Court are unlike those seen in the lower courts. There, the proportion of probation sentences for mental health

Table 4.19 Disposition of Felony Arrests in Superior Court, Personal Offenses,[a] Total Arrests 1977 and 1976-1977 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion Z-Score*
Arrests	100.0 (15,371)	100.0 (399)	
Convictions	19.7 (3,030)	18.3 (73)	-.70
Prison	33.6 (1,017)	23.3 (17)	1.86
Probation	10.7 (331)	12.3 (9)	.38
Probation and jail	40.4 (1,223)	53.4 (39)	2.26[b]
Jail	3.7 (112)	6.8 (5)	1.40
Other	11.4 (347)	4.1 (3)	1.98[b]

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

Table 4.20 Disposition of Felony Arrests in Superior Court, Personal Offenses,[a] Total Arrests 1979 and 1979-1980 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion Z-Score*
Arrests	100.0 (18,869)	100.0 (716)	
Convictions	23.4 (4,418)	18.7 (134)	-2.94[b]
Prison	38.4 (1,698)	35.1 (47)	.79
Probation	9.3 (409)	9.0 (12)	-.12
Probation and jail	38.5 (1,700)	44.7 (60)	1.50
Jail	3.2 (142)	2.2 (3)	.66[b]
Other	10.6 (469)	9.0 (12)	.65

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

clients was relatively low, while that of probation plus jail was relatively high. In the Superior Court, on the other hand, there was generally reduced consistency in the differential disposition of mental health clients (Tables 4.19–4.22).

For example, their differential exposure to imprisonment varied with respect to both the type of offense and the time period concerned. Further, while they were on the whole accorded probation in approximately the same proportion as the total group convicted in this court, during the 1979–1980 period the proportion receiving this sentence was significantly reduced. The reverse was true for the probation plus

Table 4.21 Disposition of Felony Arrests in Superior Court, Personal Offenses,[a] Total Arrests 1977 and 1976-1977 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion Z-Score*
Arrests	100.0 (20,450)	100.0 (614)	
Convictions	19.1 (3,913)	22.5 (138)	2.00[b]
Prison	11.4 (446)	5.1 (7)	-2.33[b]
Probation	17.5 (686)	15.2 (21)	.71
Probation and jail	53.0 (2,075)	68.8 (88)	2.59[b]
Jail	7.5 (294)	7.9 (11)	.22
Other	10.5 (412)	7.9 (11)	.96

a. Burglary, theft, and vehicle theft.
b. Significant at .05, two-tailed test.

Table 4.22 Disposition of Felony Arrests in Superior Court, Personal Offenses,[a] Total Arrests 1979 and 1978-1980 Arrests of 1978 Cohort of First Admissions to Department of Mental Health, Los Angeles County

	County	*Mental Health Cohort*	*Difference of Proportion Z-Score*
Arrests	100.0 (25,276)	100.0 (974)	
Convictions	19.0 (4,793)	19.2 (187)	.14
Prison	19.1 (917)	21.9 (41)	.97
Probation	14.1 (676)	10.2 (19)	-1.41
Probation and jail	54.9 (2,631)	53.5 (100)	-.38
Jail	4.7 (225)	4.3 (8)	-.26
Other	7.4 (344)	10.2 (19)	1.59

a. Burglary, theft, and vehicle theft.

jail sentence. Mental health clients were given this disposition in relatively higher proportions for both personal and property offenses, except for conviction on property offenses in the 1979–1980 period, when the proportion approached that given the total convicted group.

Such shifts in the comparative proportion of dispositions accorded mental health clients suggest that in the Superior Court, which deals with more serious offenses, there may be somewhat less routinization of disposition patterns in cases involving mental health clients than may be found in the lower courts. Required in the Superior Court

Table 4.23 Two-Sample Test of Difference of Proportions, Superior Court Dispositions of Arrests for Felony Personal Offenses,[a] Total Arrests and Arrest of 1978 Cohort Prior and Subsequent to First Admission to Department of Mental Health, Los Angeles County

	County		*Mental Health Cohort*			
	1977	*1979*	*1976-77*	*1979-80*	*Proportions*	*Difference of Z-Score*
Convictions	3,030	4,418	73	134	.54	1.54
Prison	1,017	1,698	17	47	.11	1.83
Probation	338	409	9	12	.11	.16
Probation and jail	1,223	1,700	39	60	.02	.46
Jail	112	142	5	3	.18	-.03

a Burglary, theft, and vehicle theft

prior to the imposition of sentence is a presentence investigation and report prepared by a probation officer. This provides for the sentencing judge fairly extensive information about the offender and the circumstances of the offense, furnishing grounds for an enlarged scope of judicial discretion and greater variation in choice of sentence.

Difference of proportions. Data presented in Tables 4.23 and 4.24 disclose the pattern of comparative change in Superior Court dispositions during the 1976–1980 period. A number of trends are apparent. First, while the proportion of property offenders in the mental health cohort who were convicted in this court show no change relative to change for the total convicted group, the proportion of personal offenders in the cohort who were convicted increased substantially ($Z = 1.54$). Second, there occurred disproportionate increases for both property and personal offenders who received a prison sentence on conviction ($Z = 2.62$ and 1.83, respectively). Third, with a single exception, changes in the sentences of probation and probation plus jail accorded mental health clients convicted for both personal and property offenses were approximately equivalent to changes in the use of these sentences for the total convicted group. The single exception was the disproportionately reduced use of the straight jail sentence for mental health clients convicted of property offenses, although small numbers in this instance would make the exception questionable.

Perhaps the single striking shift in Superior Court dispositions over the 1976–1980 period was the comparative increase in the use of the prison sentence for mental health clients. This was more the case for personal than for property offenders. Less striking, but nonetheless apparent, was the trend toward equivalence with the total convicted

Table 4.24 Two-Sample Test of Difference of Proportions. Superior Court Dispositions of Arrests for Felony Personal Offenses,[a] Total Arrests and Arrest of 1978 Cohort Prior and Subsequent to First Admission to Department of Mental Health, Los Angeles County

	County		*Mental Health Cohort*			
	1977	*1979*	*1976-77*	*1979-80*	*Proportions*	*Difference of Z-Score*
Convictions	3,913	4,793	138	187	.03	.86
Prison	446	917	7	41	.18	2.62[b]
Probation	686	676	21	19	08	-.26
Probation and jail	2,075	2,631	88	100	03	-.73
Jail	294	225	225	8	.01	-3.09[b]

a Burglary, theft, and vehicle theft
b Significant at .05, two-tailed test.

group in the proportionate increase in both probation and probation plus jail. Thus, whatever tendency the Superior Court exhibited in according mental health clients some level of distinctive treatment was expressed in a greater readiness to use the prison sentence.

SUMMARY AND CONCLUSIONS

Arrests

The findings of this study clearly suggest that the rates of arrest for a population cohort under treatment in community mental health programs are consistently higher than those for the general population. Nevertheless, the pattern of distribution by type of offense for which the mental health cohort are arrested is parallel to the pattern for the general population.

The general form of the differences in arrest rate between individuals under community treatment and the general population may be summarized as follows:

(1) Females in the mental health cohort are arrested at higher rates, particularly for misdemeanor offenses, than are females in the general population.
(2) Arrest rates fall less rapidly with advancing age for the mental health cohort than for the general population. Aging has relatively less effect in reducing the arrest rates of mental health clients.
(3) Arrest rates for the Hispanic and Black members of the cohort are substantially lower than for these groups in the general

population. In contrast, arrest rates for Anglo clients of the department are higher than for the general Anglo population.

(4) Within the mental health cohort, arrest rates for Anglo and Hispanic males are lower for the older (over 25) age group than for the younger (under 25) age group. In the Black male group, in contrast, the high rates of arrest for those under 25 persist in the older, over 25, group. This feature of the Black male members of the mental health cohort suggests the possibility that the Department of Mental Health may be inadvertently selecting out of the Black population only the more crime-prone of its mentally ill members.

(5) Rearrest rates of the mental health cohort decline as offenses become more serious. This may indicate that, as is likely for the general population as well, there occurs an increased use of imprisonment for mental health clients who commit more serious offenses.

The analysis of differential arrest rates should not be allowed to obscure the fact that mental health patients under treatment in the community are a small fraction of the total number arrested. It is important to bear in mind that despite their higher arrest rates, the mental health cohort contributes a very small increment to the total volume of arrests. The data of Table 4.1 show that of the 1,737,344 arrests in both the general population and the mental health cohort recorded for Los Angeles County during the years 1976 to 1979, the 30,090 arrests for the latter may be conservatively estimated as having constituted 1.7% of the total. But since they made up 1.3% of the adult population, the proportion of their arrests was some 30% greater than their proportion in the population. They may thus be seen as another of the special populations—such as males, the youth group, and the disadvantaged minority groups—that in a modest way contribute more than their proportionate share to the police workload.

Patterns of Felony Arrest Dispositions

The bulk of previous research in this area has focused only on arrest rates (Teplin, 1984, this volume). In contrast, this chapter examines the entire criminal justice process. Thus, we have explored the distinctive character of dispositions accorded arrested mental health clients charged with felony personal and property offenses as they were selected and moved through the police, lower court, and Superior Court stages of the criminal justice process. To discern any differences between dispositions accorded mental health clients and those

accorded the total arrested population at each stage, a cohort of community mental health adult clients was identified who were first admitted to the Los Angeles Department of Mental Health in 1978. The arrests and dispositions for a 24-month period before and after initial date of admission was then compared to those of the general arrested felony population.

Police dispositions. While not differing from the total arrested population in their proportional frequency of arrest for both personal and property offenses, mental health clients were generally more frequently released by the police without the filing of a charge after admission to the Department of Mental Health. However, when arrested for personal offenses, mental health clients were more likely to be released at the station level, to be confronted with a felony charge, and to have the complaint denied by the prosecutor's office. When arrested for a property offense, mental health clients were more likely to be faced with a misdemeanor rather than felony charge, and less likely to have the complaint denied. Although the police tended more frequently to release arrested mental health clients, in cases of personal offenses they more frequently filed a felony complaint, only to have those complaints more frequently rejected for prosecution. Thus, mental health clients arrested for personal offenses who were not released were more often than "normals" faced with a felony complaint but less often moved to prosecution. In contrast, mental health clients arrested for a property offense who were not released were more likely to have a misdemeanor rather than a felony complaint filed, and more likely to be faced with prosecution.

Trends in the differential pattern of police disposition of arrested mental health clients during the 1976–1980 period of the study show, first, a differentially greater increase in arrests of mental health clients during this period for both personal and property offenses. With the single exception of police releases of clients arrested for personal offenses, in which the trend was indistinguishable from that for the total personal offense group, all other disposition categories show differentially greater increases for the mental health client group. For both personal and property offenders, there was a greater increase in both felony and misdemeanor filings for the mental health group, coupled with a greater increase in complaints denied by the prosecutor's office. Thus, the net differential trend over this period was a growing involvement of enforcement agencies in dealing with the mentally ill population.

The trend in disparity between the police disposition pattern for mental health client arrestees and for the total arrested group revealed

a declining difference for property offenders and an increasing difference for personal offenders. Stated otherwise, police disposition of mental health clients who were arrested for property offenses came over time to resemble more closely those for the entire group of arrested property offenders. In contrast, for mental health clients arrested for personal offenses, the disposition pattern grew less similar.

Lower court dispositions. The pattern of differential dispositions of identified mental health clients in the county's lower courts was identical for those who were both personal and property offenders. While the proportion convicted did not deviate materially from the proportion of the entire convicted group, mental health clients were less frequently accorded straight probation, more frequently given sentences of probation plus jail and jail only, and less frequently given residual "other" sentences. The significant pattern difference was thus a reduced use of straight probation coupled with an increased use of local incarceration.

On the other hand, when examining the before and after pattern, the trend indicates a differential increase in convictions for mental health clients. The trend regarding differences in the use of probation was toward parity with its use for the total convicted group. But the two types of disposition entailing incarceration tended over time to be differentially accorded mental health clients convicted for personal offenses. Mental health clients convicted for property offenses, except for the differentially growing proportion convicted, tended also differentially to be accorded the jail-only sentence. The net effect of these trends in all likelihood was to increase the proportion of mental health clients among violent offenders incarcerated in the county jail.

As to trends in the overall disparity in disposition between mental health clients and the total convicted group, the pattern over the 1976–1980 period became more pronounced. This was the reverse of the trend in pattern disparity for police dispositions, where pattern disparity tended to decline.

Superior Court dispositions. Cases of mental health clients that reached the Superior Court after their first admission into community mental health facilities received dispositions generally quite similar to those accorded the total covicted group. The few differences that did exist concerned the reduced proportion of personal offenders who were convicted; the high proportion of personal offenders among mental health clients given sentences of probation plus jail; the high proportion of property offenders committed to prison; and the lower proportion among property offenders accorded jail-only sentences.

Trends in Superior Court dispositions over the before and after period included a differentially greater increase in convictions of mental health clients for personal offenses and, for these as well as for property offenders, a greater increase in the use of prison sentences. The only other differential trend concerned property offenders among mental health clients. These tended over time to be accorded jail-only sentences in lower proportions.

Finally, disparity in disposition patterns between convicted mental health clients and the total convicted group show a reduction over time. The patterns for the two groups became emphatically more similar. The trend toward reduction of disposition pattern disparity was more pronounced at the Superior Court than at the police stage, reversing the increase in disparity evident at the lower court stage. The reason for the reversal of the pattern disparity trend in the lower court is not altogether clear. A possible explanation may lie in the fact that this court deals principally with misdemeanor offenses and has shown a tendency differentially to deny probation in cases involving mental health clients, and differentially to accord such offenders incarceration sentences in the county jail.

Conclusion

In conclusion, while some of the findings presented were anticipated, it was quite unexpected to find the overall pattern of arrest rates within the general population reproduced in the mental health cohort. Indeed, the initial contact with the criminal justice system by community mental health clients is generally a mirror image of society, except that it is more intense. Exceptions, of course, were found to this general pattern of arrest, but it was also instructive to find that high arrest rates are not ipso facto indicative of wholesale incarceration of community mental health clients.

The analysis of disposition patterns suggests that during the latter half of the 1970s in Los Angeles County, at least, the treatment of mental health clients arrested on an initial felony charge was largely determined by the official view of the seriousness of the offense. Both the police and the prosecutor were highly selective in cases of a charged personal offense. Those not released at the station level or rejected for prosecution were moved to the trial stage on a felony charge. In contrast, in cases of arrest on a felony property offense, smaller proportions were released by police or rejected for prosecution and were moved to the trial stage on a reduced misdemeanor charge.

Table 4.25 Comparative Intensity Rates of Incarceration for Felony Personal and Property Offenses, Total Arrests and Arrests of 1978 Cohort of First Admissions to the Department of Mental Health, Los Angeles County

Level of Incarceration	*County*				*Mental Health Center*			
	Person		*Property*		*Person*		*Property*	
	1977	*1979*	*1977*	*1979*	*1976-77*	*1979-80*	*1976-77*	*1979-80*
1. Total arrests	15,371	18,869	20,450	25,270	499	716	613	973
2. Percentage:								
a. Probation	12.9	12.1	15.0	13.9	14.8	10.6	14.8	9.5
b. Probation and jail	16.4	14.3	23.8	28.5	24.8	27.0	32.5	31.2
c. Jail	4.9	4.6	8.6	9.5	7.3	6.3	8.5	11.8
d. Prison	6.6	9.0	2.2	3.6	4.3	6.6	1.1	4.2
e. All levels	40.8	40.0	49.6	55.5	51.2	50.5	56.9	56.7

Less distinction respecting type of charged offense was apparent in the treatment of mental health clients at the lower court stage, but the distinction emerged emphatically for those moved to the Superior Court stage where only felony charges were tried. Those charged with personal offenses were more likely to be convicted than were property offenders and more likely to receive a prison sentence, while those convicted of a property offense were more likely to be accorded commitment to the county jail.

What is evident from the results presented, then, is that the interaction between community mental health clients and the criminal justice system is complex. Given that there are higher arrest rates for community mental health clients, it is important to understand how this heightened contact translates into actual restrictive controls ranging from straight probation to imprisonment.

Drawing from the data already presented, Table 4.25 summarizes the levels of control imposed on the 1978 first-admission cohort. Here, again, it is clear that, overall, the mental health cohort is always accorded a higher rate of incarceration than that found in the general arrested population. However, it should be evident from the table that the form of incarceration is relatively less severe. For example, there are consistently lower rates of prison imposed upon the mental health cohort. While straight probation is seen at about the same relative rate for both groups, the mental health cohort receives such sentences at a lower rate after being admitted into a community mental health program. Finally, what is revealed is a major use of jail and probation in lieu of other forms of incarceration, especially after admission to the mental health program. This pattern is not evident in the general arrested population. Is it possible that the criminal justice system uses local custody and local community forensic psychiatric jail programs as a way of coping with the question of being "mad and bad?"

In sum, it appears that formal identification as a mental health client has a mitigating effect on final disposition for some types of offense. However, assessment of the danger a person poses to the community appears to be a more important determinant of disposition than does the person's status as a mental health client.

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Chapter 5

ADOLESCENT PSYCHIATRIC HOSPITALIZATION AND SOCIAL CONTROL

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The intent of this chapter is to provide some empirical data on the psychiatric hospitalization of adolescents in contemporary society, and to suggest an interpretive framework for understanding the use of psychiatric hospitalization as a means of social control. The empirical data derive from a research project in which the authors participated (Guttridge, 1981; Guttridge and Warren, 1981), and from existing data gathered by others. The interpretive framework emphasizes social control as a general phenomenon whose specific forms and targets vary historically with political and economic circumstances (for a variety of discussions of this framework see, for example, Rose, 1979; Scull, 1980; Warren, 1981).[1]

Adult psychiatric hospitalization—especially involuntary civil commitment—has received considerable attention from legal scholars and social scientists for approximately the last decade, giving rise to a proliferation of case law (Wexler, 1981) and empirical studies (Hiday, 1977; Warren, 1977; Morris, 1978), and a continuing debate over the propriety of depriving persons of liberty in the absence of a criminal offense (for a summary, see Morse and Zusman in Warren, 1982). During the period of interest in adult psychiatric hospitalization

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in the mid-1960s and 1970s, the commitment of children and adolescents[2] to mental hospitals received little notice from lawyers and social scientists. In a typically partisan statement, Szasz (1977: 1005) commented that "perhaps because children have no rights, the issue of their rights to protection from psychiatrists posing as their would-be protectors has received scant attention."

One reason for the relative lack of concern with adolescent mental hospitalization in comparison with that of adults is that the commitment of minors is seen as the business of parents more than of public welfare. Adults may be involuntarily committed to mental hospitals under various state laws providing for emergency detention or evaluation and treatment, or they may submit themselves voluntarily to treatment. Persons under 18, however, can be committed voluntarily, in general, only as a result of parental action and not of their own volition, although they can be committed involuntarily under the same procedures as adults.[3]

The special legal problem of minor as opposed to adult commitment to psychiatric hospitals rests upon doctrines concerned with the *parens patriae* power of the state, and the identity of interest between parent and child. Although a parent is entitled to direct his or her child's fate (including "voluntary" placement in a mental hospital), the state is also the legal parent of the child, superordinate to the natural parent. Therefore, the child is at more risk of liberty deprivation than the adult in psychiatric hospitalization cases, since either the parent or the state may initiate commitment. In many states the law permits parents to place their child in a mental hospital without procedural protections (Ellis, 1974; Note, 1976; Note, 1978).

A second reason for the neglect of adolescent psychiatric hospitalization is the lack of empirical data on its scope and characteristics. Statistics on all kinds of public mental health agency clients are published, sometimes using age as a breakdown factor. However, if mental hospitals are private and do not receive federal, county, state, or local funds, then their inpatient censuses need not be reported to statistics-collecting public agencies. Thus, much of the information that might be relied on for an assessment to the extent of confinement of minors is not available; one can only refer to bits and pieces of data.

In addition to the lack of empirical data (with a few exceptions, such as Miller and Kenney, 1966), there has been little research in adolescent as opposed to adult commitment. The recent constitutional-legal and research interest in adult involuntary commitment since the 1970s was sparked in part by the theoretical and empirical exposés of mental hospitals in the 1960s by social scientists and

critics such as Szasz (1961), Scheff (1966), and Goffman (1961). The various critiques, the rapid legal developments, and the empirical studies both before and after the introduction of reform legislation in a number of states (contrast, for example, Scheff, 1964, and Warren, 1977; and see Hiday, 1977) gave the topic of involuntary adult commitment an air of significance and urgency. All this has been absent in the area of adolescent psychiatric hospitalization. There has been no Goffman of the adolescent ward (but see Kovar, 1979); there are few statistics, few empirical studies, and few interpretations of those statistics and studies that do exist (but see Schwartz, 1983; Schwartz and Krisberg, 1982).

However, since the early 1980s there has been a developing legal interest in the plight of hospitalized adolescents, in the form both of law journal articles (see Ellis, 1974; Note, 1976; Note, 1978) and case law (see Wilson, 1978; Wexler, 1981: 247-281). It appears to be time for social scientists to take an interest in this issue and provide the kinds of empirical data and research interpretations that could guide developing social and legal policymaking in this area. This chapter is intended as a preliminary "state of the art" venture into documenting and understanding psychiatric hospitalization of adolescents as a social control measure.

IMPACT STUDY

Some of the supportive data for our argument are derived from a larger research enterprise that was designed to study the impact of a piece of juvenile justice legislation—AB3121—in California. The larger study was funded by LEAA. The intent of the larger study was to examine the impact of implementation of several provisions of the law, with impact referring generally to the system consequences of the law, and implementation to the manner in which practitioners have carried it out.

AB3121 had a number of disparate provisions; the data discussed here pertain to a provision related to status offenses, especially runaways. In California, the population of juveniles under the social control auspices of the state are divided into "600s"—delinquent offenders; "601s"—status offenders (runaways, truants, and incorrigibles); and "300s"—neglected and dependent children. Prior to AB3121, all three types of juveniles could be detained in "secure facilites" such as juvenile hall; subsequent to AB3121, which went into effect January 1, 1977, status offenders could no longer be detained in such facilities.

In the first phase of the legislative impact study, we were responsible for a subcomponent to determine the impact of the law on the juvenile court system in Los Angeles County. During interviews with juvenile court practitioners, we found that many of them talked about "getting around" the status offender provisions by having juveniles diagnosed as mentally ill and sent to mental hospitals rather than detained in juvenile halls as they had been prior to the legislation.

In the second phase of the legislative impact study, we transferred the focus of our subcomponent to the mental health system as a possible alternative source of social control for troublesome adolescents who were no longer candidates for the traditional secure facility placement. Our interviews with police, probation officers, district attorneys (although not generally public defenders), judges, and parents convinced us that the status offender provision was seen by many of these persons as taking away a needed placement resource rather than as remedying an existing wrong. They were interested, therefore, in obeying the letter of the law—in not detaining status offenders in juvenile halls—but they were also interested in continuing to utilize secure detention as a control mechanism for troublesome youth.

We investigated both the feasibility and, to a lesser degree, the actuality of confining status offenders to mental hospitals as a means of social control. A context of feasibility is provided by two factors: the fiscal changes in the handling of deviants that have taken place over the last decade or so (including the deinstitutionalization movement), and the medicalization of deviance. This context of feasibility became the theoretical model within which we interpreted our empirical findings.

Our investigative research strategy to determine actual hospitalization rates was threefold. We searched and utilized existing data sets for materials on age distributions in various types of mental hospitals over time. We attempted to survey both the numbers and populations of psychiatric facilities in the Los Angeles County area, a strategy that proved to be unproductive.[4] Guttridge undertook a comparison of four psychiatric facilities for adolescents, in part to determine whether or not there had been changes in the type of population in 1977 and 1978 as compared with 1976, and specifically whether or not there had been an increase in admissions related to status offense behaviors with the advent of the law.

The four psychiatric facilities were roughly stratified by the SES level of the population served.[5] The range was from a public county facility serving a low-SES population to a private hospital taking almost no public funds and serving a relatively middle-class SES

Table 5.1 Variables Associated with Length of Psychiatric Hospitalization of 1119 Adolescents Hospitalized in 1976-1978

	Hospitals				
Variables	*1. County/ Public, Lower SES (N = 302)*	*2 Nonprofit Private, L/M SES (N = 301)*	*3. Private Profit, LM/M SES (N = 298)*	*4. Private Profit, M SES (N = 218)*	*Overall or Mean (N = 1119)*
Length of Hospitalization in Days					
Mean	13	25	43	106	42
Median	11	18	33	65	20
Range	1-88	1-254	1-276	1-465	1-465
Type of Payment					
Public insurance	29.2	54.7	26.5	1.8	29.9
Private insurance	10.6	28.7	62.8	95.0	45.8
Missing (includes direct public subsides)	60.2	16.6	10.7	3.2	24.3
Type of Commitment					
Involuntary	84.3	50.5	13.1	0.6	41.6
Voluntary	15.3	49.5	86.9	99.4	58.2
Missing	.4	0	0	.4	.2
Diagnosis (Discharge)					
Schizophrenia	24.5	15.6	12.4	15.6	17.2
Psychosis	5.0	1.0	0.0	3.7	2.3
Suicidal	1.7	0.0	0.0	0.0	.4
Antisocial	25.5	56.1	53.7	31.7	42.4
Personality disorder	3.6	.7	3.0	21.1	6.1
Depression	13.9	10.6	24.8	18.8	16.9
Runaway reaction	.7	8.3	.7	4.6	3.5
Drug abuse	9.3	4.3	1.3	.9	4.2
Organic syndromes	2.0	.3	1.7	0.0	1.1
Other	2.0	2.0	1.7	2.3	2.0
Missing	11.9	1.0	.7	1.7	3.9

a. Adapted from Guttridge (1981).

population. There were two intermediate hospitals, one of which was private and one of which received public funds through a county contract (see Table 5.1).

SOCIAL CONTROL AND THE POLITICAL ECONOMY

The social control perspective on deviance emphasizes the importance of considering control as a total system rather than discussing

one form of social control while excluding others from consideration. Spector (1981) has provided an overview of the various elements that constitute this system. In addition to civil and criminal law, the contemporary state has several other modes of "handling troublesome rascals." Those of most relevance to this discussion are the private social sector, the medical establishment, and the growth of entitlements to benefits, all of which, says Spector (1981), are supplanting legal and correctional approaches to the handling of deviance.[h]

These newer methods of social control (some of which, however, have historical precedents) are often presented as "more humane, less intrusive, and more progressive than the older ones," while at the same time they have "expanded the power of the forces of disapproval over the forces of trouble" (Spector, 1981: 138). A clear example of this social control dialectic is the deinstitutionalization movement of the 1960s and 1970s, which had as its goal the removal of deviants from 24-hour institutional care. This policy movement, directed mainly at mentally disordered persons and juvenile delinquents, had as its guiding philosophy entitlement to the "least restrictive alternative treatment" principle, often phrased as "community treatment" (Lerman, 1982).

The deinstitutionalization movement has had several outcomes that indicate an apparent relaxation of the institutional mode of handling deviants in favor of a more treatment-oriented mode. In the area of mental health, the population of state mental hospitals decreased in most areas of the country in the 1960s and 1970s to such an extent that scholars now speak of an "emptying" of these institutions (Lerman, 1982). In the area of juvenile justice, Massachusetts closed down all its juvenile public correctional facilities, while in many states there was a rush to establish new, federally funded "diversion" programs for deinstitutionalized youth (Lerman, 1982).

If the impact of the deinstitutionalization movement on the actual rate of institutionalization is measured only for one part of the system, then a rather distorted picture of implementation may be obtained. For example, if the only measure of deinstitutionalization of the elderly mentally disordered is public mental hospitalization rates, then the elderly have been deinstitutionalized: The rate of mental hospitalization for this population dropped from 400 per 100,000 in the 1950s to 200 per 100,000 in the 1970s. However, if the rate of institutionalization in homes for the aged and dependent is measured for the same time period, then these figures are reversed: There was a gain from 200 to 400 per 100,000 (Teknekron, 1978: 20-21). Similarly, if the only measure of states' compliance with deinstitutionalization policy is the rate of juveniles incarcerated in public correctional

facilities then deinstitutionalization clearly occurred. However, if the total rate of juvenile incarceration is considered, then the rate per 100,000 actually rose during the decarceration movement (Lerman, 1982).

The phenomenon of shifting populations from one segment of the social control system to another has been referred to as "transinstitutionalism" (Warren, 1981). The causes of transinstitutionalism have been traced to the coexistence of an ideology favoring decarceration with high unemployment and state fiscal crisis. From the policitical economy perspective on social control, Rose (1979: 445) comments: "Deinstitutionalization is best understood as a political and economic measure designed to sustain near-bankrupt state governments and to establish the basis for transferring funds from public services to the private sector."

As Foucault (1965) notes in his historical analysis, the asylum, since the birth of capitalism, has been a storing place for those unwilling or unable to work within the system. In today's high-unemployment society, the category of adolescent is added to that of the elderly, the mentally disordered, the mentally retarded, and the physically ill on the roster of types of individuals unable to participate fully in the working economy of capitalist society. Furthermore, there appears to be a demand from parents to incarcerate their offspring, a direct demand that is absent in the case of adult types of deviants. Given this double jeopardy, we would expect the rate of youthful incarceration in various types of asylums to have increased with greater rapidity than that of adults under 65 during the past few years.

But even if asylums can warehouse the unproductive, they still cost the society money. From the 1900s to the 1970s, the cost of incarceration was borne by the public sector, moving from county to state, then to federal resources, and finally to a system known as "revenue sharing," in which revenues from a variety of sources are combined to provide care. The 1970s and 1980s saw the development of a different kind of institution, a type of institution that promises to warehouse people more cheaply than the state institution. The board-and-care home and the nursing home for the indigent elderly or mentally disordered exemplify this new type of private social control institution (Estes and Harrington, 1981; Emerson, 1981). The cost of control is shifted from the state and county to a combined federal welfare/entrepreneurial system (Warren, 1981). As a result, the cost of care to the public sector drops. One estimate of the cost reduction involved was from $31 per day for a state hospital inmate to $14.50 per day for a broad and care home inmate (Rubin, 1978: 102).

THE PSYCHIATRIC HOSPITALIZATION OF ADOLESCENTS

Lerman (1980, 1982) has drawn attention to the indirect effects of juvenile delinquency law on the public psychiatric hospitalization of adolescents at the national level, and has provided an explanation based in part on the political economy. The Federal Juvenile Justice and Delinquency Prevention Act of 1974, which was the legislative arm of federal deinstitutionalization policy, provided fiscal incentives to states to remove status offenders from public correctional facilities. States were enabled to collect money for deinstitutionalization but could still transinstitutionalize—that is, place status offenders in private or public noncorrectional facilities, as well as private correctional facilities (Lerman, 1982). Of all the transinstitutional routes, for juveniles "the mental health system represents the fastest growing category of institutional care—on both a short-term and a long-term basis" (Lerman, 1980: 292). Lerman's national findings echoed our research experiences at the state level.

One result of the transinstitutionalization of juveniles from juvenile correctional facilities is that while the population of adults in public mental hospitals—particularly the elderly—has been declining, the population of those under 18 has been increasing. The per-100,000 rate of admission to state/county mental hospitals of persons with no prior inpatient care decreased from 70.6 in 1962 to 57.1 in 1975, with the most marked decrease in the 65+ age group—from 163.7 to 36.7. However, the under-15 rate increased from 6.0 to 15.5, while the 15–24 age group increased from 76.9 to 91.8.

The private psychiatric hospital may also be used to incarcerate troublesome youth, as our California research indicates (see Table 5.1 and Guttridge, 1981). In Minnesota, according to Schwartz (1983), private insurance carriers are experiencing economic difficulties as a result of the increased utilization of private psychiatric hospitalization for youth. In 1976 there were 1123 juvenile admissions to private psychiatric hospitals or wings in the Minneapolis area, accounting for 46,718 patient days, while for the first six months of 1983 these figures were 1124 and 43,855, respectively. The rate of psychiatric hospitalization per 100,000 population of juveniles was 187 in 1976 and 412 in 1983.

In addition, Schwartz (1983) has drawn attention to the increasing use of chemical dependency inpatient facilities for youth. Schwartz and Krisberg (1982) found:

> In 1980, there were an estimated 3000 to 4000 juveniles admitted to in-patient chemical dependency treatment programs. Although

it is unknown how many juveniles were admitted to such programs in the early 1970s, it is generally assumed that the numbers were substantially less because there were few residential treatment facilities at that time.

In addition to private psychiatric hospitals, chemical dependency units appear to have joined group homes, residences for the emotionally disturbed, and other child welfare institutions (Lerman, 1982) as part of the "hidden system" of juvenile social control (Schwartz, 1983).

The growth of private psychiatric hospitals and chemical dependency units is paralleled by the shift to private, private-profit, and corporate medical care in general, and also to private juvenile corrections (Lerman, 1982). The shift to the private sector for the provision of care and control is generally understood as one outcome of the states' and later the federal government's attempts to withdraw from increasingly costly welfare provisions (Scull, 1980). Parents have been enabled to utilize private psychiatric hospitalization of their offspring by the inclusion of psychiatric coverage in private insurance plans.

Since the 1960s, there has been a rapid extension of insurance coverage by carriers such as Blue Cross and Blue Shield into the inpatient (but not the outpatient) mental health area. In the four adolescent psychiatric hospitals we studied, most of the admissions not paid for by public funds were paid for by private insurance, and almost none by parental payment (see Table 5.1). Using private insurance, admission must be justified by an admitting diagnosis taken from the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (henceforth DSM). Since the fees in the hospitals studied ranged from $180 to $300 per day in 1977 (one hospital we were not allowed to study, which took no public funds, cost $900 per day), clearly these hospitals would exist only with difficulty without payments by insurance companies.

This expansion of the medical handling of deviants through the expansion of rights in insurance coverage is a good example of the role of entitlement to benefits in shaping the social control system (Spector, 1981). In theory, the expansion of entitlements is an example of a countermovement to the general proliferation of modes of social control beyond the legal system. However, in the specific case of adolescent psychiatric hospitalization, this new entitlement intersects with the trend toward medicalization to produce a substantial deprivation of liberty for some unknown proportion of youth. As Spector (1981: 153) indicates, the search for new entitlements can have unintended consequences, mainly because entitlements are granted not "in vacuo" but in a socioeconomic context.

One unintended consequence of the entitlement to psychiatric services under medical policies may be more "voluntary" psychiatric hospitalization of young people. This effect is less likely for the adult holders of medical insurance, since adults are not likely to turn themselves into mental patients simply because other people see their behavior as troublesome. As indicated earlier, there is an apparent direct demand for psychiatric placement of children on the part of parents which is absent for the majority of other populations voluntarily seeking mental hospitalization.

There appears to be a demand for the psychiatric hospitalization of adolescents at all class levels, but in particular from parents at the higher end of the spectrum (Hospital 4 in Table 5.1, with over 90% voluntary admissions) and from the public sector at the lower end of the spectrum (Hospital 1 in Table 5.1, with nearly 85% involuntary admissions). Parents have been financially enabled to utilize the psychiatric hospital route by the expansion of insurance benefits. Their reasons for doing so appear to be quite wide: They may have tried outpatient therapy for the child and failed to help him or her, they may want to avoid routine parental duties (Note, 1976: Szasz, 1977), gain respite from a troublesome adolescent (Ellis, 1974; Board of Supervisors, 1980), or placate a new mate jealous and resentful of the child (Kovar, 1979).

> In family crisis situations, it is often the middle class parent who is unable to manage what might appear as normal adolescent behavior of the acting out kind. . . . In these cases, there is no real severe pathology, but the family is unable to cope . . . What has occurred most often with the private hospitals is that the parent will take the child into the facility on an emergency basis. The hospital then assigns a child psychiatrist to the patient. This practitioner may never have seen this child before, but will keep the child in a facility when he does the evaluation, treatment and planning for the child. In many cases it is the family (the parent) who is in crisis and not the child [Board of Supervisors, 1980: 8].

At the lower social class levels, the drying up of funding for delinquents and other wards of the court in some states (including California) have left probation officers and the courts with fewer and fewer placement alternatives for troublesome children—fewer foster homes, fewer group homes, and less accommodating juvenile halls. The psychiatric hospital, with its growing number of beds and its support from public and private insurance, is an attractive alterna-

tive, despite the "technicality" of an absence of significant mental disorders on the part of some admittees.

Within the context of social control as a multifaceted system with historical, political, and economic determinants, several phenomena appear to promote the psychiatric hospitalization of youth in trouble. The ideology of juvenile status and delinquent offender deinstitutionalization, coupled with a continuing demand for the incarceration of youth from both parents and the public sector, has facilitated juvenile transinstitutionalism. The shift from public to private social control, a consequence of economic depression, has helped to shape transinstitutionalism. The medicalization of deviance, promoting a shift from the juvenile correctional to the juvenile mental health system, has given it further shape.

Since the nineteenth century, entire sets of people have been transformed by the medical model: from drunks to alcoholics, from criminals to psychopaths, from delinquents to emotionally disturbed children, and from bums and bag ladies to chronic schizophrenics (Spector, 1981: 152). The medicalization of deviance intersects with transinstitutionalism to facilitate the utilization of private psychiatric hospitals for youth.

The medicalization of troubled youth has a historical precedent in the *parens patriae* approach to juvenile delinquents. Since the beginnings of the juvenile court, the predominant policy perspective on juvenile deviance has been paternalistic rather than moralistic, although in recent years the tide has turned somewhat with the expansion of the due process rights of minors. Misbehaving juveniles have for decades been handled as troubled and needy rather than wicked and wayward, a general orientation that has, as indicated, become more and more specifically medicalized in tone and practice.

The medicalization of deviance is seen by some—often psychiatrists—as a beneficial humanitarian reform, while it is viewed by others—often lawyers—as a harmful expansion of social control (Conrad and Schneider, 1980). The involuntary placement of adults in psychiatric hospitals constitutes a substantial deprivation of liberty; for adolescents, voluntary placement is also generally against their will (Morse, 1978). Thus, the debate over the benign or, alternatively, the harmful dimensions of involuntary psychiatry is extended to the involuntary and voluntary hospitalization of the young.

The view of involuntary psychiatry as harmful to the child is expressed by Thomas Szasz, a psychiatrist. Szasz asserts that since children do not and cannot consent to psychiatric treatment, they are by definition (like involuntary adults patients but unlike voluntary

adult patients) slaves to the authority of psychiatry. He asserts that "a child assigned to the role of mental patient is doubly incriminated and incapacitated: as a minor, and as mad" (Szasz, 1977: 1005). Furthermore, he insists that psychiatric intervention into the life of a child is by definition harmful, both because the child sees the psychiatrist as a powerful and dangerous figure out to control him or her (Szasz, 1977: 1016) and because psychiatry threatens the child's needs for dignity, privacy, and self-esteem (Szasz, 1977: 1009). From the opposite perspective a child psychologist, Kovar (1979: 193), notes that "the hospital can be a sanctuary for the abandoned child from a destructive life at home, enabling him to develop competences and experience loving relationships" and cites a number of cases such as one 17-year-old boy for whom "life in the hospital, however limited, compares favorably to living with his father."[8]

We would argue, with Morse (1978), that—beyond the debate over harm versus benefit—the involuntary (or parentially voluntary) psychiatric hospitalization of a minor involves a deprivation of liberty that is anathema to constitutional notions of liberty unless there is solid justification for it. In a medicalized polity, such a justification would seem to be the presence of a mental disorder listed in DSM. However, we would argue—as have recent court cases—that since the deprivation of liberty is so massive, and the stigmatization of psychiatric hospitalization so potentially severe, that only the more serious psychiatric diagnoses merit the bypassing of the "least restrictive alternative" principle into the mental hospital (see also Morse, 1978).

Instead, it appears that the psychiatric hospital is being used for the control of adolescents who are not, in the main, severely impaired psychiatrically, but who are more or less emotionally disturbed, behaviorally deviant, or (in a minority of cases) simply lacking alternative placements. In his analysis of current trends in the institutionalization of juvenile delinquents, Lerman (1980: 287) states that recently "the mental health profession has extended its services to persons not usually cared for in a hospital—alcoholics, drug users, and adolescents with a variety of 'transient' behavioral problems." The implication of this statement is that the adolescents admitted to psychiatric institutions in recent years are not necessarily mentally ill but are likely to be behaviorally deviant. At the same time, they must have psychiatric diagnoses in order to obtain admission and/or insurance coverage; "behavior problem" will not suffice as an insurance category. What we would expect, therefore, if Lerman's assertion is to be demonstrated empirically, is for the adolescents' diagnoses to be mild rather than severe, and oriented to adolescent behaviors and

characteristics rather than to severe psychiatric symptomatology. And this is what we found in our research.

As indicated in Table 5.1, of 1119 adolescent inpatients admitted to four psychiatric hospitals in the Los Angeles area between 1976 and 1978, we found that over 70% of the admissions were for antisocial, depressive, runaway, drug abuse, or personality disorder diagnoses using discharge data and DSM II diagnoses (see also Ginsberg, 1973: 16; Note, 1978: 197).[9] Less than one-fifth of the admissions were for serious (psychotic or schizophrenic) mental illness. In contrast, adult admittees to mental hospitals have more serious diagnoses. Schizophrenic diagnoses constitute 50 to 60% of the state hospital population (Gallagher, 1980: 91); in U.S. psychiatric hospitals as a whole, "schizophrenia is the major diagnosis of admission . . . where the sufferers from this illness fill the largest proportion of beds" (Rosenberg and Raynes, 1976: 97).

The education of troubled adolescence with mental illness cannot be confirmed at this time by available evidence; indeed, some psychiatrists and legal scholars claim that "severe" diagnoses are avoided because of their greater potential stigma for the child (Note, 1978). However, we found that hospital staff in the field of adolescent psychiatry—including psychiatrists, routinely divided their charges into "behavior problems" with "nothing wrong with them" and the "really mentally ill," with the former far outnumbering the latter.

Our evidence indicates for California—as Lerman's (1980, 1982) work does for the nation—that such hospitalization is being used for the social control of a wider variety of troubled adolescents than might be indicated under a strict application of the medical model (see also Schwartz, 1983). Our overall findings, thus, can be tentatively generalized; such is not the case for our more specific findings on the relationship between diagnosis, length of stay, type of payment, and SES, which are limited by our California location and by the nonrandom character of the selection of the four hospitals.

The length of stay of adolescents in the four hospitals we studied varied widely, from a mean of 13 days for the public, lower-SES hospital to a mean of 106 days for the private profit middle-SES hospital (see Table 5.1). In the literature on the relationship between social class and psychiatric facility utilization, there is a strong direct relationship between mental hospitalization and lower socioeconomic status, whether one takes the labeling or the psychiatric perspective on mental illness (for a summary of these issues, see Gove, 1975: Ch. 3). In the case of adolescents in our study, using length of stay rather than admission as our measure, we found that the higher the SES level of the clientele, the longer the average stay. These findings

need to be supplemented by an analysis of admission rates of adolescents to psychiatric hospitals by SES.

The relationship between SES, length of stay, and source of funding may be an essentially economic one. The state can no longer afford, as it could in the 1950s, to control its deviants by lengthy incarceration in public institutions (Scull, 1980). And the proportion of hospital funding derived from private sources is clearly related to longer patient hospitalization, indicating the possibility of the operation of a profit motive. The percentage of hospital funding deriving from the public versus the private sector is also related to the proportion of voluntary to involuntary admissions. The increase in voluntary admissions into hospitals with a greater proportion of private funding provides a rough indication of the demand from middle-class parents for the medicalized social control of adolescence, especially when considered in relationship to length of stay. As Dillon et al. (1982: 421) note, under current case law "the child whose parents can afford to pay for his institutionalization has less protection than his poorer counterpart" and thus may be liable to longer institutionalization.

Finally, there is a clear, although less strong or linear relationship between diagnosis and the set of variables already considered. The proportion of patients with more serious diagnoses—schizophrenia and psychosis—is highest in the public hospital, where the mean length of stay is the lowest. The proportion of patients with the type of diagnosis that we found to be related to troublesomeness in adolescents—antisocial, runaway reaction, and personality disorder—was highest in the two SES-intermediate hospitals (just as the proportion of severest diagnoses was lowest in these two hospitals), accounting for over half in the highest-SES hospital but under a third in the public hospital. Whether one takes the psychiatric or the labeling perspective on mental illness, at least in this study it seems clear that severity of diagnosis is not the factor most predictive of length of stay in adolescent psychiatric hospitalization.

We found, very roughly, that the larger the proportion of fees paid to the hospital by private insurance and the higher the SES level of the hospital site, and—less clearly—the milder the diagnosis, the longer the stay of the adolescent in the facility (see Table 5.1). Our work (Guttridge, 1981; Guttridge and Warren, 1981) indicates that there is something of a symbiotic relationship between private hospitals and the families of adolescents; the private hospitals make money from extensive stays in the hospitals (by adolescents who do not, in the main, have severe diagnoses), while the adolescents' parents gain some respite from their troublesome offspring. While labeling theory predicts that a lack of power and resources would precipitate hospitalization and longer in-hospital stays for the lower-class adult patient, a

social control perspective predicts, for adolescents, the separation of class origins from power and resources. Thus, if middle-class parents are bothered by their adolescents' behavior, they have both the resources (financial, through insurance policies and/or fees) and the power (of legal or medical decision making over the adolescent) to hospitalize the minor. The middle-class adolescent is more liable to "voluntary" incarceration than the lower-class adolescent.

SUMMARY AND DISCUSSION

We have examined some limited data on the psychiatric hospitalization of adolescents in the context of a social control model of deviance and its relation to the political economy. The trends fostering the use of psychiatric hospitalization of adolescents include a demand for parents for institutional placement (an interesting topic of inquiry in its own right), the lack of alternative placement resources for both parents and the public sector, the deinstitutionalization movement and the transinstitutional response, the entrepreneurial expansion of private social control facilities, and the medicalization of juvenile (and other) deviance. We have been able to document the development of a mental hospital system that mixes a variety of youth in trouble (ranging from the seriously symptomatic to the homeless) in a relatively class-segregated manner, with the more middle-class youth relatively more deprived of procedural protections and relatively more liable to lengthy incarcerations.

So long as the demand for adolescent social control continues, and so long as these trends are not interrupted, the continuation and expansion of adolescent hospitalization can be expected. However, there are some countertrends. As indicated in the introduction, legal scholars are becoming more interested in the topic of adolescent psychiatric commitment; some of them are writing on the topic in ways that suggest a new advocacy (for example, Dillon et al., 1982). Both this specific legal interest and the general movement for children's rights—due process and otherwise—could have a countering impact.

Although there are legal challenges to it, it does not appear that the medical model of deviance is in imminent danger of collapse. However, there is evidence that the insurance companies who are being asked to subsidize this form of social control are becoming aware of the potential for financial loss (Board of Supervisors, 1980) and are beginning to limit inpatient hospitalization benefits for minors (Schwartz, 1983).

The shifting of fiscal responsibility back and forth between the public and private sectors, and between levels of government, may pose no long-term solutions to the economic problems of social con-

trol. Rather than saving money overall, as some economists claim, revenue sharing and privatization may simply shift the money around and provide a temporary respite (Rose, 1979). Thus, the pressure to save money may again build up, precipitating changes in the locus of social control. It would be useful for us, as social scientists, to prepare to observe the next asylums into which those released from the mental hospital could be put. Foremost among the possibilities seems to be the chemical dependency unit (Schwartz and Krisberg, 1982). It would also behoove those of us who work in or for governmental agencies to institute a statistical watch on all types of asylum, under whoever's ownership they flourish, and by whatever name they pass.

NOTES

1. The term "social control" has been used to indicate all the means by which society is reflected in the behavior of individuals, from socialization and internalization to incarceration in total institutions. The usage in this chapter is intended to reflect the latter rather than the former meaning.

2. The commitment of minors can be seen as one issue (Szasz, 1977), or as a developmental issue that divides children from adolescents (Note, 1978). However, this chapter is concerned with adolescents (from about 13 to 18) rather than with children, since the data relied upon are within that age bracket. In addition, adolescents far outnumber children in psychiatric hospitals: Approximately 80% of nonadults admitted to inpatient psychiatric treatment are 13 to 19 years old, while 16% are between 6 and 13 (Note, 1978: 197).

The mean age of our sample of cases (see Table 5.1) was 15.5; 52% were males and 48% females; 77.6% of the sample were Caucasians, 12.8% Hispanic, 8.1% Black, and 7% Asian.

3. In California, as in most other states, involuntary commitment requires a psychiatric element (the person committed must be mentally disordered) and a behavior element (the person committed must, by reason of the mental disorder, be dangerous to others and/or dangerous to self, and/or gravely disabled).

4. The response to two survey mails to mental hospitals in the area was close to 0.

5. The classification was ecological and reputational, based on residents' knowledge of the areas into which Los Angeles is divided. Although we had access to the adolescents' medical records, the parents' actual income or occupation was rarely available in the files. The roughness of our measure should be kept in mind when evaluating Table 5.1.

6. Spector (1981) discusses other modes of social control that are not directly relevant to adolescent psychiatric commitment but are for other types of deviance handling. For example, the welfare mode he mentions is relevant to the new board and care system for ex-mental patients, which combines private entrepreneurship with federal social security funding (Emerson, 1981).

7. Lerman (personal communication) denies that there is any "fiscal crisis of the state" and claims that social control practices continue to follow public as well as private money. He cites, for example, the recent expansion of the child welfare system in the handling of juvenile delinquents.

8. Szasz (1977) is against not only the inpatient psychiatric hospitalization of minors but also their outpatient treatment. He argues that psychiatry should only be provided on a truly voluntary basis; children who are under parental authority have no effective choice. In contrast to Kovar's (1979) claims, Szasz notes: "Not a single one of my patients who had been subjected to psychiatric treatment as a child felt that it had done him or her any good . . . they all felt that having to go to a shrink was humiliating and shameful . . . The therapist was their parents' agent in whom they neither wanted to, nor could, confide" (Szasz, 1977: 1007).

The difference between Szasz's and Kovar's accounts may have to do with the socioeconomic level of the minor patients. Szasz, as a psychiatrist accepting only voluntary patients, probably has well-to-do clients for whom the psychiatric hospital would have been an affront. For poor, unwanted, or abandoned children, however, the reverse can be true. In both cases the child may be intimidated by and mistrust the psychiatrist.

9. Discharge rather than admission diagnoses were used in our studies because records were kept by discharge data. DSM II had not yet been superseded by DSM III at the time we collected our data. The diagnostic categories used in Table 5.1 were collapsed from ninety specific diagnoses after consultation with a psychiatrist and a psychologist.

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Chapter 6

INCOMPETENCY, INSANITY, AND INVOLUNTARY CIVIL COMMITMENT

DAVID B. WEXLER

For the past decade and a half, the United States has witnessed a virtual explosion of law relating to the mental health system (Wexler, 1981). Perhaps as an outgrowth of the civil rights movement, U.S. courts began to accord rights to criminal suspects, to prisoners, and to mental patients.

The initial thrust of mental health law activity involved the civil commitment process as well as the rights of the institutionalized mentally ill. Civil commitment reforms were of both a procedural and a substantive nature. Procedurally, due process safeguards -such as the right to counsel and to a heightened standard of proof regarding committability- were grafted on to civil commitment hearings. Substantively, mental health codes were rewritten to tighten and narrow the criteria for involuntary commitment. Broad, "paternalistic" bases for commitment were rapidly replaced with bases grounded in the "police power" concept of dangerousness.

Developments occurred, too, in the criminal commitment system (Wexler, 1976), and changes took place in such areas as incompetence to stand trial, the consequences of an acquittal by reason of insanity, and transfers of mentally ill offenders from prisons to mental hospitals.

Just as the activity in this field began to slow its course, as evidenced principally by the unwillingness of the Supreme Court to encourage judicial action aimed at expanding the rights of the mentally disabled, the insanity acquittal of John W. Hinckley, Jr., prosecuted for the attempted assassination of President Reagan, rekindled interest in the area. A flurry of proposals were introduced in legislative halls

seeking to abolish the insanity defense, to shift the burden of proof to the defendant, to facilitate the long-term confinement of insanity acquittees, and to adopt a standard of "guilty but mentally ill."

Even though the post-Hinckley case activity was addressed primarily at the insanity defense area, civil commitment law reformers ought to be aware of the potential connections between the systems of both civil and criminal commitment. Scholars and reformers have thus far paid too little attention to the intricate interrelationships among the pieces of law that fit together to form the total picture of mental health law. As this chapter will demonstrate, if one aspect of mental health law is tinkered or tampered with, pressures are likely to mount that will push toward certain types of tinkering or tampering with other aspects of mental health law or practice. For example, if, from an array of options, a decision is made to structure the law of competence to stand trial in a certain way, pressure may then be generated to rework the law of civil commitment in a way that will be compatible with the competence provision. As a result, certain patterns of law or practice are likely to emerge (Wexler, 1983). The present chapter will explore some of the interrelationships between civil and criminal commitment. As will be seen presently, the civil commitment system relates to two principal components of the criminal commitment system: incompetence and insanity.

CIVIL COMMITMENT AND INCOMPETENCE TO STAND TRIAL

The relationships between the systems of civil commitment and incompetency commitment are both practical and conceptual. Moreover, in terms of movement of persons between the two systems, activity may be noted in both directions: movement of persons from the civil commitment system to the system designed for person incompetent to stand trial, as well as movement of persons incompetent to stand trial into the civil commitment system. Each direction will be discussed in turn.

From Civil Commitment to Incompetence to Stand Trial

The relationship between the civil commitment system and the incompetency system has been most evident in those states that have, with or without prodding from judicial decisions, substantially tightened their commitment laws. Wisconsin is an obvious case in point.

There, in the mid-1970s, in response to the decision in Lessard v. Schmidt (1975), the legislature adopted a new civil commitment code. Designed to exclude the nondangerous mentally ill from commitment, the code emphasized dangerousness as a commitment criterion and imported substantial procedural protections into the commitment process.

Dickey (1980) has undertaken an empirical investigation of the impact of the 1975 Wisconsin legislation, particularly as the legislation intersects in practice with the system of incompetence to stand trial. Dickey found that (1) in the one-year period following enactment of the law, incompetency commitments rose 42%; (2) a substantial number (up to 42%) of incompetency commitments in the years following enactment of the new civil commitment code were of persons charged with misdemeanors; (3) between 60% and 80% of the misdemeanant commitments were from the state's largest county; (4) between 20% and 25% of incompetency commitments involved persons charged with the misdemeanor of disorderly conduct; and (5) at the end of the commitment period, the criminal charges were generally dropped.

Presumably, a number of persons charged with minor offenses and committed for evaluation or treatment as incompetent to stand trial are persons who, under the older and looser Wisconsin commitment law, would have been civilly committed. With civil commitment now an unavailable tool for dealing with these persons, arrest on a minor charge, often followed by an incompetency commitment, appears to be the remedy if community services are unavailable, if community tolerance wears thin, or if community actors and officials believe, despite the civil commitment law, that hospitalization is warranted.

The Dickey study calls attention to the fact that a legislature must attend to questions of finance and community resources even when it tightens a commitment code. Policymakers interested in the relationship between civil commitment and incompetence commitments should also be alert to the fact that the governmental entity responsible for providing mental health services may differ depending on the nature of the commitment. For example, the state may absorb the cost of hospitalization for a civilly committed patient, but the county may be responsible for the cost of hospitalizing a criminal defendant found incompetent to stand trial. Often, the financial factor weighs heavily in the commitment decision. Consider the following example:

> A criminal defendant in a rural county had been committed to the Arizona State Hospital as incompetent to stand trial (IST). After the defendant had been confined as IST for a few months, the superior court judge was visited by the County Board of

Supervisors, who successfully urged the judge to dismiss the criminal charges and to recommit the patient pursuant to the civil commitment process.

The decision to dismiss the charge and to recommit the patient civilly rather than to continue the IST commitment had certain enormous consequences. In addition to avoiding the prospect of eventual criminal trial, confinement pursuant to a "civil" rather than a "criminal" commitment label would have much to do with the patient's security status while in the hospital, influencing, for example, whether he would be housed on an open ward or instead on the far less attractive maximum security unit.

Was the board of supervisors' recommitment request grounded in such humanitarian and clinical considerations? Hardly. Instead, the supreme motivating force, according to the judge who agreed to the recommitment, was the fact that the cost of hospitalizing an incompetent criminal defendant falls by statute on the county in question while the comparable cost of maintaining a civilly committed patient is, in Arizona, shouldered by the state [Wexler, 1981: 117-118].

From Incompetence to Stand Trial to Civil Commitment

The relationship between the systems of criminal incompetence and civil commitment, particularly in terms of the movement of persons from the former system to the latter, was brought to a head by the Supreme Court's decision in Jackson v. Indiana (1972). Prior to this, it was constitutionally permissible to commit an individual indefinitely as incompetent to stand trial. Thus, even if nondangerous, even if noncommittable under the civil commitment system, and even if charged with a relatively minor offense, a person who might never gain competence might be held "pending trial" for an inordinate length of time. Jackson v. Indiana, however, sought to terminate the practice of allowing incompetency adjudications to serve as de facto final dispositions. Basically, the case invalidated indefinite incompetency commitments. The Court held:

> A person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute

the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant.

Since the Jackson case, if an incompetent defendant is found unlikely to gain competence in the foreseeable future, the defendant must either be released or civilly committed. To the extent that a state's civil commitment law is relatively loose in its commitment criteria, the civil commitment of persons unlikely to attain competence in the foreseeable future ought not to pose a particular problem. If, however, a state adheres to the progressive model of tight, narrow, and explicit commitment criteria, the commitment of such persons may prove problematic.

At the time of the Jackson decision, for example, the California statutory scheme of civil commitment was particularly rigorous. Under the Lanterman-Petris-Short Act (LPS), commitment for anything more than a brief period could have been achieved only through (1) annually renewable conservatorships for persons found to be "gravely disabled"—that is, mentally unable to provide their "basic personal needs for food, clothing, or shelter," or through (2) 90-day maximum commitments for mentally ill persons who, as evidenced by recent overt acts, attempts, or threats of violence, are found to be "imminently dangerous." The 90-day commitments could be renewed only upon proof that the patient, while confined, again acted violently.

The Jackson case, therefore, created a loophole in California law. Before this case, an incompetent defendant could have been confined as incompetent for an indefinite period, and resort to the LPS Act's civil commitment scheme was, for those persons, unnecessary. After Jackson, however, incompetent defendants unlikely to regain competence in a reasonable time could be confined, if at all, only under the LPS Act. And the rigors of the act made commitment a difficult task. After all, even a mentally ill defendant charged with a serious offense might well be able to provide for food, clothing, and shelter and accordingly fall outside the "gravely disabled" conservatorship definition. And if such a defendant refrained from acts, attempts, or threats of violence within the recent past, even the "imminently dangerous" commitment provision would be to no avail.

Against that statutory backdrop, the California legislature sought to close the loophole relating to defendants charged with dangerous felonies and suffering from possibly long-term incompetence to stand trial. The approach taken by the California legislature was to amend the definition of "gravely disabled" to include not only a condition of

being mentally unable to provide for food, clothing, or shelter but also to include:

> A condition in which a person has been found mentally incompetent . . . and all of the following facts exist:
>
> (i) The indictment or information pending against the defendant at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.
>
> (ii) The indictment or information has not been dismissed.
>
> (iii) As a result of mental disorder, the person is unable to understand the nature and purpose of the proceedings taken against him and to assist counsel in the conduct of his defense in a rational manner [California Welfare and Institutional Code].

Not surprisingly, the new provision was challenged as a transparent attempt to circumvent the Jackson principles. Nonetheless, in Estate of Hofferber (1980), a divided California Supreme Court—after judicially grafting onto the statute an additional requirement that the commitment court find the patient to constitute a current danger—upheld the challenged legislative enactment.

In considering the intricate connection between incompetence to stand trial and the structure and content of civil commitment laws, note that, had the Hofferber dissent prevailed, the California legislature might have been induced to plug the gap by a far more extensive revision of the LPS Act. After all, had California's civil commitment code been "loose" instead of "tight"—had it had a vague definition of dangerousness, had it dispensed with the requirement that dangerousness be shown by a recent overt act, had it opted for longer rather than shorter durational limits on confinement—the 1974 amendment to the LPS Act would have been unnecessary to effectuate the civil commitment of "permanent incompetents," and the Hofferber issue would never have arisen. By crafting a narrow amendment tailored specifically to the Jackson problem, therefore, California may have taken an action that appears to some aesthetically and conceptually curious, but that action permits the state to retain intact the basic structure of its modern civil commitment code.

CIVIL COMMITMENT AND INSANITY ISSUES

The lesson for civil commitment law derived from the teachings of its relationship to incompetence to stand trial provides an apt analogue in the area of law concerned with the disposition of defendants acquitted

on the grounds of insanity ("insanity acquittees"). A state may seek the hospitalization of insanity acquittees by processing those persons through the generic civil commitment system (or through a system closely comparable to it), or it may fashion a separate, "special" system for committing insanity acquittees. A special system may involve, for example, automatic or nearly automatic long-term hospitalization which will terminate only if the hospitalized insanity acquittee carries the burden of proving his or her readiness for release. Some have argued forcibly that constitutional considerations require treating insanity acquittees in a fashion substantially similar to civil committees (Morris, 1982). Nonetheless, in Jones v. United States (1983), an important recent decision, the U.S. Supreme Court disagreed with a large portion of that proposition.

Jones v. United States

When he was charged in the District of Columbia with attempted petty larceny (attempted shoplifting), a misdemeanor punishable by no more than one year in prison, Michael Jones successfully raised the defense of insanity. Under local law, he was then committed automatically to a mental hospital. Moreover, this confinement was for an indefinite period—until such time as he could affirmatively establish, by a preponderance of evidence, that he was no longer mentally ill or dangerous.

After Jones had been hospitalized for more than a year longer than the maximum term for which he could have been imprisoned had he been convicted—he demanded on due process grounds to be released or at least recommitted pursuant to the applicable civil commitment statute. In conformity with the due process requisites of Addington v. Texas (1979), commitment under the general civil commitment statute would require the government to prove by clear and convincing evidence that Jones remained mentally ill and dangerous.

On June 19, 1983, the Supreme Court, by a 5-4 vote, rejected Jones's argument. Justice Powell, writing for the majority in Jones v. United States, announced the rule that "when a criminal defendant establishes by a preponderance of the evidence that he is not guilty of a crime by reason of insanity, the Constitution permits the Government, on the basis of the insanity judgment, to confine him to a mental institution until such time as he has regained his sanity or is no longer a danger to himself or society." In the District of Columbia, an insanity verdict constitutes a finding that the defendant was in fact insane at the time of the criminal act and establishes beyond a reason-

able doubt that the criminal act was committed. According to the majority, the verdict is sufficiently probative of mental illness and of dangerousness to justify commitment and to support an inference of continuing mental illness.

Finally, although the Jones Court recognized that due process requires that the "nature and duration of confinement bear some reasonable relation to the purpose for which the individual is committed," the Court supported a fully indefinite commitment based on the insanity acquittal alone. In the Court's words, "there simply is no necessary correlation between severity of the offense and length of time necessary for recovery. The length of the acquittee's hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment." Several features of the Jones case warrant discussion.

First and foremost, the Court's reasoning is based largely on the fact that an insanity verdict in the District of Columbia constitutes an affirmative jury determination that the defendant *committed a criminal act* and *was legally insane* at the time of that act. The Court viewed that affirmative jury determination to be sufficiently probative of mental illness and dangerousness to justify commitment. In some jurisdictions, however, an insanity verdict is ambiguous regarding whether the defendant committed a criminal act, and in a large number of jurisdictions an insanity verdict merely casts a reasonable doubt on sanity at the time of the criminal act. In those jurisdictions, therefore, a statutory procedure of automatically and indefinitely committing insanity acquittees may, despite the Jones case, continue to be constitutionally suspect. A state legislature sitting in a "reasonable doubt" jurisdiction and wishing to ensure the constitutionality of an "automatic and indefinite" commitment scheme, however, need only pass a statute reallocating the burden of proof of insanity issues and placing the burden on the defendant.

Jones is also noteworthy in its remarks regarding dangerousness. Recall that Jones was prosecuted for the misdemeanor of attempted petty larceny. Jones argued that an insanity acquittal on that charge ought not to establish his dangerousness for commitment purposes. Using sweeping and significant language, however, the Court rejected his argument. It stated that "the fact that a person has been found . . . to have committed a criminal act certainly indicates dangerousness." Further, Justice Powell wrote:

> We do not agree with petitioner's suggestion that the requisite dangerousness is not established by proof that a person committed a non-violent crime against property. This Court never has held that "violence," however that term might be defined, is a prerequisite for a constitutional commitment.

The Court's language strongly suggests that the commission of a nonviolent offense against property—or, for that matter, the commission of perhaps any criminal offense—should be constitutionally sufficient evidence of dangerousness to sustain the commitment of an insanity acquittee or even of one not actually charged in criminal court. The federal constitutional test of dangerousness may now mean no more than what a state chooses to define as criminal. Conceivably, in light of the Jones case, states might be able to revamp their civil commitment codes to authorize the indefinite civil commitment of a presently mentally ill person shown, at a civil commitment hearing, to have committed a criminal offense because of mental illness. Such a course of action would be the civil commitment counterpart of a criminal prosecution at which the state is permitted to assert the insanity defense over the objection of the defendant (compare Lynch v. Overholser, 1962).

Jones is interesting, too, in the manner in which, for the issue at hand, it conflated equal protection and due process analysis. At earlier stages of the litigation, Jones invoked an equal protection argument. He claimed it was irrational to deny insanity acquittees the type of hearing accorded civilly committed persons—a hearing at which the government bears the burden of proof of committability by clear and convincing evidence. In the Supreme Court, however, the emphasis was on due process rather than equal protection. That is because the Court and the parties agreed the two arguments were, for the particular question at bar, essentially the same. In the words of the Court:

> That is, if the Due Process Clause does not require that an insanity acquittee be given the particular safeguards provided in a civil-commitment hearing under *Addington*, then there necessarily is a rational basis for equal protection purposes for distinguishing between civil commitment and commitment of insanity acquittees.

Although equal protection and due process concerns merged in the precise issue before the Jones Court, future litigation is likely to address the propriety of certain other discrepancies in the treatment of insanity acquittees compared with that of civilly committed patients. Several illustrations follow.

Jury Trial. The District of Columbia provides for a jury at civil commitment hearings. As an insanity acquittee, Jones was committed automatically, without even having a commitment hearing, let alone a jury trial. Under the District of Columbia insanity acquittee commitment scheme, however, Jones was accorded a hearing 50 days after

his commitment. At that hearing, which did not provide for a jury, Jones was given the opportunity to prove that he should no longer be hospitalized.

In the Supreme Court, Jones argued that he was denied equal protection by the absence of a jury at his 50-day hearing. The Court, however, disagreed. Since Jones was committed because of the sanity determination at his criminal trial, the Court viewed the relevant comparisons, for equal protection purposes, to be between a civil commitment hearing and the criminal trial, not between a civil commitment hearing and the 50-day hearing. And since Jones had been given a jury trial in his attempted petty larceny prosecution, the Court held that "the absence of a jury at the 50-day hearing 'is justified by the fact that the acquittee has had a right to a jury determination of his sanity at the time of the offense.'"

Does the Court's reasoning suggest that if Jones had been tried for an offense not triable before a jury—for instance, for an offense punishable by no more than six months imprisonment (Baldwin v. New York, 1970)—equal protection principles would have entitled him to a jury trial at his 50-day hearing? If so, would a legislature striving to equalize treatment between insanity acquittees and civil committees do so by according jury trials to the acquittees or by removing the jury trial right of the civil committees?

Release Procedures. Typically, civil patients may be released on the unilateral action of a hospital. Often, however, insanity acquittees may be released only if the court concurs. Since Jones did not challenge "the disparity of treatment of insanity acquittees and other committed persons," the Court did not resolve that equal protection problem. In the lower courts, however, equal protection attacks to the discrepant procedures have usually failed. On the occasions that such attacks have succeeded, there has been pressure to achieve equality of treatment not by easing the release procedures for insanity acquittees, but by toughening the procedures for releasing the civil patients (Wexler, 1983). Note, however, that requiring court approval for the release of insanity acquittees—or even for "police power" civil patients—may not be the release inhibitor that it at first appears to be. By requiring a hospital to share release responsibility with a court, the court approval system may make the hospital less hesitant to recommend release (Wexler, 1981).

Dangerousness and Mental Illness. Recall that the Jones Court upheld Jones's commitment as a danger to others simply because he was found to have engaged in the act of attempted shoplifting. In so ruling, the Court found no due process objection to a state adopting an extraordinarily expansive definition of dangerousness—one that

could embrace any criminal act, even a nonviolent one. Suppose, however, that a state chose to adopt an expansive definition of dangerousness only for insanity acquittees while retaining for the civil commitment area a rather tight test of dangerousness. Would such a classification survive an equal protection challenge? If not, would the insanity acquittee commitment law definition be narrowed by a legislature, or would the civil commitment law definition be broadened?

Similar problems exist with respect to possible disparities between the two areas in the definition of mental illness for commitment purposes. For instance, should the sort of mental disorder used to exculpate from criminal responsibility be the same sort of mental disorder that, when coupled with dangerousness, is sufficient to civilly commit?

Even apart from equal protection concerns, coordination between the concepts may be especially important in jurisdictions that rely on the civil commitment system to confine insanity acquittees (In re Torsney, 1979). And if insanity acquittees are subject to commitment pursuant to a separate, "special" system, an equal protection problem will arise if different definitions of mental disorder are employed in that system and in the civil commitment system.

Suppose, for example, a serious mental disorder such as psychosis is needed in a given jurisdiction to civilly commit, but a mental condition such as kleptomania, pyromania, or a certain personality disorder is sufficient to relieve one of criminal responsibility and to lead to an automatic commitment as an insanity acquittee. Would such a scheme offend equal protection? And if so, would the legislature respond by narrowing the availability of the insanity defense or by expanding the types of mental disorders sufficient to trigger civil commitment?

Periodic Review and Burdens of Proof. The insanity acquittee commitment scheme upheld in the Jones case authorized automatic commitment by virtue of the insanity acquittal alone. That acquittal carried with it sufficient evidence of mental illness and dangerousness, the Court reasoned, to justify commitment without the necessity of a civil commitment hearing. Furthermore, the Jones Court upheld a scheme authorizing the indefinite commitment of insanity acquittees, subject only to the right to periodic judicial review at which the acquittee would bear the burden of demonstrating his or her readiness for release.

It is important to note that the civil commitment scheme in the District of Columbia, although requiring an initial hearing and an affirmative governmental showing of a person's mental illness and dangerousness, itself provides for indefinite commitment subject only to the right to periodic judicial review at which the civil patient

would bear the burden of proving his or her readiness for release. Had the District of Columbia civil commitment system followed the practice of a number of other jurisdictions and accorded periodic review hearings at which the government bore the burden of establishing a patient's continuing committability, an important equal protection inquiry, not present in the Jones case, would have arisen.

Were such a challenge to arise and be successful, legislatures might respond either by placing the periodic review burden of proof on the state in both systems or by placing it on the patient in both systems. Given the post-Hinckley fear of releasing insanity acquittees prematurely, legislatures would likely take the latter course, which would have a serious impact on the current durational limit provisions of many civil commitment codes.

If equal protection becomes a viable mental health litigation strategy in the future, the law regarding insanity acquittees will have an obvious and potent relationship to the law of civil commitment, and vice versa. Certain discrepancies in treatment between the two groups may, of course, pose greater difficulties than will others. Yet, in the wake of Hinckley, and from the flavor of the Jones case, one senses the existence of substantial pressures making it unlikely that the courts will readily strike down special state schemes for dealing with insanity acquittees.

Policy Considerations

When one puts aside the equal protection questions, there nonetheless remains an interesting avenue of inquiry: the extent to which the absence of a special system for processing insanity acquittees generates legislative pressure to shape a state's generic civil commitment code in a specific fashion. In Arizona, for example, there is no special system for handling insanity acquittees. Instead, insanity acquittees in that jurisdiction may (following a fairly lengthly evaluation period) be committed only according to the terms of the state's general civil commitment code. In California, by contrast, a special insanity acquittee dispositional system is securely in place. Basically, upon an acquittal on grounds of insanity, unless the court finds the acquittee's sanity to be fully restored, the acquittee will be committed. After a mandatory minimum waiting period of 90 days, and annually thereafter, the acquittee may file an application for release. At a release hearing, the applicant has the burden of establishing his or her restoration to sanity.

Given its rigid separate system for confining insanity acquittees, California can afford to have a particularly narrow and streamlined generic civil commitment code. After all, its civil commitment code will not have to deal with the population of insanity acquittees. On the other hand, in Arizona, which lacks a special system, the civil commitment code is the exclusive vehicle for confining insanity acquittees. Accordingly, although Arizona's civil commitment code is relatively tight and protective, its civil commitment standards and durational limits must be looser than the California LPS Act standards and limits. Surely a legislature would not comfortably say that insanity acquittees must be confined only according to the civil commitment law (which is the case in Arizona), and then in the same breath say that persons may be civilly committed as dangerous only for a 90-day period, renewable only if a violent act, attempt, or threat occurs during the 90-day commitment period (which is the case in California).

Arizona's civil commitment code authorizes renewable 180-day commitments for mentally ill persons who represent a danger to others. The code follows the modern trend of defining dangerousness with some specificity and of requiring that dangerousness generally be evidenced by recent overt acts. Thus, "danger to others" means the danger of "inflicting substantial bodily harm upon another person within thirty days" and should be based on a history of recent behavior. This history may include the patient having seriously threatened another, or it may involve the patient "having inflicted or having attempted to inflict substantial bodily harm upon another person within one hundred eighty days preceding the filing of the petition for court-ordered treatment."

Particularly in order to accommodate the commitment and recommitment of insanity acquittees within the confines of Arizona's civil commitment code, however, the statutory requirement of a recent (within 180 days) overt act or attempt to inflict substantial bodily harm upon another is relaxed in two important and far-reaching instances:

> (i) If the proposed patient has existed under conditions of being restrained by physical or pharmacological means, or of being confined, or of being supervised, which have deterred or tended to deter him from carrying out acts of inflicting or attempting to inflict bodily harm upon another person, the time limit of within one hundred eighty days preceding the filing of the petition may be extended to a time longer than one hundred eighty days as consideration of the evidence indicates; or

> (ii) If the bodily harm inflicted upon or attempted to be inflicted upon another person was grievous or horrendous, the time limit of within one hundred eighty days preceding the filing of the petition may be extended to a time longer than one hundred eighty days as consideration of the evidence indicates [Ariz. Rev. Stat.].

It seems, then, that if insanity acquittees are to be accommodated within the framework of a general civil commitment code, the provisions of that code are likely to be designed to reflect that accommodation. Such codes may relax the requirement of recent overt acts, lengthen the commitment period, and ensure that recommitment is a viable option. Note, however, that once such measures are taken in a general civil commitment code to prevent the premature discharge of insanity acquittees, the measures may be used as well to restrict the liberty of general civil patients. Many now believe, therefore, that although only a small number of persons are acquitted by reason of insanity, it may be worth devoting attention to drafting a model, "special" commitment law for insanity acquittees. With such an approach, a legislature under post-Hinckley pressure to deal dramatically with the disposition of insanity acquittees could go about its task without having to tamper with the basic structure of the state's civil commitment system.

Another policy question, however, relates to the appropriate duration of a special insanity acquittee commitment law. The Jones Court approved on due process grounds a scheme of automatic and indefinite commitment. That approach is, of course, at the opposite end of the spectrum from the route that would basically treat insanity acquittees in "parity" with civil committees. An attractive intermediate option, however, is the one unsuccessfully urged by Jones: special commitment that must terminate (absent general civil commitment) at the time the patient's prison sentence would have expired had the defendant been convicted.

The Jones Court did not find the intermediate position to be constitutionally compelled. Recall that the Jones decision stated strongly: "There simply is no necessary correlation between severity of the offense and length of time necessary for recovery. The length of the acquittee's hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment."

Contrary to what the Court says, however, in one crucial respect (unfortunately not even noted by the dissent) there *is* a "necessary correlation between severity of the offense and length of time necessary for recovery," and the "length of the acquittee's hypothetical criminal sentence" is therefore not "irrelevant to the purposes of his

commitment." A key purpose of the commitment is to treat the patient so that his behavior will improve and others in society will fear him no more. But if successful invocation of the insanity defense can lead automatically to a period of confinement longer than a criminal sentence, then criminal defendants charged with any but the most serious of offenses will generally choose not to assert the defense (Wexler, 1981) and will therefore probably not be treated at all. The intermediate position is therefore preferable to the Jones approach. Under the intermediate approach, the cost of successfully asserting the insanity defense is not so high as to dissuade a defendant from asserting it. Instead, the therapeutic and protective purpose of the commitment will be met, and the defendant will avail himself of the "length of time necessary for recovery."

Interestingly, therefore, although in many ways a state may wish to treat insanity acquittees in a manner different from civilly committed persons, after some time (for example, the maximum criminal sentence that could have been imposed) it is probably important to treat insanity acquittees in a manner similar to civil patients. Otherwise, a principal purpose of the insanity acquittal system may go unserved. Once again, then, there is an important link between the civil and criminal commitment systems.

Perhaps, despite Jones, state legislatures will reject automatic-indefinite commitment. Perhaps, too, state courts interpreting state constitutions will be persuaded by the therapy-inducing rationale of the intermediate test and will adopt that test in lieu of Jones. After all, that decision only held that the constitution permits automatic and indefinite commitment, not that it requires it.

CONCLUSION

As this volume as a whole indicates, there is a close relationship between the systems of mental health and criminal justice. And as this chapter indicates, even within the mental health system itself, there are civil and criminal aspects. For too long, those two aspects have been separately studied. The civil and criminal commitment systems are, however, integrally connected both in theory and in practice. To do sensible work, scholars and policymakers must become sensitive to that integration.

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III

POLICING OF THE MENTALLY ILL

The police perform a pivotal role in relation to the mentally ill person. Available 24 hours a day, they are summoned whenever "something . . . ought not to be happening, and about which someone had better do something now" (Bittner, 1971). Not surprisingly, police are one of the primary sources of referral for psychiatric assistance. In light of recent budget cuts in psychological services, police must develop an ingenious system in order to handle situations involving the mentally ill.

Chapter 7 provides an in-depth look at the factors that determine the police officer's choice of disposition. It is demonstrated that the decision to hospitalize, arrest, or handle the situation via informal means is determined only partially by the degree of symptomatology exhibited by the citizen. The police officer's dispositional decision is determined by a myriad of sociopsychological and social structural exigencies. Peter Manning's chapter adds a cross-cultural perspective to the research literature concerning the police officer's role. He compares police response to the mentally ill in two cities, one in the United States and the other in England. Manning finds that the social organization of response to requests for service is determined, in part, by the system of classification and communication in the police department.

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Chapter 7

MANAGING DISORDER
Police Handling of the Mentally Ill

LINDA A. TEPLIN

Police have long been recognized as a primary mental health resource within the community. They play a major role in referring persons for psychological treatment, particularly within the lower socioeconomic strata (Warren, 1977; Sheridan and Teplin, 1981; Gilboy and Schmidt, 1971; Bittner, 1967; Munoz et al., 1969; Rock et al., 1968; Liberman, 1969; Hollingshead and Redlich, 1958). The realization that police serve as a mental health resource has led to a number of studies of police handling of the mentally ill (see Bittner, 1967; Matthews, 1970; Rock et al., 1968). However, while these investigations have made important contributions to the research literature, they predate significant public policy reforms (such as deinstitutionalization) that have complicated the relationship between police and the mentally ill. Given the potential effects of these changes in public policy, what is needed is an examination of police practices within the current sociopolitical milieu. Drawing on data from an observational study of 1382 police-citizen encounters, this chapter will examine police involvement with mentally disordered citizens, with particular emphasis on describing the decision-making rules underlying the three major resolutions: hospitalization, arrest, and "informal" disposition.

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BACKGROUND

Police involvement with the mentally ill may be traced to common law and is grounded within two legal principles: (1) the police power function—that is, to ensure the safety and welfare of the public; and (2) *parens patriae*, which involves protection for the disabled citizen (Fox and Erickson, 1976; Shah, 1975). Most mental health codes specify the parameters of police involvement with the mentally ill and instruct police to initiate a psychiatric emergency apprehension whenever the person is either "dangerous to self or others" or "because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm" (see Illinois Revised Statutes, 1981; California Welfare and Institutional Code, 1980; New York Mental Hygiene, 1980).

Despite the legitimacy of police authority afforded by most mental health codes, the disposition of mentally ill persons is by its very nature a complex social process. While the law provides the legal structure and legitimacy of the police officer's power to intervene, it does not (and indeed cannot) dictate the police officer's particular response in any given situation (Bittner, 1967). The police, unlike other professionals (such as physicians), do not have a body of technical knowledge that may be used as formulae in the performance of their role (Rumbaut and Bittner, 1979). As with all law enforcement decisions, the police must exercise discretion in choosing the most appropriate disposition (Goldstein, 1979; Manning, 1977; Wilson, 1968), and thus develop an informal operative code to "handle the situation." In mental health cases, the situation is further exacerbated by the inherently nebulous definition of "mental disorder." There is a large gray area which, depending on cultural values and administrative practice, might be labeled as being either criminal or psychiatric (Stone, 1975). In short, dispositional decisions vis-à-vis the mentally ill are an inherently problematic social judgment.

Although a number of studies have investigated or commented on the interaction between the police and the mentally ill (Cumming et al., 1965; Liberman, 1969; Matthews, 1970; Sims and Symonds, 1975; Teplin et al., 1980; Fox and Erickson, 1976), there has been relatively little research examining the officer's decision-making process. The most significant work in the area was conducted by Bittner (1967). Bittner found that police were hesitant to make psychiatric referrals, and that they made such referrals reluctantly. In the police officer's view, hospitalization was initiated only when the case became or had the potential of becoming a serious police problem. The elements that made a case a "serious" police matter were indica-

tions that, if a referral were not made, external trouble would proliferate (for example, danger to life, physical health, property, or to order and public places). Bittner found that police required that there be indications of external risk accompanied by signs of serious psychological disorder (such as suicide, violent acts, or public nuisances) in order to justify a psychiatric referral. The mental hospital was not the police officer's first choice; the decision to initiate a hospitalization was a residual resource, the utilization of which was determined by the absence of other, nonofficial alternatives. Other investigators have confirmed police reluctance to initiate an emergency apprehension finding that their underlying sentiment was that transporting the mentally ill was an inappropriate task for a police officer (see Rock et al., 1968; Matthews, 1970; Schag, 1977).

Structural constraints further reduce the likelihood of the police initiating a hospitalization. Rock et al. (1968) found that the more procedural steps there were between the street and the hospital, the less likely an emergency procedure would be employed by the police. Similarly, Matthews (1970) noted that the police officer must calculate how much time alternative courses of action would consume as compared to hospitalization.

In light of the pivotal role that police play vis-à-vis the mentally ill, it is somewhat suprising that there have been relatively few recent investigations of this relationship. With the exception of two rather small-scale studies (Schag, 1977; Urmer, 1973), there has been no major study of this issue since Bittner's (1967) seminal work. This omission is all the more crucial given that there have been several major public policy modifications instituted since Bittner collected his data. First, deinstitutionalization has resulted in a number of persons receiving outpatient treatment within the community who would have formerly been hospitalized. Second, the legal context regarding patient rights has resulted in specific restrictions regarding psychiatric treatment. Finally, fiscal reductions in mental health programs have resulted in an increasing number of mentally ill persons who, because of a lack of available programs and/or a paucity of individual financial resources, are denied treatment (Kiesler et al., 1983). These factors have had the cumulative effect of increasing the number of mentally ill persons residing within the community (Kiesler, 1982; NIMH, 1983) and also, presumably, of increasing the frequency of police-citizen contact. At the same time, reductions in mental health funding have reduced the available number of inpatient beds in public hospitals (NIMH, 1983), as well as the breadth of treatment alternatives (Kiesler, 1982). In short, changes in public policy have increased the burden of the mentally ill on law enforcement officials.

At the same time, the more stringent mental health codes and the diminished treatment options reduce the available referral options.

In view of these countervailing policies, police are likely to have adapted their informal operative code to the current sociocultural milieu. This chapter will set forth the basic decision-rules central to the three major alternatives available to police: hospitalization, arrest, and informal dispositions. In so doing, it will be demonstrated that the disposition of a mentally disordered citizen is based less on the degree of apparent symptomatology than on a complex array of contextual and situational variables.

METHOD

In order to avoid the limitations of retrospective data and/or official statistics, a naturalistic but quantifiable data set was required. It was decided to conduct a large-scale observational study of everyday police activity in order to observe firsthand their handling of mentally disordered persons in general, as well as to compare the incidence of arrest for mentally disordered versus non-mentally disordered persons. To this end, police officers in a large northern city (Standard Metropolitan Statistical Area of over 1,000,000) were observed in their everyday interactions with citizens for 2200 hours over a 14-month period during 1980-1981; 283 randomly selected officers were included. Observers included the author as well as five clinical psychology graduate students (three male, two female). Observations were conducted during all hours of the day; evenings and weekends were oversampled in order to obtain a maximum of data within a minimum amount of time. Data were collected in two busy urban police precincts that included residents ranging from the lowest socioeconomic level to the very wealthy. These two precincts are typical of this particular city and are fairly generalizable to any large northern urban area. All types of police-citizen interactions were observed, irrespective of any mental health component. This procedure was necessary in order to be able to obtain data on non-mental-health-related situations to use as baseline comparisons.

Although a standardized mode of assessment to test for the presence of mental disorders would have been preferable, the naturalistic setting of the research precluded making in-depth streetcorner psychological assessments aimed at discovering hidden pathology. In view of the limitations imposed by the naturalistic setting, the presence of mental disorder was ascertained by the fieldworker via a symptom checklist that listed the major characteristics of severe mental disorder—

for example, confusion/disorientation, withdrawn/unresponsive, paranoid, inappropriate or bizarre speech and/or behavior, and self-destructive behavior. Thus, criminal behavior per se was not defined as being indicative of mental disorder, despite the fact that it is included in the DSM III as a symptom of sociopathy (DSM III 301.70). Rather, the focus was on identifying those persons visibly suffering from more severe forms of mental illness (schizophrenia, major affective disorders, and so on).

A person was defined as being mentally disordered if he or she possessed at least one of these traits and was also given a global dummy rating of "mentally disordered" by the fieldworker. Both the presence of traits and the global rating were necessary in order to avoid categorizing persons as being mentally ill when they were merely exhibiting bizarre or unusual behavior. The environmental context, as well as a number of extrapsychiatric cues, were taken into account by the fieldworkers when making these judgments. An example will clarify the need for this procedure. A "streetperson" found by police to be loudly shouting and running down the street naked on a cold night in January would have been coded as being mentally disordered. However, similar behaviors exhibited on a warm June evening by a group of drunken college students were recognized as being bizarre but not indicative of mental disorder. It should be stressed that the definition of mental disorder was made conservatively in order to err in the direction of making a Type I error rather than a Type II error. Moreover, all fieldworkers were students from a graduate clinical psychology Ph.D. program and had received extensive training in conventional assessment techniques as part of their graduate programs. Nevertheless, in order to ensure that this measure accurately discriminated between persons who did and did not exhibit signs of serious mental disorder, a validity study was undertaken. Using a sample of 61 randomly selected jail detainees, the results of the measure used in the present investigation were compared to those generated via a standard psychological instrument, the NIMH Diagnostic Interview Schedule (Robins et al., 1981). It was found that the two measures were correlated quite highly: Fisher's Exact Test, $p < .001$; Kendall's tau-B = .739; Yule's Q = .977. There was 93.4% agreement between the two measures as to the presence or absence of severe mental disorder (psychosis).

In order to minimize evaluation apprehension on the part of the police officer, neither tape-recording devices nor extensive note-taking was permitted during the observations. The apparent lack of an obvious formal data collection procedure appeared to enhance cooperation between the police officer and the observer. However, in

order to facilitate recollection of the data for subsequent transcription, fieldworkers were allowed to make a list of all the police-citizen encounters that took place during the observational period. A sample list might read: "(1) 9:20 pm, shoplifting at Peoples Drug Store; (2) 10:15 pm, disturbance in schoolyard, Byrne Elementary School;" and so on. This list was subsequently used by the fieldworker to facilitate data transcription. Data recording was conducted in two ways:

Quantitative Data. The objective characteristics of the encounter were coded according to an instrument specifically developed for this purpose, the "Incident Coding Form." This instrument was designed to record the concrete behaviors and descriptive categories central to the police officer's handling of all police-citizen encounters. It was extensively pilot-tested prior to the data collection, and tests of interrater reliability exceeded 97% for the coded information. A form was completed for every encounter between a police officer and a citizen that involved at least three verbal exchanges. In order to maximize interobserver reliability, all fieldworkers were given three months of special training using both videotapes and field situations. In addition, reliability was subsequently monitored via periodic spot checks.

Qualitative Data. Each fieldworker was given a dictaphone for home use so that a narrative of the shift could be reconstructed after the observation period. These qualitative data were recorded according to a specified format that included general shift information, impressionistic data concerning the fieldworker's observations of the officer, and (most important) a complete narrative of all police-citizen encounters. This last data component detailed the police officer's reasoning underlying his or her discretionary judgments in relation to the handling of the situation.

Excluding traffic stops, 1072 police-citizen encounters involving 2122 citizens were observed and coded. In addition, approximately 1800 pages of qualitative information were recorded. However, only a portion of this data base is relevant to the present research question and will be presented here. Of the 1072 citizens observed, 85 persons involved in 79 encounters were defined by the fieldworkers to be mentally disordered. This chapter will present an analysis of these 85 citizens. Given the nature of the research question, the bulk of the analysis is confined to the qualitative data, of which there are two types: (1) data from the 79 observed police-citizen encounters involving the 85 mentally disordered citizens; and (2) anecdotes communicated to the fieldworker by the officer concerning the officer's prior experiences in handling mentally disordered persons.

Table 7.1 Police Disposition of Apparently Mentally Disordered and Non-Mentally Disordered Citizens[a]

Disposition	*Non-Mentally Disordered*	*Mentally Disordered*	*Total*
Hospitalized for mental disorder	0 (0.0%)	10 (11.8%)	10 (0.5%)
Arrested	133 (6.5%)	14 (16.5%)	147 (6.9%)
"Informal" (Other)	1904 (93.5%)	61 (71.8%)	1965 (92.6%)
Total	2037	85	2122

a. Includes all citizens, regardless of their role in the encounter, excluding traffic incidents.

FINDINGS

Table 7.1 illustrates the relative frequency of the three major dispositional categories: hospitalization, arrest, and informal disposition. As Table 7.1 illustrates, hospitalization is an exceedingly infrequent event (less than 0.5%). Arrest, although occurring more frequently among apparently mentally disordered persons than among non-mentally ill persons (see also Teplin, 1984) is also a relatively rare disposition. Table 7.1 shows that police most frequently resolve a situation informally (71.8% for persons exhibiting signs of serious mental disorder and 93.5% for non-mentally ill persons). Given the potentially disruptive nature of many of the symptoms of mental disorder, it is most interesting that police so rarely resort to a formal disposition. This analysis will present some of the underlying factors characterizing each of the three major dispositions. Drawing information from the qualitative data, the following sections will demonstrate that the dispositional decision is a complex construction of reality, related only peripherally to the degree of psychiatric symptomatology.

Hospitalization

The apparent disinclination by police to initiate an emergency hospitalization is strikingly similar to the findings of Bittner (1967). However, while the results of the two studies are substantially similar, the raison d'être for the infrequent utilization of the hospital was based on a number of structural characteristics peculiar to the current post-deinstitutionalization milieu. First, police initiation of hospitalization is limited by the reduced number of psychiatric placements available to them. While state hospitals once were the primary treat-

ment facility, they have been replaced by community-based mental health centers. Unfortunately, these mental health centers (many housed within private hospitals) have very strict criteria for admission.

The qualitative data indicate that virtually every police officer was aware of the rather stringent requirements for admission into the local psychiatric hospital: The individual must be seriously ill—actively delusional or suicidal. The police knew that persons who were mentally retarded, alcoholics, or defined by hospital staff to be "dangerous" were persona non grata at the hospital. Similarly, persons with criminal charges pending, no matter how minor, were deemed unacceptable. It was common knowledge among officers that if the citizen did not fit the above-mentioned criteria, another disposition was needed. The following vignette illustrates an encounter that fulfills the above-mentioned criteria for hospitalization:

> We were on the scene in less than a minute. The citizen in question was a black male, about 45 years old, who was standing on the sidewalk with his arms outstretched, spinning around in circles. The sergeant, making reference to the officer's background, said the man was a training helicopter pilot. The officer and the sergeant got the man to stop spinning. They attempted to question him, but the man was completely out of it. He gave no indication that he understood what was going on. He didn't talk at all during the encounter. The officer called for a wagon to take the man (to the hospital) [Shift 86, Encounter 3].

The following situation was one in which the mentally disordered person was too public in her deviance to be ignored by police. Hospitalization was initiated because the citizen fulfilled the hospital's criteria that the patient be seriously delusional.

> At 22:00 a radio call came in saying there was a white female, age 28, who was taking off her clothes in front of the ( ) Building. As we arrived, there were several other officers on the scene. A white female, age 28, was dressed in dirty clothes and was very disheveled. She was repeatedly pulling up her T-shirt, exposing herself and making obscene gestures at the crowd that had gathered. Several officers helped her into the wagon. She kept saying, "Fuck the mayor." She said she had walked all the way from (the suburbs) to make some statements to the mayor. When the officers put her in the wagon, she continued yelling out the back. . . . There was no evidence of alcohol or drugs, so it looked like a straight psychiatric case [Shift 171, Encounter 2].

Suicide attempts are taken quite seriously by the police and are readily admitted by the hospital, as indicated by the following anecdote:

> Three months ago, Officer I was working the midnight shift. It was about 2:30 a.m. He was driving and had another officer with him. They . . . happened to notice a man standing on a corner, wearing a sweatshirt, parka, and slacks. He was about thirty years old, white. As they drove by, they noticed him wave. They said it was the kind of reaction where he probably didn't really need the police until he saw them, and decided to stop them. They . . . came back, pulled up, with the passenger-side officer rolling down his window and asking what he wanted. The man responded that he wanted to go to the (psychiatric) hospital. They asked him why. Before anyone could do anything, he pulled out a knife and plunged it into his chest [Shift 38].

Despite the importance of police in aiding the mentally ill, "handling mentals" was not regarded as a good pinch and was largely unrewarded by the department. This, coupled with the scarcity of placements and the strict criteria for admission, tended to inhibit psychiatric referrals. Moreover, the current philosophy of community-based treatment apparently discourages police from using the hospital as a resource. Police perceive rapid deinstitutionalization of "their mentals" to be both a personal slight on their judgment, as well as an indication of the hospital's unwillingness to "do something." All of these factors serve to inhibit mental health referrals and enhance the likelihood of other types of disposition.

Arrest

Arrest was not a particularly frequent disposition; only 16.5% of the 85 mentally disordered persons were arrested. Nevertheless, the arrest rate for suspects exhibiting signs of serious mental disorder was significantly greater than that for non-mentally ill suspects for similar types of incidents (Teplin, 1984). Apparently, there are a number of characteristics common to situations involving mentally disordered persons that appear to increase the probability of arrest. The requirements of policing are to handle situations so that the officer is not required to return to the scene (Bittner, 1967). As a consequence, arrest was often the only disposition available to the officer in situations where persons were not sufficiently disturbed to be accepted by the hospital, but were too public in their deviance to be ignored.

The qualitative data from the present investigation indicate that it was common practice for police to obtain a signed complaint in situations where the person was thought by police to require psychiatric hospitalization. The logic underlying this procedure was to ensure the ready availability of an alternative disposition (arrest) in the event that the hospital found the individual unacceptable for admission. The police officers' apparent ingenuity was clearly born out of necessity since, as previously mentioned, the hospitals had very specific criteria for admission. The following vignette illustrates a situation in which the person was apparently mentally disordered but was thought to be insufficiently ill to be accepted by the hospital:

> The officer indicated that this man had been on the street calling women names, calling them whores, and shouting at black people, calling them "niggers" and chasing them. The officer said he thought the guy was crazy, "you know, paranoid." . . . A woman had signed a complaint and asked that he be arrested because he was bothering her . . . The man sounded like a paranoid schizophrenic . . . both from my observation of him and his response to questions the officer put to him in the station. He was very vague about himself and who he was, and felt that people were out to get him. He couldn't understand why he was in the police station. When he was taken to his cell, he began shouting to be let out, and kept shouting the rest of the time I was there. The officer said the man denied having had any psychiatric treatment or being under psychiatric care. In this situation, he was charged with disorderly conduct. The officer said that there wasn't enough to take him into the mental health center, because his behavior wasn't that severe for the hospital to accept him [Shift 119].

Similarly, in situations in which the person is defined to be "too dangerous" by the hospital, arrest is the only disposition available to the officer:

> A young man was banging on his mother's door with a meat cleaver. He was threatening to kill someone else and was trying to get into his mother's home for a gun. She wouldn't let him in, and had called the police to get rid of him and/or to calm him down. When the police got there, Officer 11 decided the man needed to be hospitalized as he was dangerous to himself and others. So they called for a wagon to take the man to the mental health facility . . . but (they) also wanted a complaint signed by the mother for disorderly in case (the hospital wouldn't take him). It turned out (the hospital) would indeed not take the man so he ended up being locked up for disorderly [Shift 180].

The irony in this type of situation is that it is precisely the requirements for emergency psychiatric detention set forth in most mental health codes ("dangerous to self and others") that render citizens undesirable by the hospitals and result in their arrest.

Persons who exhibit symptoms that cross the boundaries of the care-taking systems meet a similar fate. As previously mentioned, mental health programs found persons with alcohol problems to be disruptive to the patient milieu and often would not accept them for treatment. Conversely, detoxification facilities felt they were not equipped to deal with persons exhibiting signs of mental disorder and would turn away persons with such "mixed" symptomatology. The following is a rather typical situation in which the jail was the last stop of several in an attempt to find a placement for a person plagued with a variety of problems:

> At 8:00 p.m., we heard a siren and saw that an ambulance was stopping in back of a parked bus. We got out of our car at the same time the ambulance personnel got out. They ran inside the bus and brought out a large burly black man. The officers greeted him with great warmth and friendliness; they exclaimed, "Charlie, what are you doing?" Charlie greeted them with equal warmth and friendliness. Evidently, Charlie was the neighborhood character, and was drunk. The bus driver, not realizing Charlie was drunk, was afraid he was ill and had called for an ambulance. The paramedics, seeing that Charlie was only drunk, left him in our charge. (The officers) asked Charlie if he wanted to go to detox and Charlie said, "Sure." they asked if he was sure detox would take him and he said, "Sure man, of course." . . . We got him in the car and went to detox. There the people took one look at Charlie and would not accept him. Evidently, he was potentially violent and disruptive and bothered the other people at detox, as well as the personnel. The officers asked if they would sign a complaint. They said yes. Charlie realized that he was going to the lock-up and was very unhappy about it, laid down on a bed and took off his shoes. The officers tried to cajole him, telling him that they were going to take him to see "Jones," evidently a friend of his at the station. Charlie said, "I'm no fool, you suckers" and wouldn't put his shoes on. After about 10 minutes, we transported him to the station. Evidently, he had been there so often that they already had a sheet on him, so it was very quick to get him into a cell. The officer explained to me that Charlie was a problem because he wasn't crazy enough to go to the mental hospital. The people at (the mental hospital) wouldn't accept him because he was potentially violent and often drunk. The detox people didn't want him, even though he

> was an alcoholic, because he was potentially violent, and bothered their other patients with his crazy ways. So that left the jail. They would put him in lock-up overnight; he would go to court in the morning, and then would be released. In the meantime, they would get him off the street. Charlie was booked for disorderly conduct. The detox facility was the complainant, although he had done nothing disorderly [Shift 81, Encounter 3].

The tendency of persons with mixed symptomatology to be arrested appears to be a function of the overall configuration of the health delivery system. Our public health system comprises a rather fragmented assortment of components. Although a complex array of services is available, each subsystem designs its programs to fit a specific need; the majority of programs are designed as if clients were created as "pure types." In this way, the narrow parameters of each of the various subsystems result in a number of persons who are unacceptable for treatment in any health-care facility. As illustrated in the previous vignette, police would often make the rounds of the various service agencies—from halfway house to hospital to "detox"—before resorting to arresting the citizen.

As Bittner (1967) found, the seriousness of the incident also determined the disposition. However, unlike Bittner's study, the definition of "seriousness" in the present investigation was not always correlated with the severity of the offense. A number of sociopsychological and sociocultural contingencies determined whether or not the seriousness criterion would be invoked. For example, situations in which a citizen was disrespectful of a police officer were nearly always thought to be serious:

> Call began at 09:45 when we received a call to investigate a disturbance at the subway station on ———— Avenue. When we arrived on the scene, we were met by a female newspaper dealer, who said there had been a woman there yelling and screaming and trying to take some of the newspapers. She said that she had called the police, but the woman who had caused the problem had left. . . . As we were walking out, however, this woman came back into the subway station . . . the newspaper woman pointed to her and said that she was the one who was causing the problem. The officer turned to (the suspect) and asked her what the problem was. She jumped on the police officer and started hitting him with closed fists, and she was really landing some blows. He was taken by surprise but, after a brief struggle, was able to pin her hands behind her and lead her out of the subway station to where the car was parked. During this time, she began screaming at him that he was an agent of the devil and that she was a messenger from God; that she would see

> to it that he was punished by God for having her arrested. Nevertheless, he put some handcuffs on her and called for the paddy wagon. The paddy wagon came, and he put her in the wagon to be taken down to the station and arrested on a disorderly conduct charge. . . . The woman seemed to be clearly mentally disordered. . . . It seemed clear to the officer that since she was disturbing the peace, she was going to be arrested for that" [Shift 291, Encounter 2].

Similarly, situations that were public, offended "decent" people, and had a willing complainant were defined by police to be serious:

> We arrived . . . and were met by an elderly woman who said there was a man sleeping in a car behind the apartment building. She said that the night before this man had been acting real crazy and had thrown rocks at the building. She pointed out the car . . . and we saw the suspect sleeping in the back seat of a rather old Dodge. The suspect presented a very bizarre sight. According to his driver's license, he had until recently shoulder-length hair. But, in what looked like a very bad attempt at self-hair cutting, all his hair had been cut off. Most of his hair was off, but there were ridges of hair all over his head and actual gouges in the scalp. There were also slash marks up and down his wrists, extending up to his elbows. The citizen looked disoriented, was very filthy, but looked physically fit, perhaps a body builder at one time. He was quite acquiescent. Since other officers had the assignment, they put cuffs on him and told him they were going to take him in for damage to property and probably for disorderly conduct [Shift 284, Encounter 1].

In sum, arrest was used as a disposition in three types of situations: (1) when hospitalization would have been preferable but the potential patient was thought to be either unacceptable by the hospital or showed symptomatology such that he or she fell into the cracks between the various caretaking systems; (2) in encounters characterized by their "publicness" and visibility which, at the same time, exceeded the tolerance for deviant behavior within the community; and (3) in cases in which the police felt that there was a high probability that the person would continue to cause a problem unless something was done. In such encounters, police would resort to arrest as a way of removing the problem person from the scene.

In general, police made a formal disposition (either hospitalization or arrest) in circumstances where, if unchecked, the situation would escalate and require further assistance from the police. If the circumstances of the case indicated that a formal disposition was required,

the officer decided whether the person could fulfill the criteria for hospitalization or if the criminal justice system should be invoked. The large gray area between behavior that is "mentally disordered" and that which is merely disorderly allows for a great deal of discretion in choosing the ultimate disposition. The degree of psychiatric symptomatology is only one of the determining factors.

Informal Dispositions

As has been found in previous studies (Bittner, 1967; Schag, 1977), informal dispositions were the predominant type of resolution; police handled 71.8 percent of all mentally disordered persons informally. They are the preferred means of disposition, requiring neither paperwork nor unwanted "downtime" (hours off the street). There are three major categories of mentally disordered persons who are likely to be handled via informal means: (a) neighborhood characters, (b) "troublesome persons," and (c) quiet, unobtrusive "mentals."

Neighborhood Characters. Neighborhood characters are persons who reside within the community and whose idiosyncracies are widely renowned among police working within the precinct. Virtually any officer can tell you about "Crazy Harry," "Ziggie," "Batman," the "Lady in Red," and "Mailbox Molly." These are all neighborhood characters who are defined by police as "mentals" but who are never hospitalized because they are "known quantities." Police have certain expectations regarding the parameters of the neighborhood character's behavior. As a consequence, a greater degree of deviance is tolerated from them. More important, the officers' familiarity with the citizen's particular symptomatology enables them to readily "cool them out," thus further facilitating an informal disposition. The following anecdote related by an officer is a rather common encounter of this type:

> There's a lady in the area who claims she has neighbors who are beaming rays up into her apartment. Usually, he said, he handles the situation by telling her, "We'll go downstairs and tell the people downstairs to stop beaming the rays," and she's happy. The officer seemed quite happy about this method of handling the problem. He could do something for the lady and, even though it's not quite the same as the kind of assistance he might give another type of situation, he could allay the lady's fears by just talking to her [Shift 220].

The following anecdote describes a situation in which a neighborhood character wished to report a crime to the police and was greatly comforted by the officer's apparent concern:

> Recently, a man in his mid-thirties . . . called the police to inform them that he was being monitored by another man. He said the man had planted a microdot in his apartment and kept track of his every action. He claimed the man who was monitoring him was able to jam his CB radio and call the man obscenities over the radio. He asked the officers to listen. He said, "See what that man's calling me?" The officers just heard garbled voices. The man said he'd also called the FBI and wanted to file a formal report with the police. The officer said he went along with the man, letting him think the officers would take such a report, but he didn't do anything with the information. The man seemed appreciative of their efforts, and they told him to let him know if he got any more information on the threatening man. The man was clearly disturbed, but as he was not dangerous to himself or others, he was not taken to (the mental hospital). The police just humored him [Shift 213].

In contrast, evidence of mental disorder exhibited by an individual unknown to the officers tends to result in a formal disposition, as the following encounter indicates. In this case, no attempt was made to reason with the person, and an emergency apprehension was initiated:

> The officer related a story to me about a man who had opened all the windows in his apartment and gone out on the roof because he felt the Martians were going to come. He wanted to disconnect all the household appliances and let out the bad air so they wouldn't destroy him. The officer felt that this was someone who needed psychiatric help, and he was brought to a mental health facility [Shift 036].

Troublemakers. If a mentally disordered citizen has been labeled as a troublemaker, the probability of a formal disposition—either hospital or arrest—is extremely low. Such people are thought to be too difficult to handle to warrant intervention. The following story is typical of such a case:

> I think Harry is paranoid. Whenever the police go near him for any reason, even if it had nothing to do with him, he would get very upset and begin calling downtown, causing all kinds of flak

> in the department. So they leave him completely alone, even though they feel he is a certified cashew nut [Shift 036].

A similar situation involved a person rejected by the mental hospital who, "whenever she came into the station, she caused an absolute disruption. She would take off her clothes, run around the station nude, and urinate on the sergeant's desk. They felt it was such a hassle to have her in the station and in lock-up that they simply stopped arresting her" (Shift 036).

Thus, being defined as a troublemaker allows the individual to act in ways that would otherwise tend to result in either arrest or hospitalization. Police feel that, although intervention may be periodically warranted in such cases, such persons are not worth the trouble.

Unobtrusive "Mentals." Persons whose symptoms of mental disorder are relatively unobtrusive are likely to be handled informally. Such persons offend neither the populace nor the police with vocal manifestations of their illness. Their symptoms are not seen as being serious enough to warrant hospitalization. Moreover, quiet "mentals" are seen as being more disordered than disorderly and are unlikely to provoke an arrest. The following encounter typifies a proactive interaction with an apparently mentally disordered, albeit unoffensive person:

> As the citizen waved to us, the officer identified her as a "crazy lady," stating he had seen her before, although he had never had any direct contact with her. . . . She was about 65, white, dressed bizarrely, hair in great disarray. She was wearing many layers of clothing, none of which were in great shape. . . . (The citizen) spoke in a hyperactive, excited way, and had a wild, fearful look. She told us this involved story about having friends who used to live (here) and . . . now were afraid to come back. She hoped the officer could do something to get these people to return, as she was now without friends and feeling destitute. The officer asked if they had moved. She said no, that they went out of town and had left their car on the street, and the car had picked up a lot of parking tickets. Her friends somehow learned about these tickets and were afraid to come back to (Northern City) as they thought something terrible would happen to them because they had all these tickets. The citizen's story didn't make any sense, but, in response to the citizen's distress, (the officer) became quite placating, sympathetic and reassuring. Rather than arguing that there was no reason for her friends' fear, he told her what to tell her friends to do, i.e., that they could go downtown and probably have some of the tickets dropped, since

they had been away. This didn't work too well. . . . The officer then gave up after the citizen wasn't placated, ending by saying, "Okay, it'll be alright dear. We have to go now" [Shift 278, Encounter 5].

In the above situation, the officer attempted to placate the citizen and allay her fears. She was neither sufficiently disordered to warrant a mental health referral, nor disruptive such that an arrest was in order. She simply needed someone to talk to, and the officer served as a mental health worker.

CONCLUSION

The police are a major mental health resource, perhaps even more so in recent years as a result of deinstitutionalization and a host of other public policy reforms. In order to handle situations involving mentally disordered persons, the police have developed a complex informal normative code. This chapter has demonstrated that the decision to arrest, hospitalize, or handle a mentally disordered person via informal means is based less on the degree of symptomatology per se than on the exigencies and constraints pertinent to each situation. The police do not rely excessively on conventional mental health resources; arrests, too, are relatively rare. Informal dispositions are (as in situations involving non-mentally disordered persons) the preferred choice. Through police officers' prior experiences with neighborhood characters, they know precisely how to respond in order to soothe the mentally disordered person without medication or hospitalization. Their acquired wisdom enables the police officer to act as a "streetcorner psychiatrist" when called to the scene. In this way, the police help to maintain many mentally disordered persons within the community and make deinstitutionalization a more viable public policy. Police departments must be made aware of their pivotal role as a mental health resource and train their officers accordingly. In this way, police handling of the mentally ill will be viewed as a legitimate function, instead of an unwanted burden placed on the criminal justice system.

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Chapter 8

POLICE CLASSIFICATION AND THE MENTALLY ILL

PETER K. MANNING

The attitude of the police toward their work more than anything produces an *hauteur* that projects unworthiness on those they ostensibly serve. In short, they view themsevles as honorable. Rich examples of ethnographic work on the police describe their attitudes toward, interactions with, and the consequences of their stereotypes of the dishonorable.[1] This is not to say that the emotional and sentimental basis of policing produces an adequate explanation of police conduct; organizational structure, strategies, and rewards all pattern the treatment of the public.

Police officers, it is argued, are constrained by other factors (Wilson, 1968). But to what degree is the officer constrained by organizational dicta? Bittner (1967a: 715), for example, views organizations as weak constraints:

> Control is exercised mainly through consultation with superiors, and directives take the form of requests rather than orders. . . . The virtual absence of disciplinary control and the demand for discretionary freedom are related to the idea that patrol work involves "playing by ear." For if it is true that peace keeping cannot be systematically generalized, then, of course, it cannot be organizationally constrained. What the seasoned patrolman means, however, in saying that he "plays by ear" is that he is making his decisions while being attuned to the realities of complex situations about which he has immensely detailed knowledge.

Bittner does not speculate on the extent to which variations in law, organizational practice, local customs of enforcement, or rewards

might alter police work. He concludes rather limply, "No one can say with any clarity what it means to do a good job of keeping the peace" (Bittner, 1967a: 701). One is left to infer the extent of their effect on any type of activity. This formulation, however, makes problematic the literature on the rational administrative or bureaucratic model of policing.[2]

Granted, Bittner is discussing peace keeping, situations in which the "future disposition of a case in the courts" (Bittner, 1967a: 700) is not a consideration. Law enforcement may bring with it other constraints. To what degree can one generalize about peace keeping from Bittner's material?[3] Is there an interplay of organizational influences and craft when the conditions described by Bittner are varied?

This chapter seeks to articulate some aspects of organizational behavior, namely the ways in which citizens' calls to the police concerning the mentally ill are interpreted, and, by inference, how calls about other noncriminal matters are interpreted, with regard to the craft aspects of policing. This craftwork, as Bittner implies, has implications for the structuring of police work as a context for managing types of citizen demand. The material presented here derives from a comparative fieldwork study of the police.[4]

PEACEKEEPING AND DEMANDS

Bittner (1967a) views peace keeping as an intuitive application of authority. He lists several *demand conditions* for action without arrest: regulation such as traffic and licensing; minor offenses that may also become the bases for an arrest; disputes having no criminal or legal component (such as quarrels, keeping order); mass phenomena such as crowds and demonstrations; controlling persons who are seen as less than fully accountable for their actions (such as juveniles, the sick, and the mentally ill) (Bittner, 1967a: 701-704).

Bittner (1967b) elaborates on this last demand condition. Legal norms specify police involvement in the care, custody, and control of the mentally ill under two conditions: when a court constraining order has been issued mandating the police to seek out, detain, and bring the person to a psychiatric facility (persons so detained may be released later if a writ of habeas corpus is granted),[5] and when the police either encounter someone who is defined as mentally ill or are dispatched via radio to a situation nominally involving a mental case. Bittner found that about 50% of these nonlegally determined demand conditions for emergency apprehension arose from on-scene encounters or requests and an equal amount from radio calls.

According to Bittner, the police are generally reluctant to take persons to the hospital.[6] He asserts that a set of additional conditions must be present for the police to intervene and specifies a set of contexts or horizons in which such a case is viewed by police, based on the organization of the perceptual field of events: the *temporal* (the perceived relationship of the problems to past and future events) the *scenic* (stable features of the background employed as a basis on which to handle the problem) and the *manipulative* (consideration of the practicalities of the situation).

Officers, Bittner explains, do make emergency apprehensions when there is a threat of suicide; when the person is in considerable disarray or shows an odd appearance of an extreme sort; when the person is highly agitated; when the person may soon create or is presently creating a nuisance or is disoriented; or when information is received concerning the mental state of the person. Nonofficial ways, rooted in the craft of policing, are employed to attain the end of controlling the mentally ill without a hospital admission. These involve police standing by while someone else acts to commit a person; police intervention to maintain control that is bounded and begins and ends in the field; "psychiatric first aid," which involves listening to talking with, and "normalizing" the behavior of the target person, and the use of alternative resources in the community for continuing care (Bittner, 1967b: 285-288).

Bittner delineates some of the ways in which legal norms can be resources either for rationalizing a decision to intervene or for prospective guidance concerning what the case will be labeled or named in the official police and/or court records, as well as for orienting the sanctioned escalation of police options. The reticence of police officers, arising from the organizational and attitudinal factors that influence their wish to avoid intervention, remains.

The Police and the Mentally Ill

Patterns of police handling of the mentally ill can be accounted for by two broad generalizations. The first is that the category "mentally ill" is a gloss on certain "powerless" and unaccountable people whether or not a warrant has been issued. This generalization is supported by Black's (1976, 1980) work in which he shows that the rate of police interventions is inversely related to other forms of social organization or control. Any intervention is the result of the failure of other forms of control residing in the vertical dimension of social organization (ranking—class or status), the horizontal dimension

(the distribution of persons in social space), and the cultural or symbolic, corporate or normative dimension (Black, 1980: 107). Black argues, for example, that when social class, intimacy, or organizational corporateness are high, the probability of enforced commitment is low (either by warrant, radio call, or on-the-street encounter). As implied by Bittner, many cases of mental illness never reach police attention because other means of control are exercised, because people are controlled under other labels or auspices, or because the suspicion of mental illness never arises. The police are often constrained because they act when and insofar as no other means are seen to be available in the situation. It is likely that Bittner is offering a subcase of Black's more general paradigm with respect to the social characteristics of the mentally ill (who are so labeled) coming under police jurisdiction.

A second generalization to be further explored is that the temporal dimension of social control determines outcomes not captured by cross-sectional or synchronic analyses such as those by Black or Bittner. An obvious feature of police work is its temporality. Descriptions of outcomes collapse the dynamic process producing these labeled outcomes. Data reporting outcomes of police decision, with few exceptions, do not discuss the processes preceding police intervention (see, however, Pepinsky, 1976; Jorgenson, 1981; Bayley and Bittner, 1982). There are no data provided on the series of processes from citizen-reporting to police intervention.[7] We can now examine two police communicational systems and how their organization might affect the processing of calls involving the mentally ill.

THE ORGANIZATIONS

The two organizations studied were one in the United Kingdom, called the British Police Department (BPD), and one in the United States, called the Midwest Police Department (MPD).[8] The focus of this project was to determine through observation and interpretation how messages involving disturbed persons were defined, what the organizations were viewed as doing with and to such messages, and how the codes into which the messages were placed, the social organization of the various subsystems, and the technology employed affected the interpretation of the messages received. Patterns of similarity and difference between and among the organizations and the organizational subsystems were sought. There were several overtly similar characteristics of the two organizations and areas (the size of the city, and of the force; centralized, computerized systems of call processing, computer-assisted dispatching; and, to a lesser degree,

the social composition of the areas). The two organizations were located in large industrialized cities of more than 2.7 million inhabitants and employed over 6700 sworn officers.

The focus of this research is the police communication system itself, as embedded in the larger structure of policing. Each police organization takes calls in a centralized communication center (reached by dialing 999 in Britain, 911 in the United States), sorts out calls, determines the services required, and assigns or refers the call. The focus is, in many respects, on the coding system itself, its operation, and the movement and interpretation of messages as they flow through the Police Communication System (PCS).

Midwest Police Department (MPD)

The communications system is complex and was intended to provide the basis for allocating police, fire, and emergency medical service to the entire metro area. (It does not; fire calls must be transferred to a fire department for disposition; emergency medical calls are transmitted by an electrowriter to Emergency Medical Services (EMS), and many calls for police in suburban areas are referred to agencies in those areas.) Calls are received and encoded by operators on a computer-cathode ray tube (VDU) that displays what has been written. The written message containing the address, the problem, and remarks is sent to the zone or district controller ("dispatcher"), directed to a given zone automatically by the computer on the basis of the location when sent by the emergency operator. The dispatcher then sets a priority for it.

Available (and nonavailable) scout cars are represented by little slots in a wooden rack on the right of the dispatcher. Copies of requests sent by 911 operators are printed out and torn off by the dispatcher, who uses them to assign cars. The dispatcher writes the precinct and car on the card (for example, scout 10-92) and places it in the appropriate slot. Data from these cards, with disposition not noted, are entered into the computer the next day, and each "run" is printed out by precinct address and time of day. The cars that handle calls have great discretion and may not call in the disposition of a call or provide any feedback.

British Police Deparment (BPD)

The BPD receives and allocates calls for services from a large metropolitan area, and although it receives calls for fire trucks and

ambulances, calls that might be better received elsewhere, these are referred. Police responsibility ends at that point. Calls are received from four distinct sources: 999 calls, which are filtered initially by operators and are ostensibly emergency calls; alarm calls, which come in either directly or indirectly to the center (bank robberies, business break-ins); calls that are referred and come in on the general police lines (fire, ambulance, calls for social services departments); and internal police calls. Calls are either accepted or referred. Those accepted are encoded or classified into a set format by the operators using a cathode ray tube-typewriter combination (VDU) that displays what has been written.

Operators must decide whether to handle a call in the center (as a major incident initially because of its importance) or send it down to one of the 32 controllers in the subdivisions. Calls can be sent on by means of telephone, VDU (directly sent and appearing in the subdivision on the controller's VDU), radio, or in some combination of these. Messages can also be sent via VHF (long-distance command for fast-response cars and dog units) or UHF (subdivisional); radio and teleprinter (which eventually prints out the messages sent between the center and the controllers); or via the PNC (Police National Computer). The message format includes date, time, incident number, classification, assignment, location, caller's name, message results, and other details of the officers taking a decision with respect to the incident (much more detailed in this respect than that of the MPD).

When the controller receives the message, this person can reclassify it, refuse to act, put it in the queue for futher action, decide that it does not require police attention, treat it as information, or assign it (either by phone, radio (UHF), or verbally).

Calls are also received by the controller via the subdivisional phone, or relayed from clerks in the reserve room, and these can be assigned or dealt with informally. All messages that arrive via the VDU are held in the machine until reported as finished or closed by the controller. In effect, this person has a record of all in-progress incidents and is responsible for monitoring police and other actions and for entering the disposition of all incidents. Other work done on the subdivision does not require this record, so that workload figures—numbers of calls and incidents handled officially—do not in fact represent the total number of jobs done, the types of work assigned, or even the number of calls to the police. Data from the formal assignments are entered in the computer at the end of each day, printed out, and sent to each subdivision.

THE QUESTION OF TEMPORALITY AND STRATEGY IN HANDLING "MENTALLY ILL" CASES

Three distinct issues are raised by the label of temporality. The first is that of the diachronic effects of a series of jobs on the behavior of officers. That is, each call arrives in a context of calls, or what might be termed a sequencing of work tasks. Officers do not order calls with respect to their sequence of arrival over the radio unless they have nothing else to do at that moment or have some legitimate reason for refusing to take a given call. That is, officers order, arrange, and selectively respond to calls, even those for which they are specifically requested. They order them in paradigmatic terms, or in analogical categories or general types of calls, largely with respect to the perceived degree of consequentiality should they not respond quickly. Such ordering and sorting occurs if and only if there is a sufficient workload to actually raise the question; otherwise, calls are responded to, avoided, or refused as they come (Ekblom and Heal, 1982: 33-34).

In the BPD, the workload is somewhere around a call an hour during busy periods; seldom does queuing or arraying by priority occur. An inference from this is that unlike urban police departments with heavy workloads, the BPD and the MPD are quite free for the most part to set their own priorities for the calls to which they choose to respond.[9] A further inference of this is that those calls that are perceived to be nuisance or order calls generally, or in particular calls glossed over the radio as "domestic," "disturbance," or "possible mental," can be avoided by refusing to answer. By calling in as engaged on "self-generated task," such calls can be treated in a desultory manner—for example, by driving slowly to the scene, taking a circuitous route to the address, or otherwise treating the calls as unimportant. In the MPD, officers are not required to report the outcome of their responses to a call to dispatchers, although it may be entered in the car's log book. The Communications Center has no record on the disposal of calls. This gives no considerable freedom to officers to "finesse" or "blow off" calls and to simply call in back-in-service after a time. It is difficult to say, however, whether any linear relationship could be found between workload (or the number of incidents handled in a given shift by a unit) and the number of "nonserious" incidents attended, although it is possible that when calls viewed as crime-related are a high proportion of the workload, units will tend not to have handled many domestics, mental cases, and the like.[10]

A second issue occasioned by a concern with temporality is that of describing the sequence that allows control to be exercised over cases sent out on the air as mental cases. There is an implicit tactical dimension to these sequences. Bittner roots his generalizations about handling cases in phenomenological terminology and uses as his criteria the horizon of possibilities that any case represents to an officer. This means that mentally ill cases are seen against a background of general expectations about what are taken to be adequate reasons for an emergency apprehension. These are stable and are called upon to make sense of the cases, to rationalize and routinize them. In addition, there are temporal features of horizons which result from the unfolding character of encounters (this is not discussed in Bittner's articles, but it is likely that a change in behavior or mood would alter the temporal horizon, and that the person would be seen as a result as "uncontrollable" and taken to the hospital). Teplin's field research (this volume) found that suspects who were mentally ill had significantly higher arrest rates (46.7%) than did suspects having no mental disorder (28.2%). This was true regardless of the type and seriousness of the offense. She concludes, in the only research that addresses this question specifically: "Other things being equal, being mentally disordered appears to enhance the probability of arrest" (Teplin, 1983: 59). A source of information concerning the mentally ill status of the person may exist prior to the encounter, but it would appear that insofar as the mentally disordered are more likely than others to be involved in serious incidents—and this label may be a result of their disrespect to an officer (a threat to his or her honor)—the disorder is a factor in the decision to arrest. Clearly, this research suggests that officers use arrest as a screening device, passing the buck to other agencies to take further decisions (see also literature cited by Teplin, 1983). It is one option used to control a situation that might otherwise be handled informally. Bayley and Bittner (1982), in a seminal paper, have suggested that in domestic cases, there are three broad stages—contact, processing, and exit—and that each of these contains subcategories or options exercised on the scene.[11] From my fieldwork and the work of Bittner, one can perhaps speculate about a similar algorithm in the handling of the mentally ill, given that the label is accepted by officers at the point of contact after a radio call is received.

Clearly, organizational and attitudinal factors predispose officers to avoid emergency apprehensions. They would prefer, perhaps in this order, to merely see, watch, or oversee the handling of the mentally

ill by some other agency or person; restore control and leave the field (perhaps using tactics similar to hose used in domestics); apply "psychiatric first aid"; or seek out someone through informal community contact who will take informal responsibility for the person (Bittner, 1967b: 285-288). If these fail, or other features operate to change the horizon within which the case is viewed, a set of conditions that are analogous and not mutually exclusive are bases for apprehension: suicide or attempted suicide; odd, extreme appearance: highly agitated behavior that might portend further violence; disoriented or nuisance behavior; or information received.

The analytic issues raised by Bittner's work cannot be resolved without an examination of additional data on the sequencing of police actions from encounter to resolution, holding constant the source of the message. This is the third theme. It is possible from field data to identify the limitations of this case study by reference to comparative organization research, which is the basis for the following analysis. The two organizations described, the MPD and the BPD, differ in several relevant ways. This analysis will focus on the effects of classification or encodation as a formal process, as well as the informal aspects of classification. We will attend to the assumptions made about a message and their role in the social organization of policing. Although this analysis is presented as tentative and is based on one case from each organization, the effects described, it seems reasonable to argue, are fairly general.[12]

ANALYTIC PROCEDURES

Two cases of message handling, one in the BPD and one in the MPD, will be presented in narrative format followed by a discussion of the role of assumptions in the processing of cases known after the fact or at the time to involve the mentally ill.[13] These assumptions, of course, operate in a complex fashion in both organizations and are patterned by codes, roles, technology, and interpretation.

THE TWO NARRATIVES

BPD

It was approximately 10:08 am when a message appeared on the VDU screen in the controller's office at Queen's Fields subdivision.

It read[14] (format is indicated by items underlined):

Serial Number	Time	Date	SD	Class
1525TC1	10:08	23 08 83	B#3	11

Location
77, Linds Rd., Ballbrook

Remarks
Lady reports possible items stolen, believes someone is still in the loft.

The controller looked at the message and decided to query the central communications center to discover if they had established whether anyone was still at the location. After typing in the enquiry, placing it in the "pipeline," and sending it to the communications center for verification, he sent a message to the Police National Computer (PNC) about the abandoned vehicle just reported by a constable. He thought there might be further information on file there such as the owner, whether it had been reported as stolen or not, and other particulars.

A reply appeared on the VDU in regard to 1525TC: "She doesn't know, that's why she phoned us."

The controller laughed at the "uselessness" of the returned information and scanned the VDU display of reported "status activity," which shows officers on duty and their present obligations. The display revealed that the permanent beat officer (PBO) for that area (77 Linds Road) was not on duty. The controller decided to sent the incident to a radio car (Bravo Mike or BM) and picked up the headset-radio-telephone: "This is Bravo Mike #3 calling Bravo Mike22, Bravo Mike22?" BM22 answered: "Yes, Bravo Mike3, this is Bravo Mike22." "Could you have a look at 77, Linds Road, Ballbrook? She's reporting items stolen, believes someone is sleeping in the loft" (laughs). "Doubts if they're still there? (laughs) Thanks, sarge," (sarcastic tone).

The controller turns to PKM: "I always send these calls as requests . . . [but] I don't get refusals."

Another voice came on the radio: "Sarge, I finished that job. I think there was a boy reported missing in that road. A teenage boy. He could be in the loft."

The controller noted this and entered onto the VDU that BM 22 had been dispatched to the incident at 10:24.

A soft sound was emitted from the console. This "bleep" announced that a reminder had appeared on the screen inquiring as to the status

of a PBO. He had exceeded the time permitted for the tasks assigned. These times are automatically assigned by the computer, once a classification entry has been made for the task and a time of assignment entered.

Another officer called in on the radio phone and announced that he had completed his inquiries at 131 Kings Road.

An officer called in to say that he would soon be "out and about." The controller acknowledged this and asked when he would be out. "I'll be out in five minutes." The status activity screen had shown him as being on refreshments in the office. The controller updated the status activity display.

5187 (collar number of an officer) called in to book on.

A reminder with sound accompaniment appeared (an officer, on a task more than twenty minutes, had exceeded status activity limits). The controller reassigned the officer, thus indicating him as being en route and giving him another twenty minutes before another reminder would appear.

A PC walked in to verbally report on his inquiries about a missing boy (these were previously assigned inquiries). The PC did not possess a radio while carrying out these duties; the controller had attempted several times to reach him. He explained that he had been serving as relief officer in the "nick" (the jail, literally, but symbolically it references the entire subdivisional offices). The results of the inquiries were not entered on the VDU because the sergeant explained that a full written report would have to be made in time. He altered the PC's status to available.

The VDU bleeped and the incident at 77 Linds Road appeared showing "action field incomplete" at approximately 11:00. This indicated that the officer had exceeded the permitted limits for such a task, and that the controller had failed to obtain the data required to close the incident.

Two WPCs (Women Police Constables) strolled into the controller's office and began to chat, asking about whether certain officers on the shift had been asked whether they wanted a curry meal during Friday night's duty (they were going to cook it and required an estimate of the number of people who wanted to eat).[15] The inspector suddenly appeared and asked if he could join in the curry.

The phone rang.

Another PC appeared in the office.

BM 22 (the driver of the vehicle is called by its number) appeared and began to talk about a volunteer parachuting jump that would yield a charity contribution from the BBC. They discussed the merits and

demerits, who had been "volunteered" for the duty by the superintendent, and whether it was worth the money offered. The officers arriving were asked whether they wanted a curry on Friday.

11:07. There were 8 people in the room (including PKM). PKM and the controller were discussing the relative merits of the German scheme of radio dispatch and the fact that, according to the controller, the German public do not call in domestics. He also volunteered that the radio room in Baltimore, Maryland, which he had seen on holiday, was superior to that of the Centreshire Police. The others in the room discussed in loud tones whether certain people had been contacted about the curry.

The PNC reply reported on the "abandoned car."

The sergeant explained to PKM the limits on recall of certain information from the computer. He asserted that the use of the machine varies from controller to controller, as does the conception of what it is meant to do.

The officers in the room asked the controller (sergeant) to produce the duty roster listing those who would be on duty Friday night. All discussed who had been contacted about the curry, guesses were made about whether absent others wanted curry, had been contacted, and how much they might want (one or two portions).

The controller asked one of the officers in the room to check on the key holder of an establishment on the High (main street), "across from Woolies" (Woolworth's).

11:20. The curry discussion carried on. BM 22 leaned over the desk and casually said that they had had a look at "the old girl's loft" and that he and his partner had found "only cobwebs and a big golden void."

11:25. The controller closed off the incident. He typed in as a result: "Mentally disturbed woman. PBO will be advised." PKM asks if a teleprint will be made of this for the PBO. The controller answered that the officer who dealt with the incident would leave a note for the PBO.

11:30. There were only two people in the office. It was again very quiet.

MPD

At 10:30 a supervisor told a few of the operators that an address, 100035 Woodyard, was a "no go" address and wrote it on a chalkboard at the side of the operator's room. They had received several calls from a woman at the address who was a known "crazy." No further

cars were to be requested by operators to be sent to that address. When subsequent calls came to the operators' room, the address was not called in by the operators, and calls involving that address (for the last 24 hours from the previous midnight) were listed showing that they were "mental calls." None of these calls were sent forward to the dispatchers, nor did officers respond. Officers and dispatchers did not receive such messages since they were screened at the operators' subsystem.

CLASSIFICATION/CODING EFFECTS: BPD AND MPD

We have focused on the BPD controller, for with him lies the primary responsibility for the formal classification or reclassification of messages that existed first as calls to the police about events and were then converted by operators into police-accepted matters, or incidents. The controller can receive messages from four sources in the BPD:[16] an incident on the screen, a telephone call, a in-person report from an officer, or a radio call (combinations are also possible). Our concern is with those that arrive via VDU.

The controller receives encoded messages via the VDU (the call described earlier was classified as a Burglary-other-11). This constrains the controller's options available for handling the incident. He acts as if the case were real for the present purposes and can add a classification only if new information arrives from either the center (his call to the center did not yield further information; it simply affirmed the ambiguity of the first call—"she doesn't know, that's why she rang us"), or from an officer (hence his later reclassification of the event as involving a "mentally disturbed" person). He can then add remarks and/or details of his assignments or attempted assignments.

The effect of the classification once the message is accepted by the controller is to reduce uncertainty insofar as the next actions available to the controller are decreased by the mode of receipt (source) and the classification of the call as an incident at the center. The controller must form an image of what prompted the calls. However, regardless of this in classification terms, the event as an object in the world is reified when a coded incident is passed on by the controller.

The image-work is depressed in salience in this subsystem because (1) all communications arriving at the controller's office have been once-processed, thus reducing uncertainty in the message; (2) the messages have been formatted and encoded into the police classification scheme; and (3) an effect is produced by the channel (VDU,

radio) of receipt itself, which alters the implicit credibility of the message. Formally, coding has occurred and can have no additional consequence unless it is changed in the course of the incident's being investigated.

What coding does is not apparent to controllers. What is concealed is the prefiguration of the event by controllers who call on previous experience with the area, neighborhood, time of day, and perhaps the actual caller, and on past contact with events perceived as being of this type. This parallels the encoded incident as it is constructed.

Coding effects on messages in the controllers' subsystem derive from format, reclassification possibilities, and the particular classification rendered.

The format limits the range of data provided and operates only when a message is received via VDU. In the case of a message received via VDU, the options for adding information are reduced to three: reclassification, remarks, and actions taken. These are the only action domains remaining, since altering other aspects of the formally constituted message is prohibited. Further, the actions previously taken are closed off, any priority given by the center is taken as tentative, and the incident is reassessed into terms of the practices and priorities of the controller. The particular classification is constraining in a special fashion. It is likely, according to my informants, that a controller will describe an event on the air (controllers do not send out calls using classification numbers, but describe what sort of event they think it to be) in a fashion that is least constraining (for example, as miscellaneous-30), unless they intend to communicate the symbolic importance of the officer responding to the event and/or to write up a report as a result of the visit. Thus, the same formally classified incident can be broadcast as, "Could you call in at 33 Gentlepool Road; see a woman about a domestic?" or, "Lady at 33 Gentlepool Road reports assault; man on premises . . . could you look into this?" The latter formulation will be far more likely to produce haste to the scene and also to generate a report. The call could have been classified in any number of categories, each having an effect on what is expected to have occurred, but the way in which it is sent out is also constraining. Formal and informal effects are difficult to disentangle. Since the 30 classes used are so gross, few incidents are actually reclassified. Some are given an additional category as a result of investigation.

These can be considered the limits of the formal effects of classification and of doing classification as provided within the formal system of transmission. There are, in addition, informal effects that arise from a variety of sources in each of the three subsystems and which

cannot be easily captured by formal concepts or terms—they are situated and arise from several sources.

Perhaps the most useful analytic approach to the understanding of informal effects or features of the handling of incidents termed to involve the mentally ill is to refer to assumptions operative in the illustration provided. These can be glossed with the term "assumptions about the incident" as received in the controller's office of the BPD. (This same analysis can be repeated for each of the three subsystems, but space does not permit this here.)

Limited Information. A message contains only a brief and stylized summary (this is one format effect), but a decision must be made; something must be shown to have been done. When the incident appeared, the controller could not tell from the message alone the degree to which the caller and the operator believed that it was likely that there actually was someone on the premises. The controller queried the center to attempt to establish if there was further information, formal or informal, that might have been forthcoming (he could have done this also via the radiotelephone to the center). The controller reported (to PKM) that if there was someone there, he would want to send two PCs. Sending two officers would have a series of implications for workload and personnel level, as many people were on refreshments while others were unavailable as a result of relieving others who were on refreshments or on assignments. He wonders: Are there children present at the residence? Is this situation dangerous to the person or her property? Will support (more personnel) be required? He then acts upon inference.

Action Decisions. He must decide whether to send, who to send, how many officers to send, where, and with what speed, and to what sort of event. He receives no feedback. He decides to send one car (two officers), and requests it. The controller sorts the message from noise in the situation and the field (conversations, requests such as the duty roster for the curry party, and so on). These distractions shift in salience during the time the incident is being handled in the controller's office.

The controller must decide what type of message it is. There are five general types of calls perceived by officers on this subdivision: crime calls, general disorder calls, information-only calls, alarm calls, and status activity reports which appear on the VDU to regularly inform the controller of the activities and status of those available. This typing activity occurs only when workload demands it (see above). In the case discussed here, the controller was dealing synchronously and sequentially with each call as it arrived. He did not have to

delay one call to deal with another, nor bury any calls in the computer queue. He dispatched them one at a time as they arose (this behavior constitutes a component of the "stylistics" of controlling). The controller treated this call as a crime call initially, sending an area car with two PCs to the address. He also assumed that it was not a crime call, that no evidence of burglary would be found, that no person would be found sleeping in the loft, and that it was reported by a woman who was too frightened to personally investigate the loft. (These conclusions came from interviewing the controller during the course of his processing the incident.)

Construction (and Reconstruction) of the Actions of Officers. The controller assumes that the officers in the field know that he is to be informed if and when there is information relevant to the controller's responsibility for processing the message. Therefore, the controller continued to "bury" the incident when it reappeared (when the message is shown with a bleep—"action field incomplete") and did not query the officers who accepted the call. This was true even after over an hour passed without a report. He waited from 10:24, when the incident was entered and shown on the VDU as having been officially assigned—actually some seven minutes after it had been actually assigned by radio to BM22—until 11:25. He assumed that the officers were en route or otherwise legitimately engaged, would attend and investigate, and would report relevant actions for selective entry on the VDU.

Reclassification and Closing. The controller received the report verbally from the officers who attended, and apparently took much from their tone of voice, posture, smiling faces, and the manner of reporting (they reported after having been talking in the controller's office for some 18 minutes). There was a pun in the verbal report when the officers said that they had seen "nothing but cobwebs and a golden void." The entered result, "mentally disturbed," was added as a remark to the incident. The controller did alter the original classification of the incident officially as a possible burglary. The understanding given to me by the controller was that the PC who made the call would leave a note for the PBO ("the PBO should be advised"). This message was not communicated to the investigating officers while I was in the room, nor did the controller leave the room before the officers returned to the area car. The official paper was not printed out for the PBO by the controller.

MPD

In the MPD, as the example shows, calls screened as being from "crazies" by the operators do not go further, regardless of the

content of the call. This fact is established by a decision taken by supervisory personnel, based on feedback from officers about the caller. This prevents any calls from a listed address being further processed. All calls from that address are treated as if they were from the same caller, about the same problem, with the same intent, and by a "crazy." This further means that no police service will be provided to that address on an indefinite, informal basis. Informal effects of other assumptions operate in the MPD on such calls.

It is likely that there are a variety of organizational and classification effects on the handling of the mentally ill in any given city that have nothing to do with the work of the police on the street, the law, or with the inter- and intraorganizational relations of the police agency.

COMPARATIVE EFFECTS OF PCS ON THE HANDLING OF THE MENTALLY ILL IN TWO ORGANIZATIONS

The two organizations described differ in the patterning or social organization of responses to citizens' calls. The calls described here provide some material for six tentative generalizations about the effects of classification in the two systems on the handling of the mentally ill by the police: (1) The degree of control varies. The more centralized system of the MPD permits them to close off initially any calls from a given address or location defined prospectively as being from "crazies." (2) The nature of the framing of calls varies. The BPD is far looser in the framing or acceptance of calls for police attention, and proportionally directs more units to incidents than does the MPD. (3) Classification effects vary: classifications are not viewed as binding in the BPD; they use fewer categories (30 versus 245); incidents can be initiated in any of the three subsystems; incidents can be reclassified or given double classification; and classifications can be altered after an event has been attended. The MPD is more formally committed to binding priorities and classifications applied by operators, has only one acceptable locus (operator) for entry of a message, and does not permit official reclassification or double classification. (4) Formal priorities are variable. Unlike the MPD, no priority is given to messages in the BPD. In general, there is weak classification of events within categories (see Manning, forthcoming). (5) The incidents are signs that are interpreted within each of the three subsystems of the two organizations and are not seen within the same perspective in each. (6) The role of assumptions varies in the two systems. Formal effects are noted above. Informal effects resulting from acting upon limited information, taking action decisions, con-

structing the actions of officers, and closing the incident also vary. Given that we are using one type of call to the MPD, we cannot fruitfully discuss these matters except to point out that informal effects cannot be discerned when formal procedures apparently limit response and/or referral.

COMMENT

Police work, it has been argued, is an honorable occupation, concerned with maintaining traditional values of patriotism, masculinity, violence, confrontation, and husbanding the sentiment of honor (see Westley, 1951; Manning, 1977). While Van Maanen, Westley, Chevigney, Skolnick, and Bittner have written about the interactional ploys used to deal with affronts to honor or "contempt of cop," and while Bittner (1970) has speculated about the consequences of the remnants of the violence obligation borne by the police, the organizational consequences of honorable thinking have been little explored.

This "honor core" of policing affects service delivery insofar as the assumptions made about the types of persons encountered and the types of work entailed lead officers to see their jobs not only as "shit work," but as potentially dishonoring. They can bring no honor as can the handling of a criminal, but they can bring shame, errors in handling, embarrassment, and encounters with citizens who are unruly and unpleasant even though they are viewed as members of the "respectable classes." Second, such matters of attitude affect the dispatching controller's discretion. Third, if technological means of handling calls increase, the context within which such encounters is placed becomes more and more abstract, useless to the officer, and difficult to use as a basis for assessing the quality of handling of such incidents. Fourth, it masks the underlying pathology manifested in the event that might aid further diagnosis or treatment, once these persons are jailed.

Formal classifications are thus misleading as regarding workload, distribution of these types of events, and the relative significance of the mentally ill in policing. Formal records of calls for service, calls referred, warrants served, and the like are profoundly misleading because they do not contain information on the disposition of the case. Conversely, records of police encounters with the mentally ill are most precise when they result from legal action (serving of warrants) and less precise as they reflect records of dispatch. Field observations, such as those gathered by Teplin (1983), Sykes and Brent (1983), and Bittner (1967a, 1967b) are much needed before the

policy implications of contact between the mentally ill and the police can even be addressed. Finally, changes in procedural rules and rules for handling police communications are not an adequate answer to the problems articulated in this chapter. The concern with honor and dishonor is a background context for hearing and interpreting calls even in a "professional" police department. It is not argued that the primary determinants of police action are symbolic and the result of interpretation, but rather that the interpretative aspects of message-processing are somewhat independent of the informational aspects. Both must be considered in order to account for the transformation of messages in a communication system.

NOTES

1. One can think in this connection of the work of Westley (1951) on "homosexuals" and "drunks"; Sacks (1972) on "moral character"; Chevigny (1969) on those who resist or argue; Skolnick (1966) on the "symbolic assailant"; Van Maanen (1978) on the notorious "asshole"; and Bittner (1967a) on police views of slum dwellers and the mentally ill (1967b). Holdaway (1983) argues that such stereotyping has been most frequently attributed to American police and subsequently uncritically extended to British police without adequate conceptual analyses nor empirical data to establish such assertions. My research suggests that he is correct with respect to the notion of the dangerous or symbolic assailant concept of Skolnick (1966). It is differentially relevant to American policing by region, size of city, and the role specialization of the officer, as well as being rather unimportant among the British forces I have studied.

2. Bittner (1967a, 1967b, 1970, 1974) argues that the social organization of the sentiments of policing produces a view of the work as a set of attitudes, practices, and procedures that have their validation in a perspective that defines the nature of success in the work rather than in external valuation or formal theories of police work (see Wilson, 1968; Clark and Sykes, 1974; Manning, 1977; Jermier and Berkes, 1979; and for a detailed, organizationally based analysis, Brown, 1981). A recent collection (Punch, 1983) examines administration generally in policing.

3. Bittner notes that data are difficult to obtain from records, since seldom are records kept on peace-keeping episodes (see Meyer, 1974). Records studies produce a view of police actions that underestimates the extent, type, and manner of keeping the peace.

4. The most recent study, in progress at both sites since January 1979, relies on observations, interviews, and data derived from official incident reports and other records of crime and calls to the police and their disposition. The research was funded by Michigan State University and LEAA Grant #79-NI-AX-0095, and was assisted by fellowships at the University of Surrey in 1979, the Centre for Socio-Legal Studies, Wolfson College, Oxford (1981-1982), and by Balliol College, Oxford (1982-1983). I am very grateful for the support and personal concern shown to me by my colleagues at Surrey, Wolfson, and Balliol.

5. See Watren's (1982) book on the court context within which such writs are hopelessly pursued. Court orders are viewed as nonproblematic because they call for skills the police are presumed to possess such as the ability to locate someone and

persuade them to accompany the police, or to use the force necessary to produce this compliance and to deliver them into the hands of others, such as an agency of the court. However, the usual problematic questions of control, honor, dignity, and potential for embarrassment remain in these interactions whether or not they are court-ordered.

6. The police may view this as a matter in which they are not expert, or they may define intervention as a question of economy, since many people they encounter may be ostensibly defined as mentally ill but are not taken in. Some may not view intervention as "real" or "good" police work, something for which they may anticipate organizational rewards; they may wish to avoid the tedious and time-consuming task of taking someone in, or they may resist locking people up with other crazy people (1967a: 281-282).

7. Research based on events recorded in official police categories (for example, as Part I or Part II crimes, "all clear on arrival," and the like) do not explore how the call was initially labeled, how it was interpreted by officers, and what effects such organizational processing might have had on messages and police actions (Scott, 1981). Police interpretations are suggested to be relevant by Black (1980: 5-7), and radio-dispatched calls are mentioned in passing by Bittner but not separately analyzed. How, if at all, does message-processing affect policing in the case of the mentally ill, and how are these communication processes, both formal and informal, related to the traditional structure and organization of police work?

8. Some of the material appeared originally in Manning, 1982b.

9. Workload effects of crime calls are inferred from data from urban police such as Black and Reiss (1967) report, but the actual process of responding to such notional events has been little studied.

10. This is another feature of the temporality of work suggested by Teplin's (1983) work on alcohol-related incidents, in which she hypothesizes that the busier the officer with crime, the less likely he or she will make a formal disposition of an alcohol offense. Insofar as alcohol and mentally ill cases are analogous order-maintenance work, this may also be true for mental cases. My data do not permit me to speculate on this matter.

11. Similar arguments for domestics have been made by Parnas (1967) and Manning (1982).

12. The case is made in detail for the generality of these effects in my forthcoming book, *Signifying Calls*.

13. The form of analysis used here has been adapted from the larger project from which these examples are drawn. The aim is to explore the effects of coding and classification, the specific roles and tasks carried out in each organization, and the technology and the interpretations made of the messages. The interest is in explicating those matters other than the informational content of the message that shape its processing. The detailed analysis of any type of message concerning, for example, the mentally ill, cannot be reproduced here in part because the effects identified are much the same for any message, and are not exclusively associated with messages concerning the mentally ill. On the other hand, cases involving the mentally ill are few in observations and fieldnotes. What follows is more illustrative of the workings of the two police communications systems than of the handling of the mentally ill. The essential features of the processing of calls is sought rather than the empirical distribution of the outcome of such calls.

14. These names and numbers are derived from an observed incident, but are modified.

15. Officers work in "sections" of approximately 25 people, including an inspector, two or three sergeants, and 20 or so PCs who rotate on 8-hour turns of duty.

16. The coding effect is treated elsewhere for each of the four sources of messages (see Manning, forthcoming).

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IV

THE DEFINITION AND MANAGEMENT OF DEVIANT BEHAVIOR

Both chapters in this section examine the definition and management of persons defined to be "dangerous." Much of the research literature on dangerousness has focused either on the relative dangerousness of the mentally ill or on the accuracy of predicting dangerous acts. There has been relatively little work on the way in which the label of "dangerous" is derived and applied.

Chapter 9 explores the process of defining persons as dangerous and argues quite convincingly that in the absence of objective standards and/or tests, the definition of dangerousness is essentially a social construction of reality. As in Chapter 7, we see that the disposition of persons who exhibit problematic behavior is less a function of their symptomatology than the result of a number of external exigencies.

Chapter 10 examines the way in which persons exhibiting deviant behavior are managed via commitment. As outlined in the introduction to this volume, the criteria for commitment have become more stringent, and most mental health codes are now based on the standard of "dangerous to self or others." Some mental health professionals feel that the emphasis on dangerous behavior as a prerequisite for commitment will result in a situation in which persons who are in need of psychological assistance but do not meet the criteria for commitment go untreated. At the same time, it is feared that the emphasis on dangerousness will result in an influx of violent patients into the public hospitals. Hiday and Suval's provocative research shows that

neither of these apprehensions has been realized. Moreover, they found that alcoholics who were "dangerous" were less likely to be committed than mentally ill persons who committed acts of dangerousness.

Chapter 9

PREDICTING DANGEROUSNESS
A Social Deconstruction of Psychiatric Reality

STEPHEN J. PFOHL

> What, then, is the role of the psychiatrist in penal matters? He is not an expert on responsibility, but an adviser on punishment; it is up to him to say whether a subject is "dangerous", in what way one should be protected from him, how one should intervene to alter him, whether it would be better to try to force him into submission or to treat him.
>
> —Michael Foucault, from *Discipline and Punish* (1979: 22)

The assessment of dangerousness is one of the most perplexing issues confronting criminal justice and mental health policymakers. Contemporary concern with identifying and controlling people who represent an immediate threat of violence to others (or to themselves) is linked both to the conservative outcry about violent crime and to liberal reform efforts aimed at depopulating public institutions of all but those who are "truly dangerous." While conservative Chief Justice Warren Burger calls for decisions about granting bail to be linked to "the crucial element of future dangerousness" (Burger, 1981: 46), liberal legal advocates have heralded clinical predictions of violence as a "valid standard" for determining who needs to be confined behind the thick walls of maximum security hospitals and prisons (Mental Horizons, 1975: 7). Indeed, the assessment of dangerousness has become the sole criterion for involuntary mental hospitalization (Stone, 1975), is advanced as a primary determinant for incarceration or maximum security (Morris, 1974), and is used in some fifteen areas of criminal justice and mental health decision making,

including judgments regarding parole, sentencing, transfer, furlough, and work-release (Shah, 1978).

Although currently buoyed by the combination of conservative and liberal concern, efforts to predict dangerousness are not new. Indeed, since the dawn of centralized state authority, diagnostic control agents have been commissioned to sort out those from whom the rest of us should be protected. During periods of dramatic social strife, such diagnostic work has taken the form of witch hunts, purges, and inquisitions. During more tranquil periods it was carried out in the everyday work of police, prosecutors, judges, psychiatrists, and the like. At all times diagnostic practice has been justified by the symbolic legitimacy of the garb in which it is dressed, garb reflecting the dominant cosmological beliefs of the day—be they based in religion, reason, or science.

In contemporary Western society, diagnoses of dangerousness are generally dressed in the clothing of clinical or medical science. This provides diagnostic specialists with a position of epistemological privilege. They are believed capable of knowing that which most of us are doomed to guess—for instance, how others will act tomorrow and whether their actions will be sufficiently harmful to justify their detention within a maximum-security public institution. This is a powerful privilege. Clinical scientists (psychiatrists, psychologists, and psychiatric social workers) are charged with reading the social and psychological text of another person's life (what someone has done and what others claim someone has done) in order to determine whether he or she should be denied freedom of movement within society. How adequate is this reading? How well does current diagnostic practice fit the rigorous scientific standards in which it is dressed? How valid are the clinical tools of prediction? How do they withstand the test of empirical research?

Equally important are questions related to the social, legal, and political implications of such privileged clinical readings. To what degree do the methods of clinical prediction—by narrowing the assessment of dangerousness to matters of individual pathology—contribute to the reproduction of an existing structure of power in society? By isolating individuals who threaten the maintenance of existing social relations, are clinical experts structurally (if not intentionally) serving the interests of those who gain the most by life as it is currently ordered? These questions are explored throughout the course of this chapter.

In order to assess the adequacy of clinical or psychiatric assessments of violence and to evaluate the practical consequences of current diagnostic work, I shall first overview what past research tells us about the validity of predictive judgments and then report on a study

of diagnostic work in action. By examining the social construction of clinical judgments, I hope to open up or deconstruct the coded political meaning of predictive psychiatric practice. The chapter concludes with a discussion of policy implications and a proposal for an alternative reading of dangerousness as a matter of social rather than clinical concern.

THE EMPIRICAL ADEQUACY OF PREDICTIVE METHODS

Despite an increasing demand for their use, methodologies for predicting dangerousness find very little empirical support. One recent review article has gone so far as to characterize the assessment process as nothing more than "flipping coins in the courtroom" (Ennis and Litwack, 1974). As inaccurate as predictions may be, equally troubling is the manner in which they consistently err through overprediction. In one study after another, the same conclusion emerges: For every one correct prediction of violence, there are numerous incorrect predictions. Thus, for all persons confined on the basis of psychiatric predictions of violence, "there are a few who would, and many more who would not, actually engage in such conduct if released" (Dershowitz, 1969: 47).

Conclusions regarding inaccuracy and overprediction are supported by a variety of empirical investigations. Wenk et al. (1972) reported on three such research efforts. The first involved efforts to develop a "violence predictor scale" to aid parole decision making. Using such predictive items as commitment offense, number of prior commitments, opiate use, and length of imprisonment, a small number of offenders were identified as likely to be violent. Nonetheless, 85% of this high-risk group never committed a violent act while on parole. In a second study, offender histories and psychiatric reports were used to assign 7712 parolees to categories reflecting a potential for violence. The results were even more discouraging. Each correct prediction of subsequent violence was accompanied by 326 incorrect predictions. The third study utilized 100 possibly predictive variables, including extensive case histories, data from psychiatric diagnoses, and the results of psychological testing for 4146 wards of the California Youth Authority followed for 15 months after release. The best indicator of future violence was a previous history of violence. Yet even this measure resulted in 19 false positives for every 20 predictions. Various multivariate regression equations were also employed in assessing the impact of the 100 variables. The best of these produced no better than eight false predictions for every accurate prediction.

A subsequent analysis of 350 variables for 2200 males paroled from Michigan prisons in 1971 produced a somewhat higher rate of predictive accuracy. For persons rated as "very high risks," 40% were arrested for violence during a follow-up period averaging 14 months (State of Michigan, 1978). Differences between the California and Michigan studies are accounted for, in part, by two factors. The offender population in Michigan had a higher statistical base rate for violence. At the same time, Michigan researchers measured subsequent violence by arrest, while the California investigators used the more stringent criterion of conviction and return to prison (Monahan, 1981: 103-104). Even under these more favorably predictive conditions, violence was overpredicted in 60% of the cases.

A five year follow-up of patients released from the Massachusetts Center for the Diagnosis and Treatment of Dangerous Persons provides additional information on the question of predictive accuracy (Kozol et al., 1972). Recommendations were made for retention or release on the basis of independent assessment by at least two psychiatrists, two psychologists, and one social worker. Each examination, moreover, included a full battery of psychological tests and a rigorous attempt to reconstruct a patient's life history using information obtained from the person's family, friends, neighbors, teachers, employers, as well as court, correctional, and mental hospital records. Of 435 released during a ten-year period, 49 releases were made against the clinical predictions of Kozol and his associates. In all, 34% of this group (predicted to be dangerous, but released anyway) committed serious assaultive acts during a five-year follow-up period. Only 8% of those released with assessments as nondangerous committed similar acts of violence. As such, the multidimensional Massachusetts prediction model may initially be seen as a great step forward.

It should be remembered, however, that 65% of the individuals labeled as dangerous did not later commit a violent act. Thus, despite its complex and sophisticated design, the Massachusetts model still overpredicted violence in two out of every three assessments. Similar patterns of inaccuracy were discovered in a follow-up of released residents at Maryland's Patuxant Institution, where a comparison of staff recommendations with subsequent recidivism yielded false positives at a rate of 54 (Stanford, 1972). Moreover, Megargee's (1970) extensive review of the relationship between psychological testing and the prediction of violence concludes that no assessment tool exists that adequately *postdicts*, let alone *predicts*, violent behavior.

Indeed, the highest rate of predictive accuracy achieved by psychological testing, a sophisticated computer-based combination of

information from such instruments as the MMPI and Q-sort, is no higher than one-in-three (McGuire, 1976). Such discouraging findings have led more recent investigators to advocate the inclusion of clinical data related to such things as cognitive mapping (Blackburn, 1983) or "unfakeable" biological parameters of violence (Woodman, 1983). To date, however, these more recent predictive strategies have proved no more valid or reliable than their clinical predecessors.

Perhaps the most convincing evidence about the inadequacy of predictive practice comes from a four-year follow-up of New York State's so-called Baxstrom patients (Steadman and Cocozza, 1974). These patients were transferred from two maximum-security hospitals for the criminally insane as a result of a court ruling on the illegality of administrative transfers that converted sentenced prisoners into indefinitely confined mental patients. Since all patients were being retained because they were presumed to be dangerous, their release provided a rare opportunity for naturalistic research on the validity of the predictive process. The results of this study confirm what was noted previously—that predictions are inaccurate and err in the direction of overprediction.

During the four-year follow-up, only 20% of these supposedly dangerous patients proved assaultive in either a civilian hospital or in the community. Of 927 transferred to lesser restrictive hospitals, only 27 were returned to maximum security. Of those released to the community, only 20% were rearrested. Virtually all of these arrests were for "nuisance crimes" such as vagrancy and intoxication. Only 5% were for felonies. Moreover, the two factors most closely associated with recidivism or rehospitalization, age and severity of criminal history, still resulted in two false predictions for every one correct prediction. Even then, the problematic rate of prediction could be achieved only by lumping patients 50 years or younger in the same age category. This means that to achieve a maximum rate of predictive accuracy (false for every correct), one must retain custody of all patients under age 50 (most patients). The results of a follow-up of 438 allegedly dangerous patients from a Pennsylvania State hospital revealed discouragingly similar results. Only 14% of these released patients acted violently during a four-year period (Thornberry and Jacoby, 1979).

The research described above suggests that predictions of dangerousness have been consistently characterized by low levels of validity. This finding is even more striking considering the fact that the patient and prison populations studies were systematically biased in the direction of positive results. Research subjects were, after all, primarily convicted offenders, sexual psychopaths, and adjudicated delin-

quents. Yet even for this highly eschewed sample, rates of false positives ran between 54% and 99%. The massive failure of these attempts to predict dangerousness is summarized by Monahan (1975, 1981), who suggests that violence is vastly overpredicted, regardless of whether one relies on standardized psychological testing, in-depth clinical assessment, past behavioral histories, or multivariate statistical research.

In the wake of considerable doubt about the validity of existing predictive methods, it is important to ask how it is that psychiatric professionals construct believable diagnostic readings of their patients' potential for future violence. How, in other words, do they socially accomplish what the empirical literature suggests cannot clinically be done? With this question in mind, let us turn to an analysis of the actual diagnostic work of a select group of psychiatric professionals, experts chosen to make predictive clinical judgments for approximately 700 patients housed within Ohio's Lima State Hospital, a maximum-security hospital for the criminally insane (Pfohl, 1978). By considering an individual's past record and assessing present performance, these examiners were asked to determine whether someone was so dangerous as to require maximum-security confinement.

Of what did their clinical readings consist? To what degree did their diagnostic work articulate the structural prejudices of a wider order of stratified social power? If the validity of the prediction of dangerousness is questionable, its political importance is not. Its practical political consequence is to invoke the power of the state to confine or release people in the name of expert clinical science.

METHODOLOGY

The following analysis is based on a field study of twelve multidisciplinary review teams ordered by a federal court to evaluate the dangerousness of each patient hospitalized within Lima State Hospital, Ohio's maximum-security facility for the criminally insane. Each team consisted of a psychiatrist, a clinical psychologist, and a psychiatric social worker. The clinical readings produced by each team were studied by a combination of several methods. Seven observers recorded information on the social dynamics of clinical work in 130 diagnostic sessions. After obtaining informed consents, observers situated themselves as unobtrusively as possible so as to note relevant features of clinician-patient interaction and to make tape recordings of all that was said before, during, and after diagnostic interviews. Participating clinicians were subsequently interviewed

by researchers who asked open-ended questions both about their diagnostic work and their participation in this study. An analysis of these several sources of data provides the basis for my interpretation of the manner in which clinicians diagnostically read the dangerousness of others.

TWO TYPES OF CLINICAL READING: THE SIMPLY DANGEROUS AND THE PSYCHOPATHICALLY DANGEROUS

Interviews with participating clinicians revealed that assessments of dangerousness were divided between two categories of patients: those whose mental disturbances prevented them from following society's rules and those who had not internalized society's rules in the first place. For analytical purposes, we shall refer to the first group as "simply dangerous" and the second as "psychopathically dangerous."

To read someone as simply dangerous, it was necessary to see that person as representing a threat to human life, having a history of past violence, and being "out of control" during the diagnostic interview. Exceptions to these criteria involved two modifications of the history-of-violence prerequisite and a host of idiosyncratic standards used as additional indices of dangerousness. Regarding past violence, teams were inconsistent in defining the issue of recency. Some teams considered any violent act as important. Others set twenty-, ten-, five-, and even two-year yardsticks of relevancy. A second qualifier involved an occasional reading of "dangerous delusions." A patient believed to be living within the representational world of such paranoid constructions was seen as likely to use violence to defend his or her delusions, regardless of whether that person had actually acted violently in the past.

Each diagnostic team also read patients according to rules unique to that particular group of clinicians. One team, for instance, placed extraordinary emphasis on the importance of information contained in the narrative text of past clinical records. Another team relied exclusively on a numerical count of previous violence, while still another focused primarily on the ability to express insight into previous aggressive episodes. Others emphasized the importance of dreams and fantasy, the results of psychological testing, or signs of repressed anger. One team even stated that what was most important was how they would feel "having this man as a next-door neighbor."

It was not necessary for patients classified as psychopathically dangerous to have had an actual history of life-threatening behaviors.

These patients, characterized by nearly all clinicians as "manipulators" and "con artists," were described by one team as a "bunch of scary boys," and by another as "lacking the very quality of humanness." Clinicians stated that there was no telling what these conscience-less individuals were capable of doing. Often they were viewed as even more dangerous than those who had actually harmed others in the past. Whereas clinicians watched for "lack of control" in their readings of the simply dangerous, they looked for evidence of "excuse-making" or "rationalization" during interviews with those suspected of being psychopathically dangerous.

Up to this point I have reported only what clinicians described retrospectively as their own criteria for assessing dangerousness. What criteria were used in the complex social interactions that characterize diagnostic work in practice? How concretely did clinicians know if someone was out of control? How was one team able to realize that two years, rather than ten, was the proper measure of the recency of past violence, while another realized exactly the opposite? How was it known that someone suspected of being psychopathically dangerous was rationalizing more than telling the truth, manipulating rather than telling an honest story? These are questions central to an understanding of the social dynamics of actual diagnostic readings. They are pursued in the analysis of the following transcripts of verbal exchanges between clinicians charged with the prediction of dangerousness. My review of these diagnostic texts is organized in keeping with the sequential order of clinical work itself; it is divided into three phases of psychiatric decision making: the preinterview, interview, and postinterview.

THE PREINTERVIEW: CONSTRUCTING A THEORETICAL NARRATIVE OF PATHOLOGY

Psychiatric professionals typically read a patient's past record before actually conducting a diagnostic interview. This enables clinicians to focus their questions on areas of mental disturbance noted during previous clinical examinations. In attempting to assess dangerousness, such readings may also alert clinicians to signs of violence in patients who have been diagnosed as dangerous at some earlier point in time. One psychiatrist explained this in the following manner:

> In terms of dangerousness we would check the past record. This gave us a pretty good idea about past performances. And when it showed considerable acting out . . . we were . . . generally apprehensive, to say the least, as to their possibility of striking out right there and then.

The collective reading of past records did more than make clinicians apprehensive of certain patients. It served as the raw textual material for constructing elaborate theoretical accounts about patients and the nature of their present pathological condition. Complex and often contradictory materials from the past were narratively assembled into relatively neat and simple clinical stories about who someone was and why he or she acted in a particular fashion. This process of narrative construction is evidenced in the following excerpt:

Psychiatrist:	Escapee . . . [patient's name] . . . You know what that means, I'll tell you what that means. It means that sometime in the past, maybe in jail, maybe ten years ago, a guy escaped and they're required to put Escapee on their chart; it doesn't mean anything at all. I have very little on him, too. He's a 19-year-old kid who got busted and who got a 20 to 40-year sentence for selling acid.
Psychologist:	Sounds like New York State.
Social Worker:	I was going to say it look justified . . .
Psychiatrist:	But he has a long history . . .
Social Worker:	He's not a nice kid.
Psychiatrist:	He's been a drug user, a drug pusher. They don't like this. They say all his life he's lied, he's stolen, he's exhibiting no moral sense.
Social Worker:	[reading from record] Cruel to animals, set fire to neighbor's . . .
Psychiatrist:	Breaking and entering, auto theft . . .
Social Worker:	. . . never loyal at anyone, no moral sense of people.
Psychologist:	There was an old study in terms of violence, too, and we haven't even discussed this, but if a kid before the age of, whatever, 10, has been cruel to animals, had a problem with setting of fires, and suffered any . . . there was like a 90 percent chance of violent . . .
Psychiatrist:	He's been to JDC, BYS. IQ of 109.
Psychologist:	Yep.
Psychiatrist:	He's never really worked. He's doing very well in the hospital.
Psychologist:	It sounds like we do have a stone here.
Psychiatrist:	We have what?
Psychologist:	Stone.

Psychiatrist: Is that the term for the . . . ?

Psychologist: No, that's our little private term—stone cold psychopath.

Psychiatrist: Yeah.

Psychologist: That last guy we saw I don't think was. I wouldn't classify him stone.

Psychiatrist: He's not stone cold.

Psychologist: Right. When he's on the street, he acts pretty stone cold, I bet. But it's situational. If you could work with it, while it's here. He's not adapting as well as the other guys. He'll get the hang of it. [This statement was in reference to the previous patient. The psychologist now continues to discuss the patient at hand.] What about relationships? Wife, girlfiend, mother, father?

Psychiatrist: He's single. I think he talks about getting a raw deal . . .

Psychologist: Oh, yeah.

Psychologist: A wooden leg! [This statement is in reference to an item the social worker has noted in the patient's chart.] I can't help it. Look at me. I've got a wooden leg.

Psychiatrist: Talk about rationalization! Wait till we get downstairs. They're loaded.

Social Worker: Oh, really?

Psychiatrist: His parents are divorced and he never got along with his stepfather.

Psychologist: What about the mother? This guy probably never got along with anybody.

Social Worker: Right. [reading from chart] He's self-centered and doesn't want to take the time to get help . . . [patient review 422].

Psychologist: That's 'cause nothing ever bothered him.

From the beginning we witness the diagnostic team using traces from the past record to construct a narrative reading of the patient as he is today. The designations "escapee," "arrested for drugs," and "long history" not only look justified but reveal that "he's not a nice kid." The repetitive assemblage of particular facts (cruelty to animals, setting fires, breaking and entering) is taken as evidence of a particu-

larly dominant storyline. The patient is someone who is "never loyal to anyone" and has "no moral sense of people."

Once articulated, this theoretical storyline appears to have a life of its own. It is supported by reference to "an old study" indicating that persons such as this patient have "a 90 percent chance of violence." Given our previous review of the predictive literature, this unnamed old study looms as peculiarly fictional. No clinical indicators are as certain as 90%. Yet, within the contextual confines of clinical reading, the line between fiction and fact is loosely drawn. Unchecked by external constraints, the psychiatric team members proceed to elaborate their prospective theoretical understanding of a patient they have yet to meet. Possible contradictions are read as consistencies. Consider the observation that this "not nice kid" who has never really worked is "doing well in the hospital." Perhaps this apparent success is really due to the patient's ability to manipulate appearances. This is implied in the psychologist's statement, "It sounds like we do have stone here." After comparing this patient to "that last guy" seen by the team, the storyline is complete. This guy is indeed a "stone-cold psychopath."

After this point, the narrative snowballs. Immediately after reading this person as a psychopath, the psychologist asks about relationships. Psychopaths, of course, are believed incapable of forming committed relationships. The fact that he is single is in keeping with what the team already suspects. Being single, especially for a nineteen-year-old, might mean almost anything. But within the narrative story of a psychopath, it assumes representational importance as one more bit of evidence. The same is true of the patient's past statements about "getting a raw deal." Even the fact that he has a wooden leg is read accordingly. At one point the psychologist actually mimics what is supposed to be the patient's style of rationalization ("I can't help it. Look at me. I've got a wooden leg"). Under other circumstances, such a physical impairment might engender sympathy. Here, it is one small part of a clinical story of psychopathy ("Talk about rationalization! Wait till we get downstairs"). Down there, more psychopaths await similar diagnostic readings of those parts of their lives inscribed into a past clinical record.

The final exchanges between team members complete the clinical picture being painted. After the psychiatrist notes that the patient never got along with his stepfather, the psychologist both asks and answers a question regarding the patient's relationship with his mother. By now, the team already knows the patient's story. He "probably never got along with anybody." Why didn't he take time to get help?

No need to ask the patient. The team already knows the answer: "'cause nothing ever bothered him." Thereafter, the patient is invited into the room to be interviewed. In this case and others, however, the interview is narratively guided by what clinicians already know. This constrictive formulation of what clinicians are going to look for and see in subsequent interviewing is found in case after case.

The psychiatrist completes his review of the record with the following summary judgment:

Psychiatrist: He had a cocky attitude but does not cause any major difficulties to the program or its function. He's workable for therapy but will need an extended period of time to achieve the necessary insight and emotional maturation. This case will be reevaluated later. So in other words, we already have the answer—that he still needs treatment.

Psychologist: Clearly true [patient review 361].

[Here the team reads a "psychopathic patient's" age as a sign that he needs to stay in maximum security longer. According to the psychologist, "The twenties is the worst decade to be a psychopath." This, suggests the psychiatrist, is because, "They haven't burned out yet." With this in mind, the psychiatrist announces his diagnostic opinion.

Psychiatrist: Well, I hate to admit this, but my mind is made up on these people even before we see them.

Psychologist: Well, there is wh- . . . we do have—it's a matter of degree here.

Social Worker: It's a matter of degree in terms of whether they stay here now or go back to court right away.

Psychiatrist: Yeah, well, I'll admit I'm a little prejudiced, but I'm going to withhold my judgment. Basically, what this guy is—what, twenty-two years of age. It's not just that he's into it. He's a psychopathic offender and he should stay here a longer time [patient review 421].

THE DIAGNOSTIC INTERVIEW: MANAGING A CLINICAL READING OF TALK

Conversation between clinicians and patients is typically structured by theories constructed about patients during the reading of the past record. Talk is managed selectively so as to elaborate the individualistic roots of the personal pathologies noted previously. A tight control over what is asked and what is heard as a valid answer permits

clinicians to expand and document their clinical reading of a patient's inner mental life. Two conversational practices used to accomplish this include a selective "offering of pathological accounts" and the offering of "explanatory commentary." Explanatory commentary follows a patient's response to a particular question. It permits diagnosticians to read beneath the literal meaning of a patient's words, to locate deeper clinical meanings. Often such explanatory commentary ("Now you can see the paranoid defenses in this type of answer") is offered only to other team members. It is as if the clinician making the observation were on-stage, making a dramatic aside that can only be heard by an audience of other clinicians. The patient sits dumb in this theatre of clinical readings. When it comes time for the patient to deliver a line, it is often prompted or cued by a leading questions, a line of inquiry offering a pathological account of behavior for the patient to claim as his or her own. This is illustrated in the following excerpts:

[This team has theorzied that the patient's problems are linked to his anger and resentment toward his father. Note how the patient is offered this particular theoretical account as an explanation of his behavior.]

Social Worker: If you were to look back at all the things you've done, that you've been arrested for and so on, would you say any of them got you, uh, did something for you in terms of getting back at your father [pause]?

Patient: Mmm, let me see if I understand your question. You're saying, that uh, uh, does any of these crimes that I've done have effect with my father?

Social Worker: Yeah, uh, where at one time you said . . .

Psychologist: Did you feel like you were getting even?

Social Worker: You know—like, "I'll get back at you, you bastard," and then go out and do something to show him up or make him feel bad or . . . [patient review 443].

[The patient in this case has been talking about his past charges for threatening his ex-wife.]

Psychiatrist: Why do you feel so intent about threatening her?

Patient: I don't know. Always around Christmastime it happens. I miss the family and . . .

Psychiatrist: And you say you don't have emotional problems? I didn't say you were mentally ill. We all as human

beings can have emotional problems. You certainly have displayed much of this. How do you feel?

Patient: I guess I do [patient review 362].

The preceding excerpts suggest that the narrative accounts offered by patients were selectively edited by clinicians even as they were uttered. Occasionally, this editing was kept from patients who thought that team members were sympathetically listening to what they had to say. During one interview, for instance, clinicians appeared to take seriously a story about how a patient was "railroaded" by a previous psychiatrist. Another team listened to a female patient's account of having been sexually abused in the hospital without revealing the true nature of their clinical reading of her words. In both instances, after the patient left the interview room, team members rewrote the clinical text to reflect what was "really" seen—evidence of paranoid or delusional thinking! As the team stated in describing the patient who claimed to have been abused, "Some of this goes on, but mostly it's just her delusions."

Overall, patients have little control over the way their talk is clinically read. In one notable case, a patient who was manifestly uncomfortable during an interview was encouraged to relax by telling a joke. After repeating a joke about a dumb Pollack told by one of the ward attendants, the patient was rudely informed that his words were not heard as a joke at all, but as a clinical measure of his true personality. The "dumb Pollack" in the joke was read clinically as a symbolic substitute for the "dumb hillbilly" that he thought himself to be.

Psychologist: Feel embarassed now? Your ears are turning a little red.

Patient: No, not embarrassed, a little idiotic that you wanted me to tell these jokes. But I guess you're just trying to make me feel comfortable.

Psychiatrist: No, I'm not trying to make you feel comfortable. People, uh, the kind of jokes that people think or tell or enjoy helps me to know something about them . . . [pause] . . . The joke that you told has something to do with the way you feel about yourself. The dumb Pollack joke. You refer to yourself as a dumb hillbilly? [patient review 423].

Teams also read the body language of patients in a similar fashion. In the next excerpt, a psychiatrist reads evidence of pathology into a "rather long look" that the patient gives the researcher observing the diagnostic session. According to the observer, the patient seemed (understandably) concerned about the fact that the interview was

being tape-recorded. The psychiatrist, equipped both with a trained clinical eye and an emerging theory that related the patient's past violence to his homosexuality, could "see" far more. He read the patient's gestures as reflective of a "certain lack of judgment."

Psychiatrist: He feels some persecution about being judged a homosexual. And—uh—when he was talking about who he was attracted to—uh—I forgot the question that preceded it, whether or not you asked if he was homosexual or what, I noted he gave a rather long look at our observer here, and—uh—I don't think that means anything much more than what we all suspect.

Psychologist: Yeah.

Psychiatrist: But—uh—I think it suggests a certain—uh—in that—uh—or lack of judgment. [As] if he was trying to cover his homosexuality, which he seemed to be doing [patient review 71].

THE POSTINTERVIEW: FINALIZING A PATHOLOGICAL READING

As soon as a patient leaves the room, the assessment process enters its final phase. In postinterview discussions, teams solidify their theories about a patient's pathology. Clinicians may begin with remarks such as, "Well, it's obvious to me . . . " or "It's pretty clear that the patient is . . . " Sometimes a final predictive reading awaits a process of negotiation and compromise. In any event, the situationally constructed nature of a particular diagnostic reading is quickly transformed into a transsituational statement about the patient's objective condition. Gone is the fact that a team's actual reading of a patient may be based on little more than the way the team interpreted the "dumb Pollack" joke that it asked a patient to recount. This actual reading is replaced by an abstract, highly technical, reconstructed reading in which this joke-telling behavior in interpreted professionally as an indicator of an "inadequate personality" or an "adult stress reaction" associated with an "inept personality." These latter instances of expert jargon appear to be more objective than the initial readings on which they are based. The same is true in case after case. The concrete social basis of specific predictive judgment is linguistically transformed into an abstract professional description of syndromes and symptoms. consider the clinicial reading of the "long look" of uncontrolled homosexuality in the last excerpt. In their final diagnostic text, clinicians transform this actual evidence into the abstract

conclusion that "he (the patient) shows apparent personality disorder, with a paranoid schizoid element."

Much of what has been observed about actual diagnostic readings in the preceding pages suggests that psychiatric decisions about dangerousness are the product of a complex and variable process of social interaction. Elsewhere I have described the way in which negotiated differences in power between team members (for instance, the typical dominance of psychiatrists over psychologists and social workers), and the manner in which clinicians anticipate the practical and political consequences of their decisions, are additional factors impacting on the predictive process (Pfohl, 1979a). At the end of each diagnostic session, however, all such social variables are buried beneath the individualistic focus of professional psychiatrist terminology. This carefully packaged terminology is more than a convenient shorthand. It is also a professional disguise for the loose situational hunches, inferences, and negotiated theorizing that produced it.

Equally important is the way in which the final clinical packaging of diagnostic opinions systematically obscures all but a highly individualistic reading of a particular patient's problems. Each of us lives a biography, the significance of which can be read at a variety of levels. Any human biography can be read as a story, not only about the idiosyncratic personal past but about a host of sociocultural economic, and political realities as well. The clinical assessment of dangerousness, as depicted here, favors one reading over all others. It reduces the complexity of multiple reality levels to the single reality of individual pathology. This is a measure of its professional success, its hegemony in the marketplace of predictive readings. In preparing a final diagnostic report, clinicians routinely transform the complex social realities of culture, class, or power into the individualistic reality of psychiatric language.

The requirement to identify individualistic clinical realities typically means that many patients will not be heard on their own terms. Most patients whose criminal and psychiatric careers have brought them to a maximum-security setting such as Lima State Hospital have lived in a milieu where most events are interpreted as occurring by "chance" or "fate." Most of them have experienced a class-based reality in which personal violence is taken as a "normal" response to affronts, challenges, and other troublesome situations. Most are presented daily with the political realities of discrimination or abusive actions by those "in charge." Yet, in the process of psychiatric assessment, accounts that employ fatalistic cultural notions, class-based definitions of violence, or a political critique of hospital practices are clinically reduced to evidence of delusional thinkings, denials of personal responsibility, and paranoid reactions. Certain social factors ("You

know, the first-degree murder thing, it was because he killed a white man" or "Well, we can't be shocked. We have to consider that this (incest) is more common among these people") can lead to a more sympathetic reading of patients. They are not allowed, however, to pass as valid theoretical accounts. Truly valid readings must be inscribed within the framework of individualistic clinical reality. This is evidenced in the excerpt to follow.

This case involves a young black male, paralyzed from the waist down, who is currently charged with carrying a concealed weapon. His parents reported him to the police for acting "too wild" around the house. Their testimony was a key element in his court commitment to Lima State Hospital. During the interview, the patient was composed but stated that he would probably continue to carry a weapon in order to protect his property, and that he had refused to take his medication because it made him sick.

After the interview, the psychologist expressed concern over the patient's paranoid state, his intent to carry a gun, his almost "unnatural fear" of someone taking his property, and his "perceived enmity or hostility towards his family." The psychiatrist elaborated on this, stating: "This is abnormal. You don't carry a knife, about to stab someone because you feel you'll get stabbed. This man is disturbed." The social worker initially seemed less sure. Couldn't the case be interpreted more sociologically? After all, this patient was living in a part of town where gun carrying could be seen as normal. In subsequent exchanges, the psychiatrist efficiently managed the conversation so that it was recognized that these broader issues were really not the patient's problem. His problem was psychiatrically refocused at the individual level. His disturbed behavior at home was the real issue. The social worker noted this and returned to theorizing about the patient's individualized trouble. Late in the interview, the social worker theorized entirely at the level of psychiatric reality. The patient's disturbed behavior was talked about as a form of compensation for his physical disability. A sociological reading of the patient's problems was reduced to an individualized psychiatric examination.

Social Worker: Uh, I agree that carrying—I think we ought to know another thing, too. This is a relatively young Black. I think he's got an attitude that is, I think indicative to many Blacks today. Which—he looks at other, maybe a White person here comes and says, "Well look, you know, why are you carrying a gun?" I mean the—I'm not saying he's looking at it from this perspective, you know, but, "Look, why shouldn't I carry a gun? I mean, Whites carry guns.

Look what you did in Viet Nam." Now, I could be off-base on this, but in . . . You have to look from whence he came. Like I know Detroit. It would not be normal to carry, to walk around with a gun.

Psychiatrist: OK. Now, I'm not disagreeing—

Social Worker: Because you don't know what's going to happen. I mean that fear in Detroit is so great, and the grabbing of power movement is so great that people do carry weapons.

Psychiatrist: Well, fine. What I was saying was this—all what you said is, I take in one hundred percent.

Social Worker: Mmm.

Psychiatrist: I take it into extreme, whatever you're saying.

Social Worker: Mmm.

Psychiatrist: But I bring it home and I come to your immediate parents.

Social Worker: And I agree with you there.

Psychiatrist: Alright.

Social Worker: Fine, because that's where . . .

Psychiatrist: And they felt the need that their son is not an adult, not controlled.

Social Worker: I agree with you.

Psychiatrist: And he's off.

Social Worker: I agree with you.

Psychiatrist: And this is the time where they called.

Social Worker: Yeah, they called.

Psychiatrist: That's right. They called for help from the [police].

Social Worker: Mmm.

[At this point the psychologist enters the conversation and engages the psychiatrist in a series of lengthy exchanges about the nature of the patient's family situation and the patient's legal status. When the psychiatrist calls for a final formulation of the team's recommendations, the social worker offers the following "individualized theorizing."]

Social Worker: I was just saying how that his rebelliousness might be a form of compensating for . . .

Psychiatrist: Oh yes. Oh, well, yes. Yes, of course, it is. All this . . .

Social Worker: Carrying a gun may give him part of his manhood [patient review 212].

Often the reduction of nonindividualistic patient accounts seems extraordinarily naive. The lower-class male, who was asked what he would do if someone started calling him obscene names, answered that it would depend on the gender of the name-caller. If it were a female, he would tell her to "shut her face." It it were a male, he would "have to get into it with him," for such a person deserved to get punched. Rather than reading this as a class-based response to displays of gender and violence, clinicians reduced this account to the alleged pathology disguised beneath. The distinction between males and females was read as an indicator of an ambivalence toward women, while the readiness to "get into it" with a male revealed that the patient's judgment remained impulsive.

Similar reductions occur when patients present themselves as political victims of exploitative institutional practices. The patient who voiced concern over mistreatment after being accused of circulating a petition that "undermined hospital policy" found his account reinterpreted as "indicative of some kind of marginal adjustment . . . because he gives a good excuse for everything." Other stories of medical, staff, or hospital discrimination were taken as documentation of rationalization and attempts to manipulate. After listening to a woman's account of having been sexually abused, one review team decided that her story provided evidence of delusions and projections of an unresolved homosexual identity. The team ignored the fact that this woman had actually testified at public hearings on institutional abuse.

The preceding examples illustrate an intrinsic element of the clinical reading of dangerousness—the reduction of a complex social situation to psychiatrized individuality. As with other interactional aspects of the prediction process, it remains backstage, away from the public eye. Never explicitly stated, it functions as an implicit guide to the psychiatric construction of dangerousness. What are we to say now that we have deconstructed this and other key elements of diagnostic decision making? Are there ways to make this process better—more effective, less arbitrary, more socially sensitive, more just?

CONCLUDING REMARKS

The psychiatric prediction of dangerousness is a political act because it invokes the power of the state to restrict the freedom of some of its

citizens (Bottoms and Brownsword, 1983). It does so in the name of an expert clinical science. An analysis of the methodological procedures of this clinical science suggests that its claim to predictive expertise is empirically unwarranted. Past research on predictive outcomes suggest that at its best, it falsely overestimates violence in approximately two out of three cases. My own research on how clinical readings of future violence are conducted suggests reasons for this inaccuracy. Diagnostic judgments are seen as contingent on a complex process of social interaction whereby clinicians construct theories about the future lives of patients based on present readings of past records. These clinical readings are subsequently expanded, modified, and justified as clinicians selectively guide the structure of psychiatric interviews and negotiate with each other over such matters as deferential status and the practical and political consequences of making a particular diagnosis. In the long run, however, all that clinicians do concretely is cloaked in the objective-sounding language of their final diagnostic report. In this text a multiplicity of social factors are reduced to an argot of individualized pathology. This is the most important political consequence of the diagnostic process. Past, present, and future behaviors are wrenched from their social context and made over into simple, believable stories of personalized disease and biographical maladjustment.

In pointing to the political implications of predictive psychiatric work, I am not suggesting that clinicians consciously victimize anyone, deliberately suppress alternative readings of the nature of dangerousness in its wider social context, or act as intentional gatekeepers of an existing social order. These things happen independent of what clinicians intend. They are a structural consequence of a nearly exclusive reliance on the medical model of social control (Foucault, 1975, 1979; Conrad and Schneider, 1980). Clinicians themselves are systematically socialized into a paradigm within which the world's troubles appear as but so many pathological variants of a healthy normality and the conformity it connotes. My criticism is thus not so much of clinicians as of that socially accepted logic that equates dangerousness with pathology and concentrates solutions to violence within the therapeutic control of individuals. The current respect accorded clinical logic as a method for predicting dangerousness has severe consequences both for individual and social justice. As such, it should be abandoned or at least significantly modified. In closing, let us examine proposed reforms at each of these levels.

THE REFORM OF CLINICAL PREDICTION: ISSUES OF INDIVIDUAL AND SOCIAL JUSTICE

Current clinical methods of prediction are unjust because they subject people to unproven and highly idiosyncratic readings of the potential for violence. There are today several proposals for reforming the prediction process which, if implemented, should reduce the arbitrary and capricious nature of clinical assessments. The first involves a *guarantee of legal advocacy*. This means that all final decisions about who is to be confined because they are believed dangerous should be made in a formal court setting with the availability of full legal protection and the possibility of a juried hearing. This will reduce the discretionary reign of psychiatric opinion without eliminating the value of careful clinical advice. It will permit psychiatric professionals to be queried about the actual bases of their predictive judgments and (not unlike this chapter) publicly deconstruct unwarranted clinical inferences.

The suggestion of advocacy and a juried court hearing is based on observations of several Lima State cases in which patients appealed recommendations made by psychiatric review teams. During these proceedings, lawyers interrogated clinical "experts" who had previously read patients as likely to be violent. The text of one predictive report stated that a patient was "a creature of pure impulse, with no controls whatsoever, no conscience, and no feelings of remorse or sensibility," and that he was "immediately dangerous to others and in continued need of hospitalization in a maximum-security facility." Legal advocates countered this recommendation with evidence that the patient "had not shown aggressiveness or assaultiveness" during his stay at the hospital. Hospital staff testified that the patient could be adequately cared for outside a maximum-security institution. Given this additional evidence, the court reversed the original clinical recommendation for continued maximum-security confinement. In this case the court widened its reading of dangerousness to include more than the text of an expert clinical assessment. The institutionalization of judicial advocacy would ensure that this would happen in each instance. For certain allegedly expert clinical witnesses, this may prove disconcerting, even discrediting (Brodsky, 1972: 95). For patients, however, it will increase the probability that their cases will be handled in a fair and defensible manner.

A second proposed reform is to limit predictive decisions to information related to actual incidences of past violence. This more rigorous

behavioral standard for prediction has several advantages. It utilizes the single best predictive factor (past behavior), more closely approximates "due process" standards employed by criminal courts, limits the discretionary snowballing of clinical theorizing, and provides a visible measure of judgment that can be consented to or contested by all parties in the predictive process. Evidence for the advantages of such behavioral standards is found in observations of Alabama's Prison Classification Project, which made judgments about the need for maximum security for each of the state's nearly 4000 inmates in 1976 (Pfohl, 1979a, 1979b). In essence, Alabama classification agents used a predictive model that attended only to the severity, frequency, and recency of violent acts. Inasmuch as this model was based on what someone actually did, rather than who clinicians thought one to be, it enhanced individual justice in the prediction process itself.

A third reform has been proposed by Monahan (1981), who suggests that the predictive accuracy of clinical assessments could be increased by including information related to statistical baselines of violence and to socioenvironmental correlates of violent action. Also to be considered are data relating to the availability of potential victims, weapons, and alcohol. By including such additional criteria, we might reasonably expect a significant reduction in the discretionary scope of current predictive techniques (for a related analysis, see Howells, 1983).

Monahan's suggestions represent an important step in widening the social vision of predictive decision making and securing a more just clinical reading for individuals encompassed within that vision. In terms of social justice, however, neither Monahan's proposals nor those concerning legal advocacy and behavioral standards go far enough. Consider the statistical and socioenvironmental factors that Monahan urges clinicians to incorporate within the assessment process. These include data on past violence, age, sex, race, socioeconomic status, and involvement with alcohol or opiates (Monahan, 1981: 104-112).

What will clinicians learn upon considering such information? Only what sociologically oriented criminologists already know too well—that young males from lower-class backgrounds are more likely than others to act with direct interpersonal violence (Curtis, 1974). How will such information be used? According to Monahan, it will enable clinicial professionals to better assist society in protecting itself from the dangers of violence. This appears both true and untrue. It is true if protection refers only to the immediate apprehension of persons with the highest short-term probability of assaulting others.

It is untrue if social protection means also addressing structural conditions that increase the likelihood of violence for "dangerous populations" as targeted by official statistical profiles. To predictively consider this structural side of the dangerousness question is to raise issues of social as well as individual justice.

With regard to social structural variables, it is important to note that not all predictive readings of dangerousness are as empirically unsupportable as the clinical models examined in the preceding pages. A sociological reading of aggregate rates of violence, for instance, is highly predictive of the age, class background, gender, and ethnicity of the typical criminal offender (Curtis, 1975). A recent study of serious criminal violence in seventeen major U.S. cities revealed that it is even possible to predict reliably the typical timing, spatial, and social context of interpersonal violence (Curtis, 1974). This cluster of factors can be read as an indicator of the potential for violence on the part of young, lower-class males who are taught that they possess symbols of power but whose daily life experience instructs them in the harsh lessons of a culturally nurtured political and economic dream unshared by them (Curtis, 1975). The consequences of the anger and frustration engendered by such socially structured contradictions may be read unambiguously in the lyrical prose of reggae singer Peter Tosh when he sings, "I'm like a stepping razor. Don't you watch my size. I'm dangerous."

Searching for signs of individual pathological disturbance, most variations of the clinical prediction model overread this simple message. Ignored is the socially structured political meaning of violence. I am not romanticizing the violence of anyone. I am simply suggesting that a sociological reading of dangerousness sees things that a clinical reading excludes. The meaning of individual acts of violence varies greatly. In one instance, violence may represent a self-conscious statement about intolerances in power. In another instance, violence may represent a passionate cry for power in the experience of its absence. In either case, it connotes a world of contradictory human action wider than the individualized confines of diagnosable psychiatric reality. To ignore this is to ignore those who benefit from and those who suffer by the social structural conditions that promote violence. It is to ignore the experience of inequality and its resultant frustrations and to ignore predictably dangerous social conditions in favor of unpredictably dangerous individuals. This in itself is a danger.

If this danger is to be avoided, current strategies of clinical assessment must be combined with the policy analyses of structurally oriented sociologists. This is not to say that clinicians need become sociologists. It is simply to suggest that clinicians who recognize the utility of incorporating social variables into diagnostic judgments might logi-

cally extend their diagnostic recommendations to include fundamental changes in social structures that predictably increase the likelihood of violent behavior. This will facilitate a more comprehensive reading of dangerousness, a reading that clinically locates a person's potential for violence within the structured confines of society—a reading sensitive to issues of social as well as individual justice.

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Chapter 10

DANGEROUSNESS OF THE MENTALLY ILL AND INEBRIATES IN CIVIL COMMITMENT

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Under civil law, the state's authority to commit an individual involuntarily to a mental hospital rests on both its *parens patriae* power (to protect individuals incapable of taking care of themselves) and its police power (to protect society). Prior to relatively recent reforms, *parens patriae* dominated civil commitment procedures and decisions. Attention focused on an individual's sickness, incapacity, and need for treatment.[1] Accordingly, civil commitment was viewed as beneficent and left in the hands of physicians.[2] Where court officials were involved, they generally deferred to medical expertise (Contemporary Studies Project, 1970; Dershowitz, 1968; Kutner, 1962; Litwack, 1974; Scheff, 1964; Shah, 1974; Wexler et al., 1971).

With the development of the mental health bar and extention of the civil rights struggle into mental hospitals, patient advocates argued the essential punitiveness of civil commitment. By focusing on the deprivation of liberty in involuntary hospitalization and the abuses that occurred under the paternalistic model (Bezanson, 1976; Ennis and Friedman, 1973; Kittrie, 1971; Miller, 1980; Morse, 1978; Steadman, 1979; Wexler, 1981), these advocates successfully directed attention to the police power basis of civil commitment and the necessity to restrain the power of the state over individuals. Accor-

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dingly, courts and state legislatures began to balance protection of the public against individual freedom. They established due process rights for individuals subjected to civil commitment and limited involuntary hospitalization to those mentally ill who were dangerous (Groethe, 1977; Ochberg and Brown, 1974; Schwitzgebel, 1981). Both the new procedural requirements and the restrictive standard of dangerousness have effected a greater involvement of legal officials and a reduced role of physicians in involuntary hospitalization decisions.

As one would expect, large numbers of psychiatrists expressed opposition to these changes in the law.[3] Some opposed the due process reforms because they resulted in handling the mentally ill as criminals and subjecting them to negatively traumatic adversary proceedings (Kittrie, 1971; Light, 1980; Scheff, 1964; Slovenko, 1977). The larger psychiatric response, however, has been against the dangerousness standard because of fears that (1) the character of the population of state mental hospitals would change and (2) persons in need of treatment would be abandoned (Chodoff, 1976; Halleck, 1974; McGarry, 1976; Stone, 1975; Stromberg and Stone, 1983; Treffert, 1974; Treffert and Kroject, 1977).

Psychiatrists argued that if civil commitment courts applied a vigorous dangerousness standard that screened out all but the most violent cases, the character of patient populations in state mental hospitals would drastically change. Patients would be more seriously disturbed, more difficult to handle, and require longer hospital stays. The concentration of such persons in mental hospitals would create havoc and destroy the treatment environment (Stone, 1975). Furthermore, psychiatrists argued that most mentally ill persons do not perform any overtly dangerous acts or threaten such acts, yet a large number of them are unable to recognize their need for treatment. A dangerousness standard ignores the issue of human suffering and its prevention by eliminating such persons from psychiatric care. Not being commitable, they would be left "to die with their rights on" (Treffert, 1974; Treffert and Kroject, 1977).

This chapter investigates the results of the dangerousness standard using a large sample of civil commitment cases from one state with a reform statute. It addresses the twin issues of the dangerousness of those being committed and the abandonment of the nondangerousness mentally ill. It also addresses the preliminary issue of the dangerousness of those against whom civil commitment procedures are begun. Specifically, we ask: How dangerous are those brought into court for involuntary civil commitment? How dangerous are those who are

committed to involuntary hospitalization by the courts? How do courts rule in cases involving nondangerous individuals? Are such persons dismissed with no help?

We address these questions for alleged inebriates as well as for the alleged mentally ill. Although the object of psychiatrists' concern about the dangerousness standard is with the mentally ill, civil commitment statutes often apply to alcoholics as well, reflecting the disease image of alcoholism. Despite statutory identification of alcoholics as appropriate for treatment through involuntary hospitalization, alcoholism's status as a mental disease has not been definitely established and accepted by either the courts (Fingarette, 1975; Kittrie, 1971) or health professionals (Knox, 1971; Meidling, 1974; Pemper, 1976; Riley and Marden, 1946; Sterne and Pittman, 1965). Because ambivalence concerning the disease model of alcoholism might affect decisions in involuntary commitment proceedings, we separate the alleged mentally ill from alleged inebriates in our analysis.

SETTING

In North Carolina (General Statutes § 122-58), the commitment process begins with a petitioner (any citizen) filing an affidavit with a magistrate/clerk alleging that another individual (the respondent) is mentally ill or inebriate and imminently dangerous[4] to self or others. If the magistrate finds sufficient evidence, he or she orders the respondent to be taken in custody to a local qualified physician for an examination. If the physician finds both mental illness/inebriety and imminent danger, the respondent is taken to an inpatient facility where a facility physician must examine the respondent again. If the previous findings are confirmed, the respondent is held for observation and evaluation until a district court hears the case (not longer than ten days from being taken into custody). If at any stage of the process evidence of mental illness/inebriety and imminent danger are not found, the respondent is to be released. Although four judgments are made prior to the district court hearing, it is the court that is to make the commitment decision on the basis of clear, cogent, and convincing evidence presented during the hearing. Unlike California and New York, a district court hearing is automatic for any respondent before he or she may be committed. The respondent does not have to petition for a hearing. Basic civil rights of notice, counsel, confrontation of witnesses, and appeal are given to the respondent.[5]

PROCEDURE

From March through August, 1979, we observed involuntary civil commitment hearings throughout North Carolina. Using an extensive checklist, two researchers in each hearing independently recorded the content of statements by lawyers, judges, and witnesses, including respondents. The checklist focused on efforts of lawyers and judges to uncover or refute evidence of dangerous acts, attempts, and threats. After a day's hearings, the two observers reviewed their checklists to make sure that neither had missed a motion, question, or piece of evidence. Notes taken during the hearings assisted in the review. Researchers also used official court documents to obtain basic demographic data and information concerning the written allegations of petitioners and physicians.

From statements by witnesses, we recorded mention of any one of five types of overt behavior that might be considered dangerous (physical attack, threat of physical attack with some action, threat of attack without any action, attack on property, and unintentionnal harm), and of the object of that behavior (self, other, or both).[6] The first three types of behavior were chosen because they place people in actual or potential danger of injury or loss of life. Physical attack includes any assault, even if it were checked when it began. Threat with some action excludes threats with attempts at physical harm but includes threats accompanied by any action that might permit the threat to be carried out later, such as threatening suicide and then buying rat poison. Threat without any action includes any statement of future action that might kill or injure a person, such as stating an intent to shoot someone. Thoughts of suicide or of another's death are not included as threats. Property attack was chosen as a fourth type of dangerous behavior because it represents such a loss of self-control and such irrationality that the attack could easily be turned against persons, so that they would be placed in fear that this violent behavior might be turned against them.[7] Unintentional harm was chosen as a fifth type, even though it is not an attack or threat. It can endanger life and limb through negligence or inability to avoid inflicting harm, such as wandering down the middle of a busy highway or pouring gasoline on a stove. Many states include such gravely disabled behavior in their civil commitment statutes.

Object of behavior is important to our analysis, because crucial differences exist between the two objects of harm—self and others. When psychiatrists predict that the dangerousness standard will lead to filling state mental hospitals with violent persons who are untreatable, they are thinking about persons who are dangerous to others,

Furthermore, it is only in the case of danger to others that the state's police power constitutes the basis of commitment. In the case of danger to self, the state's power rests in its *parens patriae* role of taking care of citizens who are unable to do so themselves (Lynch v. Baxley, 1974; see also Goode, 1975; Greenberg, 1974). Some legal scholars argue that the incarceration of an individual, even in a hospital, when society is not threatened approaches too closely violation of basic freedom. Hence, involuntary commitment under *parens patriae* should not be permitted; or, if it is allowed, it should be limited to cases of suicide and to self-mutilation attempts and threats (Brooks, 1978; Greenberg, 1974).

Although dangerousness is only one of two criteria for civil commitment, we shall focus on evidence of dangerousness and assume that mental illness or inebriety is established in each case. By law, the court is to find fact of mental illness or inebriety as well as dangerousness; generally, however, the presence of either of these is not questioned. A state of inebriety on admission is considered an obvious and simple observation, and psychiatric diagnosis of mental illness is considered in the realm of professional expertise. Almost never did attorneys or judges challenge the state of inebriety on admission or the psychiatric diagnosis of mental illness given in testimony or in affidavit (Hiday, 1981).

In our analysis, we first examine the distribution of respondents across type and object of dangerous behavior to describe the dangerousness of those brought into the civil commitment process. Second, we examine court decisions within each category of dangerous behavior to see whom the courts are committing to involuntary hospitalization and whom they are releasing. It should be emphasized that the dangerous behavior we describe is all such behavior alleged by witnesses in court testimony. It therefore includes dangerous behavior that did not reach the required level of proof (clear, cogent, and convincing) and excludes dangerous behavior that might have actually occurred but was not alleged in court. Failure to elicit witness testimony as to the presence or absence of specific dangerous behavior makes it impossible for the court to make a determination of a respondent's dangerousness independent of the psychiatric record.

SAMPLE

Most hearings were at state mental hospitals (81.5%); 10.9% were at other inpatient facilities; and 7.6% were in county courthouses. Of those hearings outside of state mental hospitals, 51.3% were in SMSAs, 25.6% in urban counties, and 23.1% in rural counties (those containing

no place with 10,000 or more population). Just over 17% of these represented a change in venue from judicial districts with state mental hospitals. We attempted to observe all venue change hearings but were unable to do so because of schedule conflicts, distance constraints, and notification problems. Hearings at state mental hospitals and in counties with regularly scheduled involuntary commitment hearings were sampled on the basis of convenience.

Our sample included 1135 respondents. Mean age was 43.4 years, with a range of 16 to 96. Few juveniles are included in our sample because the statute specified a different, "voluntary" procedure for them. Almost two-thirds of the respondents were white, one-third were black; less than 1% were other. Median monthly income of respondents was $303, with a range of $0.00 to $6250; only 19.8% were employed. However, income information was available on only 7.4% of all respondents and employment information on only 27.1%. Among those without income information, 3.1% were classified as upper middle class by observing dress and speech or on the basis of education/occupation information. The rest were observed to be lower class or lower middle class.[8]

Of the 1135 cases, 45.3% had no formal hearings. When a respondent was already released, when a facility physician recommended release or outpatient treatment to the court, or when a respondent signed voluntary papers, the court either held no hearing and signed papers ordering whatever the physician recommended (25.9%, N = 294) or held a brief hearing without taking testimony from any witnesses (19.4%, N = 220). Sometimes these brief hearings were used to lecture the respondent about taking medicine, keeping appointments with the mental health center, or controlling behavior. If the family were present and objected to release or outpatient treatment, the court held a formal hearing. Comparatively few alcoholic respondents received formal hearings, as many were dismissed from the hospital after detoxification before the scheduled hearings. There were 621 hearings with witnesses (49.9% had one witness; 32.9%, two witnesses; 11.1%, three witnesses; and 4.0%, four or more witnesses).

In this chapter we will confine our analysis to the allegedly mentally ill and inebriate adults at initial commitment hearings with witnesses. Rehearing cases—that is, cases of those who are currently involuntarily committed and being considered for a commitment extension—are excluded because the great majority of those we observed represented chronic cases of clear dangerousness to self as defined by a total inability to care for their basic needs. Juveniles were excluded

since most are "voluntarily" admitted and only aberrant cases come under involuntary commitment procedures. Inclusion of these cases would thus confound our analysis. We are left with 392 allegedly mentally ill respondents, 129 allegedly inebriate respondents, and 22 allegedly mentally ill respondents with a secondary diagnosis of alcoholism (hereafter referred to as "dual diagnosis").

RESULTS

Dangerousness of Respondents in Civil Commitment Court

Table 10.1 presents the number of cases with witness testimony about respondents' dangerous behavior by type and object, and by diagnostic category. Since hearings often involved several witnesses who testified about more than one episode of behavior, all witnesses were counted equally in examining testimony in a case. Although the categories used to classify behavior are comprehensive, they are not mutually exclusive, because witnesses could differ in their testimony about whether a dangerous act occurred or whether a respondent engaged in more than one dangerous act. For instance, one witness could testify that the respondent threatened to beat up someone, while a second witness testified that the respondent was a very gentle person who never had threatened to harm another. Thus there was a total of 230 mentally ill respondents with allegedly dangerous behavior but 386 allegations of one of the five types of dangerousness, 44 such inebriate respondents but 61 allegations, and 10 such dual diagnosis respondents but 21 allegations.

Among the mentally ill and dual diagnostic categories, threats were the most frequently reported dangerous behavior, and threats without any accompanying action were more than twice as frequently reported as threats with some action to execute them. Physical attacks were the next most frequently reported, followed closely by unintentional harm. Property attacks were the least frequently reported.

Compared with the mentally ill, alcoholic respondents had few allegations of dangerousness, and their pattern of types of dangerous behavior also varied. Only 34.1% of alcoholics had evidence of dangerous behavior, while 58.7% of the mentally ill had such evidence ($p < .001$, difference of proportions). Nearly half the allegations about alcoholics charged unintentional harm (45.9%), whereas that category constituted only 22.3% of allegations about the mentally ill

Table 10.1 Cases with Testimony of Dangerous Behavior by Type, Object, and Mental Illness or Inebriety Status

Type of Behavior[a]	*Mental Illness Only (N)*	*Inebriety Only (N)*	*Inebriety as Secondary Diagnosis (N)*
Physical Attack	107	6	6
Self	14	2	3
Other	88	4	3
Both	5	0	0
Threat with Action	45	5	2
Self	3	0	0
Other	39	5	2
Both	3	0	0
Threat	97	18	5
Self	13	4	2
Other	73	11	3
Both	11	3	0
Property Attack	51	4	4
Unintentional Harm	86	28	4
Self	77	27	4
Other	2	0	0
Both	7	1	0
N of Allegations	386	61	21
N of cases with evidence of dangerous behavior	230	44	10
Self	53	20	5
Other[b]	109	12	2
Both	68	12	3
N of cases with no mention of or all evidence denying dangerous behavior	162	85	12
Total N	392	129	22

a. Behavior types not mutually exclusive.
b. Property attack included as dangerous behavior directed at others.

($p < .001$). Frequency of reports of other types of dangerous behavior, however, followed the same progression among the inebriate as among the mentally ill and dual categories.

From Table 10.1 we see that the primary hazard posed by respondents engaging in attacks or threats was to the welfare of others—85.9% of all allegations of attack and threats. Attacks and threats of injury to self alone were involved in only a relatively few cases—less than

8.8% of all allegations of dangerous behavior. Respondents who are dangerous to self are much more likely to endanger their welfare by grave disablement than by any other types of dangerous behavior. Harmful behavior of a single type of dangerousness that endangers both self and others is quite infrequent, although combined allegations (for example, unintentional harm to self combined with a threat against another) resulted in similar proportions of cases with evidence of harm directed toward both as toward self alone among mentally ill respondents and as toward others among the inebriate and dual respondents. In all, dangerous to self (alone) cases constituted 23.0% of all mentally ill cases with allegedly dangerous behavior. With inebriate and dual respondents, the proportion was greater (45.5% and 50.0%, respectively). Curtailment of the state's ability to intervene in the life of a mentally ill or inebriate person whose only victim is himself would thus effectively exclude a significant proportion of respondents from commitment.

Perhaps the most important finding in this table is the large proportion of respondents with no testimony alleging any of the five types of dangerous behavior (41.4% of the mentally ill, 65.9% of inebriates, and 54.6% of the dual respondents). It is especially important when one considers that the easy cases are disposed of prior to reaching court by prehearing agreement between psychiatrists and counsel for release, outpatient treatment, voluntary hospitalization, or some other alternative to involuntary hospitalization. It is the more difficult cases—that is, cases of respondents who the psychiatrist thinks meet the criteria and need involuntary hospitalization—that get a formal court hearing.

COURT DECISION BY DANGEROUSNESS

Table 10.2 presents the court decision by each type of alleged dangerous behavior and by mention of the object of such behavior within diagnostic categories. Of cases with evidence alleging one or more of the five types of dangerous behavior, 66.1% of mentally ill respondents, 36.4% of inebriate respondents, and 70.0% of dual respondents were committed (difference between mentally ill and alcoholic respondents, $p < .001$). The highest commitment rate for all diagnostic categories came in cases in which there was testimony of property attack (72.5% among mentally ill respondents, 50.0% among inebriates, and 75.0% among dual respondents), and, for mental illness and dual categories, of physical attack (71.9% and 66.7%, respectively). The lowest commitment rates came in cases in

Table 10.2 Court Decision by Type and Object of Alleged Dangerous Behavior by Diagnostic Category

	Mentally Ill		*Inebriate*		*Mentally Ill*		*Total*	
Type of Behavior[a]	*N Alleged*	*% Committed*	*N Alleged*	*% Committed*	*N Alleged*	*% Committed*	*N Alleged*	*% Committed*
Physical Attack	107	71.9	6	16.7	6	66.7		
Self	14	50.0	2	0.0	3	66.7		
Other	88	76.1	4	25.0	3	66.7		
Both	5	60.0	0	—	0	NA		
Threat with Action	45	62.2	5	20.0	2	50.0		
Self	3	66.7	0	—	0	NA		
Other	39	61.5	5	20.0	2	50.0		
Both	3	66.7	0	—	0	NA		
Threat	97	66.0	18	44.4	5	60.0		
Self	13	61.5	4	50.0	2	50.0		
Other	73	65.8	11	36.4	3	66.7		
Both	11	72.7	3	66.7	0	NA		
Property Attack	51	72.5	4	50.0	4	75.0		
Unintentional Harm	86	65.1	28	50.0	3	100.0		
Self	77	68.8	27	51.9	3	100.0		
Other	2	0.0	0		0	NA		
Both	7	42.9	1	0.0	0	NA		
N of cases with evidence of dangerous behavior	230	66.1	44	36.4	10	70.0		
Self	53	52.8	20	40.0	5	60.0		
Other[b]	109	67.9	12	16.7	2	50.0		
Both	68	73.5	12	50.0	3	100.0		
N of cases with no mention of or all evidence denying dangerous behavior	162	35.2	85	12.9	12	33.3		
Total N	392	53.3	129	20.9	22	50.0		

a. Behavior types not mutually exclusive.
b. Property attack included as dangerous behavior directed against others.

which testimony of threats was given. Under all behavior types except for unintentional harm, there was a tendency for behavior directed against self to have lower proportions committed than dangerous behavior directed against others or against both self and others.

Because both the total number of allegations of dangerousness for alcoholics, and of cases of dual diagnosis, are small, considerable caution is needed in interpreting the findings. However, it is striking that for alcoholic respondents, the commitment rates were precisely the opposite of what would be expected if commitment were assumed to be most likely for the most dangerous behavior. Only one of the six inebriates who allegedly engaged in a physical attack was committed (16.7%), and only one of the five inebriates who threatened with action (20%) was committed. In both instances the attack or threat was directed against another person. Higher rates of commitment prevailed in cases alleging unintentional harm (50.0%). These findings suggest that more serious attacks by alcoholics against others are processed through the criminal justice system.

In contrast to mentally ill respondents, alcoholics were more likely to be committed if they were reported to be dangerous only to self (40.0%) than if they were reported to be dangerous to others (16.7%). As with the mentally ill, being dangerous to both self and others is more likely to result in commitment than being dangerous toward either for both the primary and secondary diagnosis of alcoholism.

Noncommitment with Allegations of Dangerous Behavior

While there is a positive association between involuntary commitment and evidence of dangerous behavior, the association is far from perfect. Why were some respondents not committed when there was testimony of dangerous behavior (N = 175)? One reason is that the evidence may not have reached the level of proof statutorily required from commitment—"clear, cogent, and convincing." A second reason is that in some cases the psychiatrist testified that the respondent was no longer dangerous or that the person could be treated outside the hospital, often because he or she had become stabilized on medication. In 6.4% of the cases of mentally ill and 38.1% of the alcoholic respondents with evidence of dangerous behavior, the psychiatrist recommended either release or a less restrictive alternative to commitment. A third reason is that in some cases the respondent's counsel persuaded the court that special circumstances had caused the client's unusual behavior, that the client was no longer dangerous, or that the client could obtain adequate help outside a mental hospital. Besides official commitment to outpatient treatment, the court often infor-

mally agreed to an alternative treatment but did not formally write it in the court order.

For alcoholics, decisions to release despite testimony of dangerousness reflect the interpretation of imminent dangerousness as just that. All alcoholics were detoxed, and most were no longer dangerous by the time of their hearings. The disoriented individual who was admitted to the hospital in a drunken stupor had changed to a sober, rational respondent in court. Of even greater significance in accounting for the release of some inebriates, despite evidence of dangerousness, is the perception on the part of some judges that mental hospitals are not appropriate treatment locales for alcoholics (Suval, 1981a). This perception is related to the belief that alcoholism is not a disease and/or is not amenable to treatment by medical personnel without the cooperation of the respondent. Some judges indicated that they were less convinced of the efficacy of hospitalization as treatment for alcoholics (compared with the mentally ill) by such statements as, "It won't do any good to commit him" and "The Alcoholic Rehabilitation Center (at the state hospital) is a waste of time." When judges did not feel that hospitalization was helpful to an unmotivated alcoholic, they simply ordered release. Where alcoholism is complicated by mental illness, judges are more willing to commit, perhaps reasoning that if the hospital can't do much to help the alcoholism, it can treat the mental illness.

Commitment without Allegations of Dangerous Behavior

Why were respondents without witness testimony of any of the five types of dangerous behavior committed by the court ($N = 259$)? For some of the mentally ill, there was evidence of a recent onset of nondangerous deviant behavior such as pouring stove-heated water on plants, being nude in the house, and running and bumping into things (23.8%). Such behavior can be annoying and disruptive, but it is not imminently dangerous by the definitions used here. Given the public's fear of the mentally ill and the association of dangerousness and unpredictability with mental illness (Fracchia et al., 1976; Steadman and Cocozza, 1978; Nunnally, 1961; O'Mahony, 1979), it is not surprising that relatives of these deviants become concerned, interpret their behavior as dangerous, and begin commitment proceedings. In cases of mentally ill respondents who have been previously dangerous, relatives may see such deviance as a first step toward one of the five types of dangerous behavior (and it may be). The court may be persuaded of a mentally ill respondent's dangerousness in such

cases. Sometimes there is evidence of the onset of bizarre actions due to the respondent's not taking his or her medication. With a history of past dangerousness, the court at times decides not to wait for a dangerous act and orders commitment.

In the case of most mentally ill and dual respondents without witness testimony alleging any of the five types of dangerous behavior (89.9%), a psychiatrist's affidavit lists facts indicating dangerousness,[9] that is, mentioning one of the five types of dangerous behavior used in this chapter. The statute allows such documentation into evidence if the respondent does not wish to cross-examine his psychiatrist. Seldom did respondent's counsel challenge the psychiatrist's indications of dangerousness in the affidavit (4.2% of mentally ill and dual cases), even though these affidavits did not always contain the legally required facts indicating imminent danger.[10] At the state mental hospitals where there was an attorney representing respondents in civil commitment cases full time and where psychiatrists could easily be called to court, respondents' counsel often did not wish to have the psychiatrist testify. Counsel had already talked to the doctor or a staff member and either knew that his testimony would be identical to what he wrote in the affidavit or that he would give evidence even more damaging to the respondent. In the first instance, counsel did not want to bother the psychiatrist unnecessarily; in the latter instance, counsel wanted to keep the more damaging facts out of evidence.

Outside of state mental hospitals, acceptance of the psychiatrist's affidavit for facts of dangerousness had a different basis. Counsel[11] tended to stipulate to the physician's affidavit in a ritualistic manner. Both counsel and judge tended to accept the medical affidavit as evidence of mental illness and imminent danger. As reported in Iowa, they viewed it without "even the slightest degree of skepticism" (Stier and Stoebe, 1979: 1390; see also Hiday, 1977b). It may have been that most affidavits were accurate in their description of dangerous behavior and there was nothing to gain by questioning the psychiatrist in court; we will never know. Given counsel's general failure to interview psychiatrists, petitioners, or other witnesses prior to court hearings, and frequent failure to interview respondents (Hiday, 1982), there is no means by which the court can judge their accuracy. Also, given the brief psychiatric examinations and respondents' often not exhibiting one of the five dangerous types of behavior during the examination, psychiatrists are taking the word of other persons on facts of dangerousness. Thus, in accepting the psychiatric affidavit as evidence of dangerousness, the court is really accepting the word of someone other than the psychiatrist.

Alcoholics were less likely than mentally ill or dual respondents to be committed without testimony of dangerousness (12.9% compared with 34.4%, $p < .001$), just as they were when evidence of dangerousness was present. Conclusory statements in court may have influenced judges: half of those committed without evidence of dangerousness were said to be in need of treatment and/or to have been previously hospitalized.

SUMMARY

The data in this study, which were collected from witness testimony in court hearings, do not support the apprehension of psychiatrists that the dangerousness standard, especially an overt behavioral standard as used here, would lead to a large increase of violent patients in state mental hospitals. They also do not support psychiatrists' fears that the dangerousness standard would lead to the abandonment of persons in need of treatment. Instead, the data indicate that (1) most respondents who are involuntarily hospitalized in initial civil commitment hearings do not seem, on the basis of court testimony, to be violently dangerous to society (indeed, respondents civilly committed are not a highly dangerous group, much less a highly violent one); and (2) those who are very sick, who might "die with their rights on" were they released under a dangerousness standard, are not being released. Even with an overt behavioral criterion of dangerousness, such persons tend to fit the dangerous-to-self category of grave disablement.

Our data also indicate differences in the processing of alcoholics and the mentally ill in involuntary commitment. Alcoholics are less likely than the mentally ill to receive formal commitment hearings, to have evidence of dangerous behavior presented in court testimony and to be hospitalized involuntarily. Further, the components of dangerousness associated with commitment for each category differ in some respects. Respondents who fall in the dual diagnosis category tend to be processed more like the mentally ill than are inebriates.

DISCUSSION

Fears of a concentration of violent patients in state mental hospitals seem to be based on a definition of dangerousness as assaultive behavior directed toward others; but as we have seen, most dangerous behavior of respondents and of those committed is not assaultive. Even when it is, very little harm results because the threat is not

executed or the assault is checked before much harm is done (Hiday and Markell, 1981). Other court studies have also concluded that civil commitment patients are not a violent lot (Hiday, 1977a; Stier and Stoebe, 1979; Warren, 1977, 1982). Further evidence that these fears are ill-founded comes from hospital studies reporting that civilly committed patients are not particularly dangerous to others (Rubin and Mills, 1983) and that rates of assaultive behavior are not significantly greater among patients involuntarily admitted than among those voluntarily admitted (Tardiff and Sweillam, 1982; Tardiff, 1982; Yesavage et al., 1983). None of these studies, including our own, deny that some civilly committed patients are assaultive, dangerous to others, and difficult to handle on the ward; but they do refute the belief that the dangerousness standard will eventuate in the destruction of the treatment environment by the accumulation of excessively aggressive patients.

Fears that respondents not committed would not obtain treatment seem to be based on the idea that mental hospitals are the only providers of psychiatric care. They overlook the expansion of psychiatric services in community mental health centers, and in general hospitals, that preceded civil commitment reform (Kramer, 1970, 1976). Furthermore, court decisions and many state statutes require the use of the least restrictive alternative to involuntary hospitalization such as voluntary hospitalization, outpatient treatment, and nursing home care (Chambers, 1972; Hiday and Goodman, 1982; Miller, 1980). Those not committed in our study were not all released outright. The court ordered less restrictive alternatives for 5.6% of the mentally ill respondents with evidence of dangerous behavior and for 2.4% without such evidence, compared with 13.6% of the inebriates with evidence of dangerous behavior and 10.6% without such evidence. Generally the alternative for inebriates was voluntary hospitalization in an inpatient alcoholic rehabilitation facility or outpatient commitment to an alcoholic rehabilitation program at a community mental health center. For dual respondents, 10.0% with evidence of dangerous behavior and 8.3% without such evidence were ordered to an alternative.

Even when the court released respondents, it often recommended outpatient treatment. Despite the law's emphasis on the police function of civil commitment and the dangerousness standard, judges were sensitive to respondents' need for treatment. Not infrequently, before releasing respondents judges lectured them on the need to take their medication and follow a doctor's orders so as not to end up in the hospital and in court again. With inebriates, there was sometimes a further admonition "to behave yourself." Court lectures coupled

with treatment received during observational hospitalization increases the likelihood that released respondents will obtain assistance from mental health facilities in the community.

Implications

Attorneys and judges are not a callous lot, vigorously applying legal procedures and criteria with no regard to the plight of the sick who are nondangerous. Nor do they attempt to replace psychiatrists in their diagnosis and treatment of mental illness. Indeed, attorneys and judges in our study tended to defer to psychiatrists in their uncritical acceptance of psychiatric diagnoses of mental illness and of psychiatric recommendations for treatment. Even the attorneys, who are civil libertarians and assume an adversary role in attempting to prevent the involuntary hospitalization of their clients, respect psychiatrists as mental health experts, accept the medical model of mental illness, and recognize mental hospitals as treatment centers (Hiday, 1983). However, they also respect the law; and as officers of the court, they are bound to follow it in applying the dangerousness standard.

The reform procedures that expose respondents to these attitudes of attorneys and judges thus reinforce psychiatric treatment when the decision is inpatient or outpatient commitment. Additionally, the court hearing itself, with its dignity and calm weighing of evidence, especially of behavioral evidence of dangerousness, probably reinforces psychiatric treatment (Sata and Goldenberg, 1977). Seen in this light, statutory reform has had the unintended consequence of making respondents more appreciative of psychiatric authority and more accepting of the legitimacy of their own involuntary treatment.

Although alcoholics are not likely to be committed to involuntary hospitalization, the civil commitment law is providing treatment to alcoholics who do not voluntarily seek help by detoxifying them while they are held prior to court hearings. This is a useful and necessary service for both individual health and safety, and for family and community well-being. Further, the law provides the possibility of continued treatment if justified in court while permitting the release of most respondents after detoxification. It also allows the judge to order alternatives to involuntary commitment. The fact that most alcoholic respondents are released after detoxification reflects doubts as to the applicability of the disease model to alcoholism and the efficacy of current treatment modes beyond detoxification (Suval, 1981b). These doubts are also reflected in the small number of cases in which less restrictive alternatives to hospitalization are ordered.

As long as no effective forced treatment exists to cure alcoholism, courts will probably continue to release inebriates following detoxification, and chronic alcoholics will probably continue their procession through the hospital's "revolving door."

Although civil commitment statutes provide for the same dangerousness criteria for involuntary hospitalization of both the inebriate and the mentally ill, in practice the law is interpreted differently. Clearly, the emphasis is on the use of involuntary hospitalization for crisis intervention rather than for long-term treatment. This emphasis can, at a minimum, provide support to the family facing a crisis brought about by an inebriate on a drinking binge (in 71% of all cases in our study involving alcoholics, the petitioner was a relative). Hospitalization affords a relatively safe environment (especially compared with the traditional alternative for the public inebriate, a jail "drunk tank") in which the alcoholic can "dry out" and the family can regroup. This provision is especially important to low-income families with few resources who are living under crowded and marginal conditions, and it may reduce the incidence of intrafamily violence. State hospitals, of course, can and do provide the setting for involuntary hospitalization; but increased availability of local mental health centers with inpatient facilities might afford a more appropriate alternative. Alcoholics who engage in serious offenses while intoxicated will probably continue to be processed through the criminal justice system rather than the involuntary commitment procedure; therefore, the availability of involuntary hospitalization will not remove responsibility from jails for providing appropriate facilities during the drying-out period.

The more controversial aspect of alcoholism is the appropriateness of the involuntary commitment procedure for retaining alcoholics after they are sober. The literature provides little support for the efficacy of treatment under either involuntary or voluntary conditions (Meidling, 1974; Moore and Buchanan, 1966). Judges seem to be responding to this lack of support by releasing most alcoholics. Many are aware of differences in the treatment of the mentally ill and the inebriate and feel that these differences should be reflected in the law. In our study, 61% (N = 44) of the judges who presided over hearings that we observed agreed that the involuntary commitment law should be changed. However, the reasons given for this belief varied widely and reflected a lack of consensus on the nature of alcoholism and the usefulness of hospitalization. Some judges wanted the law changed to make commitment of the alcoholic easier, commenting that it is difficult to keep the alcoholic confined beyond the drying-out period because dangerousness is hard to demonstrate once even temporary

sobriety has been achieved. Others felt that the law should be different because the alcoholic's problem is different, and that the purpose of involuntary hospitalization should be simply to dry out the alcoholic. Several judges remarked that alcoholism is a sickness but is not identical with mental illness. Among advocates and opponents of changing the law, some doubts were expressed as to the appropriateness of mental hospitals to treat the inebriate; however, there did not seem to be an effective alternative to offer in place of hospitalization.

While the data from this study indicate that the very sick mentally ill are not being abandoned, we still know little about what happens in the community to respondents who are released. Nor do we know what happens to those ordered to outpatient commitment. Too often communication between the hospital and community mental health center is minimal, and court findings are not likely to be conveyed to center personnel. Those stabilized on medication at the time of a hearing may stop taking their medication outside of the hospital, in which case their psychiatric symptoms reappear and they may become dangerous again. No empirical data exist to ascertain how often such a scenario occurs. We did observe a number of cases with testimony alleging that a respondent had been "doing fine" until he quit taking his medication, at which time his behavior became bizarre and/or dangerous. Civil commitment courts could use an effective follow-up system that would provide communication as well as monitoring and enforcement of outpatient commitment orders. If there were civil commitment court personnel equivalent to criminal court probation officers, it would be possible to monitor respondents in the community to assure continuation of their medication, and this would probably go far in alleviating the problem of recurring dangerousness (Chambers, 1972).

If respondents not hospitalized are simply left on their own to obtain treatment in the community—even when ordered into outpatient treatment—and do not obtain help, they may be arrested and incarcerated in a jail or prison. Some have argued that if society cannot get rid of its troublesome members in mental institutions, it will force them into the criminal justice system (Abramson, 1982; Lamb and Grant, 1982; Rachlin and Rachlin, 1975; Stone, 1975; Whitmer, 1980). Empirical evidence for this proposition is not clear (see Chapter 3, this volume). There is a need for a study that will follow respondents not involuntarily hospitalized by the court to ascertain if they are later diverted to the criminal justice system for the behavior that had caused others to petition for their involuntary hospitalization.

The recent reforms in civil commitment criteria and procedures have brought about substantial improvements in individual liberty

and have corrected the major abuses of paternalism in most states where they have been investigated.[12] But while these laws have made it less likely that the nondangerous mentally ill and non-mentally ill deviants are incarcerated indefinitely in mental hospitals, and while the expansion of mental health services has made it more likely that the nondangerous mentally ill will obtain treatment outside of mental hospitals, there are still sick persons who suffer a lifetime in the community without any treatment, or who go without treatment until their condition deteriorates to a state of dangerousness. Mental health practitioners, family members, and other concerned citizens, therefore, have been active in pressing for legislation that would bring help to these individuals. Much of their pressure has been directed toward broadening the dangerousness criterion for involuntary hospitalization. They have been successful in Washington State, which made more inclusive the statutory definition of "gravely disabled" and "likelihood of serious harm" (Durham and Pierce, 1982). Such changes should be monitored to ascertain their effects on individuals and on hospital populations.

Some pressure has been directed toward securing alternative paths for forced treatment. This has been successful in North Carolina, which recently passed legislation to allow outpatient commitment of the nondangerous mentally ill who are capable of surviving in the community with available supervision, who are unwilling to accept psychiatric treatment, and who have a history of dangerousness when they failed to follow a treatment regime. The results of this new legislation should be studied, as it offers the potential of satisfying the concerns of both individual freedom and the alleviation of human suffering.

NOTES

1. Despite this focus, there have been many violations of its underlying philosophy, such as use of commitment to get rid of annoying deviants, neglect, and even abusive treatment of those committed (Kittrie, 1971).

2. It is not always psychiatrists who are the medical doctors into whose hands the committed are placed.

3. Not all psychiatrists have been opposed to the changes in the law (see Halleck, 1980; Kohle et al., 1978; Robitsher, 1978, 1980; and Sata and Goldenberg, 1977).

4. In October 1979, after we completed our court observations, the North Carolina General Assembly removed imminent from dangerous as a criterion for commitment (N.C.G.S. § 122-58.2(1) (Supp. 1979)).

5. Hearings are in the judicial district of the inpatient facility unless a respondent requests a change of venue to the county of petition when not in the same judicial district. If not taken to one of the four state mental hospitals, a respondent may be taken to a Veterans Administration, private, or county hospital, if he or she, respectively, is a

veteran, chooses to pay for private hospitalization, or is a resident of a county with public psychiatric hospital beds approved for such use. Hearings held at state mental hospitals and at three other judicial districts with inpatient facilities are in a conference-type room at the facility. Hearings for all other respondents are held in a county courthouse, some in closed courtrooms, and some in a judge's chambers. At each state mental hospital, there is one full-time attorney assigned to represent all involuntary admissions in the commitment process, while in other judicial districts, court-appointed attorneys or public defenders are assigned to represent respondents. Private counsel, of course, can be hired to replace the public counsel provided.

6. We also recorded the frequency, recency, and seriousness of such behavior, but we will not use these other dimensions of dangerousness in this analysis. For a discussion of the development of the legal components of dangerousness and their distribution in our sample, see Hiday and Markell (1981).

7. Property attack has been disputed as a criterion for involuntary commitment. Hawaii's involuntary commitment law specified dangerousness to property (that is, "inflicting damage to any property in a manner which constitutes a crime") as a ground for commitment (1976 Hawaii Sess. Laws Act 130 § 1.), but that ground was held unconstitutional (Suzuki v. Yuen, 1977). Property attack that may result in injury to persons was not at issue.

8. Most respondents were lower class as manifested by uneducated speech, but a few respondents and/or their relatives were noticeably different in being college educated, in a professional or managerial occupation, well spoken (articulate testimony with correct grammar and abstract concepts), and/or clothed in a tailored suit/dress as worn by court officers. These respondents were coded upper middle class.

9. N.C.G.S. § 122-58.3 requires that the petition include facts indicating dangerousness. "Facts" on a petition, however, are only hearsay in court. Counsel may insist that, for dangerous behavior to become evidence for involuntary commitment, a witness must testify to it in court. There were cases of respondents' being released because no one appeared in court who had firsthand knowledge of their dangerousness.

10. Facts indicating imminent danger were missing in 10.1 percent of the cases. We were conservative in making our judgment of whether the psychiatrist gave the required supporting facts for imminent danger; thus a statement that a respondent attempted suicide, omitting a description of the behavior that constituted the attempt, was judged as supporting facts. Also, we judged descriptions of threatening and assaultive behavior not seen by the psychiatrist but told to him by others as supporting facts. A diagnosis, or facts not indicating dangerousness in and of themselves, such as "can't sleep" and "takes baths incessantly" were not judged as supporting facts. Sometimes the psychiatrist left the box for these facts blank.

11. All counsel outside of the four state mental hospitals were either public defenders or court-appointed except seven who were privately retained.

12. In some states the reforms have not been carried out in practice or have been only partially followed (see Stier and Stoebe, 1979; Zander, 1976).

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V

THE MENTALLY DISORDERED OFFENDER: CONVICTION, INCARCERATION, AND PAROLE

This section examines the treatment of the mentally disordered offender at three different points in the criminal justice process: defense (specifically, the use of the insanity defense), the incarceration experience, and probation and parole.

No other area in mental health law has drawn as much controversy as the use (or, more accurately, the alleged misuse) of the insanity defense. The public erroneously perceives the insanity defense to be both commonly invoked and frequently successful. Their outrage, spurred by John Hinckley's acquittal for shooting the President, has resulted in numerous modifications in current legal standards, criteria, and procedures governing the insanity defense. Sales and Hafemeister's chapter goes beyond mere polemics, and examines the empirical research vis-à-vis the insanity defense. They argue that although much of the research has focused on issues important to the lay public (for instance, investigations of the characteristics of NGRI acquittees, and postacquittal treatment and recidivism), the research has failed to address critical legal issues central to the development and implementation of a rational legal policy.

Chapter 12 examines the convicted mentally disordered offender. Unbeknownst to the general public, one of the largest categories of mentally disordered offenders are those who have been convicted of a crime, are incarcerated, and suffer from mental disorder. This chapter presents the results from a national survey of Department of Correction personnel. The authors assess the perceptions of these on-line workers concerning the prevalence and treatment of mentally disordered prisoners. This study shows that greater resources must be allocated to develop treatment programs within prisons in order to provide humane treatment to all prisoners who are suffering from a mental disorder. Without adequate resources, only those who exhibit the more visible symptoms of mental illness (that is, persons who are behavior problems) will receive treatment.

Perhaps the least investigated area in mental health and criminal justice is the probation and parole process. This omission may be due in part to the fact that mentally disordered offenders rarely receive probation; they are most often found incompetent and are treated via the commitment process. Similarly, parole boards are usually loathe to grant parole to persons suffering from severe mental disorder, believing that an offender having difficulty living in a correctional facility will be unable to adjust to the outside world. Nevertheless, nonpsychotic symptoms (such as personality and substance-abuse disorders) are critical in determining both probation and parole decisions. Moreover, correctional staff act very much as mental health workers in maintaining their clients in the community.

Chapter 13 details the existing literature relating to these issues. In so doing, the authors pose some intriguing questions pivotal to the probation and parole system.

Chapter 11

EMPIRICISM AND LEGAL POLICY ON THE INSANITY DEFENSE

BRUCE D. SALES
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In light of the recent attempted assassination of President Ronald Reagan and the subsequent trial of the accused, John Hinckley, the insanity defense has once again emerged as a major legal policy issue and the focus of significant public attention. As a result, Congress and a number of state legislatures reconsidered their then current laws, and many states substantially revised their approach to dealing with the mentally disordered offender.

Despite this rush to action, it has become obvious that there is too little empirical evidence on issues surrounding the insanity defense, and what there is has not made its way into the hands of legislators, or, if received, is not being used in the formulation of new public policies. Clearly, the misuse and nonuse of relevant social scientific information by legislators is a critical issue that begs for systematic study (Massad et al., 1983; Saks and Barron, 1980). Yet perhaps of equal import for discussions of the insanity defense may be the fact that what research there is has not addressed many of the critical issues that are contained in legal policies on this topic.

For instance, consider the recent American Bar Association (ABA) position on insanity. Among other things, it proposes a new formulation of the insanity standard which is more restrictive than the most widely used standard today. If adopted, or if a state currently uses a formulation that is of equal or greater restrictiveness, then the ABA position would place the burden of proving sanity on the prosecution. If a state refuses to adopt this new standard and maintains a more liberal formulation, then ABA recommends that the burden be placed

on the defendant to prove his or her insanity. Some argue that the burden issue is strictly a legal-normative one and that social scientists should not be commenting on it. This assumption is invalid, however. The ABA position is shifting the burden depending on the legal standard for insanity. If the standard is too loose from the ABA perspective, they attempt to compensate and decrease the probability of acquittal by placing the burden on the defendant. If, on the other hand, it is restrictive, then they assume that acquittals by reason of insanity will be radically reduced. Hence, they feel that shifting the burden to the prosecution is a fair way to compensate the defense bar for allowing this measure to be adopted. Their assumption here is that giving the prosecution the burden will make the defense attorney's job easier, make the prosecution's more difficult, and increase the probability that the defendant will be acquitted. Whether shifting the burden will change the probability of acquittal is an empirical issue that needs to be addressed and whose impact needs to be made known. Such information, if reliable and valid, should provide part of the factual foundation to guide legislative decisions on this topic. As yet, however, there is no direct research on the issue.

An assessment of the current research on the insanity defense and its relevance to critical legal policies is therefore needed. This chapter will focus on this concern. The second section reviews the empirical literature, organized by the conceptual topics it addresses (Pasewark, 1981, and Steadman and Braff, 1983, also provide reviews in this area). The third section focuses on the relevance of this research to critical legal policy issues.

REVIEW OF EMPIRICAL LITERATURE

Perceptions and Use of the NGRI Plea

One major series of studies has been conducted to discover how frequently various groups think the NGRI plea is entered and how often they think it has been entered successfully (Pasewark and Pantle, 1979; Pasewark and Seidenzahl, 1979; Pasewark et al., 1981). Estimates on these two items were gathered from Wyoming college students, state legislators, community and state hospital mental health personnel, and the residents of two Wyoming communities. Each group grossly overestimated both the frequency and success of the plea. In Wyoming during the two-year time period considered (in the early 1970s), only 102—less than one-half of one percent of the 22,102 defendants charged with a felony—entered an

insanity plea, with only one defendant being successful in the use of the plea (a success rate of 1%). The students estimated that an NGRI plea was entered in 37% of all cases, the legislators said 21%, the residents of the two communities guessed 43%, the state hospital professional staff did the best at 13%, while the state hospital aides did the worst at 57%. As for the success rate of those entering the plea, the students conjectured a 44% success rate, the legislators 40%, the community residents 38%, and the community mental health center professionals 19%. The authors suggest that the widespread publicity given by the media to such cases may be responsible for these findings. In addition, these surveys showed that many of the respondents were unfamiliar with the mechanics of the NGRI plea, and, with the exception of the legislative group, the majority expressed disagreement with the underlying philosophy of the NGRI plea and favored its elimination.

As for the actual use and success of the NGRI plea, there are few comprehensive data. Most reports are limited to brief intervals taken during different time periods in different jurisdictions. Yet, what data there are conform to the Wyoming report noted above and suggest that the number of cases in which the defense has been raised, let alone successfully pursued, is quite small. For example, Criss and Racine (1980) cite an unpublished paper that posits that substantially less than 1% of all American criminal cases raise the issue of insanity. As to success rate, it has been reported that New York State had 25 NGRI acquittees in 1973, 37 in 1973, 55 in 1974, and 61 in 1975—amazingly low numbers in light of the large general and criminal population within that state. Pleading practices made it unfeasible to determine how often the plea was actually made, and thus the statewide success rate of the NGRI plea was not ascertained (Pasewark et al., 1979a). However, another study focused on a single county in New York (Erie County), allowing the authors to overcome this problem. Between 1970 and 1980 they recorded 197 insanity pleas, with 51 of them successful (Steadman et al., 1983). Oregon averaged 100 individuals per year found not responsible by reason of insanity for 1978-1980 (Rogers and Bloom, 1982). It was estimated that there were 67 NGRI adjudications in Missouri in 1978, with attempts to be more specific frustrated by a state law that closes court records to public view in cases resulting in an acquittal or dismissal of the charges (Petrila, 1982). Michigan from 1974 to 1979 averaged 45 NGRI adjudications per year (Criss and Racine, 1980).

Little overall interest has been shown by the states in maintaining any systematic record of the use of NGRI pleas, a most unfortunate omission in view of the continuing public and professional controversy

over the use of the plea and recurring legislative and judicial attempts to tinker with, if not abolish, this defense in criminal trials. Nevertheless, it appears that the number of NGRI acquittals represents a very small portion of those individuals entering the criminal justice and mental health systems (Phillips and Pasewark, 1980).

Characteristics of Persons Found NGRI

In those studies which have examined NGRI acquittees, a fairly consistent portrait has emerged of these individuals (Phillips and Pasewark, 1980; Cooke and Sikorski, 1974; Criss and Racine, 1980; Morrow and Peterson, 1966; Pasewark et al., 1979b; Rogers and Bloom, 1982; Singer, 1978; Petrila, 1982). Generally they are in their mid-thirties, Caucasian, male, without a high school diploma, unskilled/semi-skilled or unemployed, and unmarried. Although showing greater variation, roughly 40 percent have undergone prior hospitalization for mental illness, and more than half were diagnosed as psychotic at the time of the crime.

The two most controversial categories with the greatest fluctuation in data are the criminal histories of NGRI acquittees and the criminal charges of which they have been acquitted. Such information is critical in that it is the basis for three common stereotypes that have been influential in directing policy decisions in the field. The NGRI acquittee has been characterized as: (1) a "mad killer" who attacks victims randomly and repeatedly; (2) a "crafty con" manipulating the system by faking insanity, who, after a short period of relatively soft hospitalization, will obtain release and return to a life of crime; or (3) a "desperate defendant" against whom the evidence is so heavily weighted that an insanity plea is the only legal option remaining.

Generally the data do not appear to support any of these projections, although it is not consistent or comprehensive enough to totally refute them either. If the first portrait—that of the mad beast, the Dr. Jekyll/Mr. Hyde who has run amok—accurately portrayed NGRI acquittees, one would expect most of them to be charged with murder, or at least serious personal assaults on a number of victims. However, there appears to be a wide fluctuation in the charges that faced NGRI acquittees, suggesting that the insanity plea is used differently in different states at different times. Oregon and Missouri report that only about one in ten NGRI acquittals are of murder or manslaughter charges, New Jersey and Connecticut one in four, and Michigan and New York one in two. A similar breakdown occurs when the target of the crime is considered: in Oregon and Missouri only about one-half of the crimes for which the NGRIs have been acquitted were for what

could be considered crimes against the person, that is, directly aimed at another person as the victim. In New Jersey and Connecticut slightly over three out of four involved such crimes, while in Michigan and New York they rose to nearly nine out of ten. However, the New York study, which supplies the most support for the "mad killer" hypothesis, also specifically notes that (1) many of the crimes are of a less serious nature; (2) nine out of ten of the crimes involved either no victim or a single one; and (3) in two out of three cases the victim was known to the defendant prior to the criminal act (Pasewark et al., 1979b). Furthermore, a later study in Michigan, the other state with the most support for this view, noted that the number of NGRI acquittals of murder represented only 1.7% of those arrested on that charge (Criss and Racine, 1980).

As for the second portrait of the NGRI acquittee, that of the "crafty con," again fluctuations in the data make it difficult to make firm statements for or against the image. Reports of the percentage of NGRI acquittees with a history of prior criminal convictions, which might suggest an experience with and capability for manipulating the criminal system, range from a low of 18% in New Jersey to a high of 66% in Missouri (although a later Missouri study reported 39%, a figure more in line with other states). However, the high percentage of NGRI acquittees with a prior mental condition history, the large number of them given the most severe diagnosis of psychosis in their evaluation, and, as will be discussed shortly, their generally high rate of rehospitalization following their release on the current charge and a criminal recidivism rate lower than or equal to that of comparable felons, all suggest that at least a sizeable proportion of the group are not faking their symptoms in order to manipulate the system. Rather, the NGRI plea is serving as a device to resume psychological and psychiatric treatment for many of them which predates and/or post-dates the criminal offense (Petrila, 1982). In addition, as both the later Missouri study and the New Jersey report note, generally most successful NGRI pleas have not been contested by the prosecution, possibly indicating a concurrence with the plea (although, as will be discussed later, it may suggest merely an acceptance of the controlling impact of the evaluator's diagnosis; Petrila, 1982; Singer, 1978).

In regard to the third caricature of the NGRI acquittee as the "desperate defendant," certainly the mere fact that the evidence is clearly set out against the defendant is not probative of the mental state of that person. Neither is it indicative that the insanity plea is a mere guise to protect the criminal who has been caught "red-handed." Although the low educational level might be utilized to buttress an argument as to why the defendant failed to better conceal the crime,

such openness also might be construed to suggest an individual who truly was not in command of his or her faculties. Thus far there has not been a study conducted that compares NGRI acquittees to convicted felons matched according to the criminal charges brought against them to determine if the evidence against the former was more certain than against the latter. Nor would such a comparison necessarily prove valid, since the NGRI acquittee may expend his or her trial resources attempting to establish a showing of insanity rather than contesting the factual evidence arrayed against him or her, as would be expected for the convicted felon.

Nevertheless, many of the same points can be made against the image of NGRI acquittees as "desperate defendants" as against the view that such individuals are "crafty cons." The prevalent psychiatric history, the severe diagnosis, the high rate of rehospitalization, and the unremarkable recidivism rate all suggest an individual who is indeed severely mentally disordered. On the other hand, it has been noted that almost one-half (44%) of the cases in one jurisdiction beginning with an insanity plea ended up with the defendant changing that plea to one of guilty, suggesting an either/or, last-gasp approach. However, that same study also found that 88% of those switches occurred after a forensic evaluation found the defendant sane[1] (Steadman et al., 1983).

Based on the above kinds of information, Pasewark et al. (1979a, 1979b) suggest other subcategories: (1) those for whom the criminal act was directly associated with a mental disorder (such a grouping would include those with previous and subsequent psychiatric histories but little prior and later criminal activity); (2) those who represent the larger criminal population and who, like any other occupational group, contain a certain number of mentally ill individuals (such individuals would tend to have both earlier and later psychiatric histories, as well as earlier and later criminal records); and (3) those for whom the classification of mental illness is a misnomer but for whom society makes special allowances, including (a) mothers who kill their children (society considers such acts crazy regardless of an absence of insanity in the individual, rather than realistically accepting the fact that the natural target for the hostility of a homebound mother may be her child; thus, society's belief in the unbreakable strength of "mother love" is preserved[2]); (b) policemen (society invests officers with great responsibility and power in protecting it and is reluctant to believe that trust has been misplaced, preferring to conclude that the criminal act was the result of some uncontrollable force such as insanity, rather than such prevalent human passions as greed, jealousy, or anger); and (c) the "I-can-feel-

sorry-for-you" defendant, for whom there is a great deal of empathy (apparently previously respectable, middle-class individuals who have been hounded into their acts, such as the professional under pressure from gambling debts who commits robbery). This third group, we suggest, would not be expected to have either a prior criminal or psychiatric history, nor would they be expected to have a high recidivism or rehospitalization tendency.

Unrelated to these portraits are three other items of interest involving NGRI acquittees derived from the New York studies: (1) the number of successful pleas increased considerably over the thirteen years studied (8 per year for 1965-1971, 47 per year for 1971-1976, and 55 per year for 1976-1978); (2) despite the fact that women made up only 13% of the acquittee group, in New York that is a great overrepresentation when compared to the prison populations, where women comprise only 4% of the inmates in state prisons; and (3) similarly, the proportion of white acquittees greatly exceeded that which would be expected from the racial composition of the prison population in that state (60% versus 31%; Steadman and Braff, 1983).

The assumption of much of this work is that by identifying the characteristics of those persons found NGRI, we have thereby determined the characteristics of those individuals for whom an insanity plea is more likely to be successful. Yet such an approach is limited, since we need to compare these characteristics to those defendants for whom the plea has failed. As previously discussed, such studies have generally been frustrated by the size and logistics problems of the investigation required, as well as local and state roadblocks to the gathering of such information (for example, laws concerning public access to court verdicts).

Steadman and his colleagues (Steadman and Braff, 1983; Steadman et al., 1983) overcame these difficulties by limiting the scope of their study and focusing their efforts on the court records of a single county. In that way they could identify all defendants for whom the insanity defense was raised and thereby compare the characteristics of those for whom NGRI pleas were successful and those for whom they had failed. At the same time they limited the generalizability of their findings and exposed themselves to the distorting influence of peculiar and isolated local events. They found that in Erie County, New York, between 1970 and 1980 there had been 205 individuals for whom insanity pleas were entered, of which 65% were convicted, 25% found NGRI, and 10% dismissed, acquitted, pending, withdrawn, or involving a defendant who had died prior to disposition. For the convicted and NGRI groups, the average age was the same (29),

while they were similar in sex (88% versus 92% males for NGRIs and convicteds, respectively), race (69% versus 62% white), marital status (88% versus 77% currently unmarried), employment status (72% versus 73% unemployed or unskilled), and prior state psychiatric hospitalization (67% versus 74% who had none). Among those with prior state mental hospital admissions, the NGRIs averaged a slightly higher and statistically significant number of prior admissions (3.3 versus 2.0), although for shorter periods (756 versus 1245 days, not statistically significant). The majority of both groups had prior arrest histories (57% NGRIs, 70% convicteds), with the NGRIs averaging fewer arrests (3.5 versus 4.7, n.s.).

An examination was also made of the offenses with which these two groups were charged. Both groups were charged most frequently with violent or potentially violent crimes, though the NGRIs were more often charged with such offenses (80% versus 69%). However, the most frequent offense, murder/manslaughter, involved NGRIs less often (35% versus 41%). Victims were involved in a majority of the offenses for both groups (80% NGRI, 70% convicted), with the only divergence, though not statistically significant, being the involvement of a female victim (56% NGRI, 37% convicted). Otherwise the results were largely the same, with the victim being predominantly white (67% versus 70%) and of a similar age (33 versus 34). NGRIs did tend to use a knife or gun in the offense more often (61% versus 44%).

Finally, an analysis was made of the symptomatology reported for the two groups. Statistically significant differences were present in four of the fourteen psychiatric impairments reported. NGRIs were diagnosed by forensic staff as more psychotic (28% versus 5%), depressed (53% versus 36%), and agitated (24% versus 12%) than the convicted group, though less inclined to alcohol and drug indulgence (0% versus 12%). However, it is difficult to determine whether the label determined the treatment or the treatment determined the label.

Armed with these data, an attempt was made to isolate those factors associated with a successful insanity plea. Overall, the factors examined provided little insight for distinguishing successful and unsuccessful NGRI pleas. Of the sociodemographic characteristics, only age was statistically significant (defendants under 25 and over 40 were less likely to be acquitted than those 25-39). Race, sex, marital status, and occupation all produced nonsignificant results. Defendants with five or more prior mental hospitalizations were more apt to be acquitted. None of the other factors seemed to influence the courts' decisions.

What was most strongly associated with a successful versus unsuccessful pleading was the finding of the pretrial forensic examination. Even though such findings are rebuttable evidence and not binding on the court, when this evaluation declared a defendant insane, 83% of the time the case was dismissed or the defendant was determined to be NGRI. When the evaluation found the defendant sane, in only 2% of the cases was the defendant found NGRI. In turn, the major factor related to a clinical finding of insanity was a diagnosis of pyschosis (where this was the diagnosis, 82% of the defendants were found legally insane as compared with only 28% of all other diagnoses). In fact, when control for this diagnosis was introduced, neither age nor number of prior mental hospitalizations remained significant. It was the diagnosis of psychosis that was the decisive factor.

In a sense, Steadman's findings are reassuring in that it appears that once an NGRI plea has been entered, the legal system trying the defendant appears to be confining itself to those factors which are relevant to a determination of insanity. That is to say, under the law the only relevant consideration should be the defendant's mental condition at the time of the crime, not such extraneous factors as the defendant's sex, race, or prior criminal status. Although clinical studies are not encouraging as to the ability of forensic evaluators to provide accurate diagnosis or to reach back to the time of the alleged crime in forming such diagnoses, Steadman's work nevertheless indicates that the appropriate issue is being considered. What is less comforting is the apparent preemption of the courts' decision-making process by mental health professionals. Although they may be the most qualified and best-equipped individuals to make determinations of mental disorder, as we shall see below the legal test of insanity requires complex judgments that should require the judge or jury to take a more active role in the ultimate decision (see, for example, Morse, 1983).

Also of concern are the reasons for the fluctuations in who chooses to pursue an NGRI adjudication. In addition to the danger that some defendants fail to exercise an NGRI plea because they perceive the consequences of such a plea as more deleterious than a criminal conviction of the charge, or because they surmise in advance that their chances of obtaining an NGRI acquittal are so low as not to be worth the risk of arousing the antagonism of the prosecution or the court by pursuing that course, some defendants may find their access to such pleas blocked by extraneous factors such as local prejudices and/or pressures against the use of the plea. For example, Steadman et al. (1983) found that a highly controversial NGRI acquittal resulted in a sharp reduction of the number of successful pleas thereafter.

Interestingly enough, they found that this did not result from the courts' becoming more conservative in granting such pleas; rather, it resulted from the clinician's altering the pattern of their examination reports, thus decreasing dramatically the number of defendants they found insane.

Detention and Subsequent Release of Persons Found NGRI

Steadman and Braff (1983), in their studies of New York acquittees, also investigated the length of hospitalization after acquittal for those individuals found NGRI and the factors related to their subsequent release. They found that 40% of the 278 persons found NGRI between 1965 and 1976 were still hospitalized in 1978, with an average length of stay of three and a half years. Of the 47% of the NGRIs released without supervision following postacquittal hospitalization (henceforth released), their average length of stay had been 406 days. A follow-up study of those hospitalized between 1976 and 1978 indicated that the average length of stay of those released was going to considerably exceed that of the 1965-1976 group.

They also found a clear trend for more severe crimes to be associated with longer detentions. The 55 persons acquitted of murder who were released averaged 500 days of hospitalization, the 25 acquitted of assaults and released averaged 398 days, while the six acquitted of burglary who were released averaged 288 days. As the authors note, the appropriateness of these variations cannot be assessed in that it is not possible to ascertain which defendants were "sicker" and thus needed longer terms of treatment.

Pasewark et al. (1982), in their study of the length of detention incurred by NGRIs and a comparison group of felons convicted of the same offense in New York, found that initially the two groups had almost the same length of detention between 1965 and 1971 (1021 days for male NGRIs versus 995 days for male convicteds; 638 days for female NGRIs versus 789 for female convicteds, with neither difference being statistically significant). However, in 1971 the responsibility for NGRIs was shifted from the Department of Correctional Services to the State Department of Mental Hygiene. Between 1971 and 1973 the NGRI men accumulated an average of 533 hospital days as opposed to the felons' 837 prison days (a significant difference), although there were no significant differences for women; the NGRI women averaged 435 hospital days, while female felons averaged 565 days. Thus there was a major decrease in the detention time of both the NGRI and felon groups, but the NGRI dropped considerably more (48% versus 16% for the men, 32% versus 28%

for the women). Steadman and Braff (1983) comment that findings such as these should not necessarily be interpreted as showing that NGRI acquittals are an easy way out, since (1) hospitalization is supposed to be based on both therapeutic and protective rationales, with release to be tied to the remission of the insanity symptoms and certification that the individual is no longer dangerous; and (2) few defendants do time for their arrest charges due to plea bargains.

Pasewark et al. (1982) utilized stepwise regression analysis in an attempt to identify those factors which influenced the length of institutionalization of their New York NGRI group. They found that those with shorter periods of hospitalization had fewer previous arrests, were married, had not committed homicide, were non-Caucasian, and had perpetrated crimes against fewer victims. Five other variables did not contribute to the significance of the regression equation: age at hospitalization, sex, number of previous hospitalizations, diagnosis of psychosis, and education. However, it should be noted that 78% of the variance was not accounted for by the variables considered, and thus other unidentified factors are more determinant of the length of hospitalization (but see Cooke and Sikorski, 1974).

Postrelease Recidivism Rate and Rehospitalization

Morrow and Peterson (1966) found that over three years in Missouri, 37% of NGRI acquittees were rearrested for the commission of a felony (generally for economic offenses and generally a repetition of the prior arrest category). Pasewark et al. (1979b) reported that of the 278 persons acquitted between 1965 and 1976 in New York, 107 were released, with 21 (20%) of them subsequently rearrested during this period. All 21 were males, as none of the 19 women in this group were rearrested through 1976. The 21 men rearrested totaled 68 arrests, with arrests for property crimes comprising the largest category (35%), followed by crimes against persons (25%), drug charges (18%), other felonies (3%), and misdemeanors (19%). Generally these subsequent crimes were less serious than the ones for which the individuals were initially acquitted. Based on these findings, the authors suggest that there is a small core of repeat offenders who are the source of the inaccurate stereotype of NGRIs as repetitive offenders who quickly return to crime after having found an "easy out."

Steadman and Braff (1983) found little difference in the subsequent arrest rates for NGRIs (35%) and those who pled the defense but were convicted (39%). Relatedly, Morrow and Peterson (1966)

compared their finding to the recidivism rates of released felons in Missouri (37% versus 35%) and concluded that the recidivism rate for NGRIs was not alarming. Similarly, Pasewark et al. (1982), in their comparison of NGRI acquittees and felons convicted of the same offense in New York, found that 15% of the released NGRIs were arrested again, although these five individuals totaled 17 arrests. Of the released felons, 18% were subsequently rearrested, although the six of them totaled nine arrests.

Steadman et al. (1983), believing that the proper comparison group should be persons released from state mental hospitals and not from prisons, compared the Pasewark et al. (1979b) results to the arrest rates of patients recently released from New York state mental facilities (Steadman et al., 1978). He found in the latter group that 9% recidivated during their first 19 months after release, suggesting that the NGRI recidivism rate could be considered troubling.

Two studies have examined the subsequent mental hospitalization of NGRI acquittees. Pasewark et al. (1979b) found that 22% were subsequently rehospitalized, with these 23 dischargees rehospitalized a total of 47 times. Of the 88 discharged men, 16 (18%) were rehospitalized a total of 34 times; of the 19 discharged women, 7 (37%) were rehospitalized a total of 13 times. Pasewark et al. (1982), in their comparison of NGRIs and convicted defendants who unsuccessfully used an NGRI plea, found that 18% of the NGRI acquittees were rehospitalized, while only 6% of the matched convicted felons entered mental hospitals subsequent to their prison release. The six rehospitalized acquittees totaled 19 readmissions (16 civil, 3 criminal), while the two released felons incurred one hospitalization each (both civil). It seems clear from these data that at least a sizeable proportion of the NGRI population are not mere manipulators of the system but actually do display symptomatology that is serious enough to bring these individuals back under the auspices of the mental health system on a repeated basis without the intervention being initiated by the criminal courts.

Impact of the Insanity Standard

One of the continuing controversies surrounding the NGRI plea concerns the language of the insanity test. The controversy has two parts: (1) what the language should be, and (2) often overlooked, the impact of that language on the trier of fact. The former may appear to require a largely philosophical answer, varying with individual views on whether and/or to what degree a criminal defendant should be absolved of responsibility for acts influenced by insanity. However,

the issue quickly takes on an empirical cast when answers are sought to such questions as: (1) what does insanity look like; (2) are there degrees of insanity, and if so, what do they look like; (3) what does the threshold between legal sanity and legal insanity look like; (4) what factors lead us to conclude one person is sane while another person is insane; (5) is it possible for a person to fake insanity, and if so, what does that look like; and (6) for people who have been found legally insane, what will the results be of treating them in various ways?

Unfortunately, space limitations preclude our reviewing the empirical work performed on the existence, manifestations, and treatment of insanity. Instead, we will focus on the equally important but largely ignored second part of the NGRI controversy: the impact of the legal language governing the NGRI process. This issue is particularly important in light of recent proposals by the American Bar Association to modify existing standards. Such language dictates how and when the judge or jury is to determine that a defendant who has entered an insanity plea should receive an NGRI acquittal. Four legal tests, separately or in conjunction, have been frequently used in the U.S. judicial system to answer these questions. The oldest, and still used in some form in 21 states today, is the M'Naghten "right from wrong" test, which focuses on cognitive status.[3] A second standard, which focuses on volition, is the "irresistible impulse" test, and it augments M'Naghten in some states today.[4] The third approach, the Durham rule,[5] was initiated in the District of Columbia in 1954. Originally intended to broaden the scope of the insanity investigation, it was concluded to be unworkable and was abandoned in the district in favor of the American Law Institute (ALI) test.[6] The ALI test, which combines cognitive, affective, and volitional components, has been adopted by the federal courts and is used in some form by 26 states (The Insanity Defense, 1983).

Despite the extensive efforts represented by the composition and application of these four standards and their variations, many people today remain unhappy with insanity pleas and acquittals. There is concern that defendants who are not actually insane are being absolved of responsibility for their acts; that all of the tests are too lenient and include defendants who are sufficiently sane as to be held responsible, even though they may show some aspects of mental illness; and that too many dangerous individuals are able to use this route as a shortcut to enable them to return to the streets, where they continue their aberrant behavior. As a result, four additional proposals have recently been raised to alter insanity defense laws: (1) modify current language to achieve a new variation of the standard (for example, see the discussion to follow of the ABA's proposal); (2) shift the burden

of proof on the insanity issue from the state to the defendant;[7] (3) eliminate the insanity defense altogether (two states, Montana and Idaho, have taken this course); and (4) substitute for or add the alternative of a "guilty but mentally ill" (GBMI) verdict to the traditional finding of "not guilty by reason of insanity."[8]

Although the four traditional tests and the recent proposals have generated extensive discussions in the journals of the legal and mental health professions, and in the popular press, little empirical work has been done to determine how the different laws will affect the processing of mentally disordered offenders. As to the statutory language governing insanity pleas, Pasewark et al. (1979b) concluded that it is probably not the decisive factor in determining whether an individual receives an NGRI acquittal. Rather, they suggest that largely unidentified factors other than the literal language of these rules of law control NGRI determinations. They assert that each of the legal rules is highly restrictive. Only when the law is successfully "bent" by the concerned parties (such as defense attorneys, judges, prosecutors, and mental health professionals) is a defendant found insane. Such manipulation, they argue, opens up the possibility that decisions on NGRI pleas are inappropriately based on other factors.

This view concerning the irrelevance of the particular test utilized gains support, albeit for slightly different reasons, from studies by Elwork et al. (1977, 1982). They demonstrated that most jury instructions, including those which contain the standard for judging insanity, are simply incomprehensible to the juries that hear these trials. They provide empirical data that show extremely low levels of juror comprehension of these instructions—so low, in fact, that jurors were failing to correctly apply the law to their own beliefs about the facts of the case.

Elwork et al. (1982) described and tested a method whereby jury instructions may be rewritten so that they are maximally understandable. With an edited version of an actual trial utilizing the M'Naghten rule, they found that mock jurors averaged 51% correct on a questionnaire designed to test their comprehension of the original jury instructions. Even for an extremely basic question such as, "Define what (the defendant) meant when he stated that he was not guilty by reason of insanity," which could be answered correctly with a simple "He did not know the difference between right and wrong," "He had a mental illness which made him not know what he was doing," or "He did not know that what he was doing was wrong," jurors given the typical M'Naghten instructions answered this question incorrectly 44% of the time. Thus it was clear that jurors were arbitrarily selecting their own standards by which to judge insanity in such cases,

exposing the decisions in such trials to the whims of caprice and prejudice. Similar results were obtained by Arens et al. (1965). They presented actual jury charges to college students and then administered them questionnaires to gauge their understanding of the instructions. They found that regardless of the legal rule utilized, either N'Naghten or Durham, the students averaged 30%-40% correct on four key questions regarding the insanity plea. They concluded, "In three out of four trials, only one-third of the jurors could be expected to recall the judge's charges with significant accuracy during deliberations on the law of insanity" (Arens et al., 1965: 22).

Despite these findings, there are studies that have detected differences resulting when one legal standard for insanity is used in place of another. One of the first and perhaps most well-known efforts in this direction was taken by Simon (1967). As part of her study of the American jury system, she presented to mock juries one of two recordings of condensed and recreated versions of two actual trials where an NGRI plea was raised as a defense. One trial involved a housebreaking charge, without any elements of violence toward another person, while the second involved the more emotionally laden offense of incest. After listening to their assigned trials, a third of the juries were given jury instructions that contained the M'Naghten rule to guide their deliberations, another third received the Durham rule, while the final third received no instructions at all. These mock juries were then left alone to reach a verdict, with their deliberations recorded as had been previously agreed upon.

In the housebreaking trial, it was found that those jurors who received no instructions gave the highest proportion of NGRI verdicts, followed by Durham, with the M'Naghten jurors giving the fewest NGRI acquittals. The difference between the M'Naghten jurors and the uninstructed jurors was significant; that between the M'Naghten and Durham jurors was not. In the incest trial, the verdicts of jurors receiving no instructions and Durham instructions were very similar, with the M'Naghten jurors significantly less likely to vote for an NGRI acquittal than the Durham jurors (a 12% difference).

Based on these findings, Simon concluded there is support for those who opposed the Durham rule because they feared it would increase the number of NGRI acquittals. However, she noted that a 12% increase is not necessarily an alarming increase (although when jury verdicts were considered, the difference jumped to 19%). In addition, she pointed out that the Durham rule seemed to be producing results closer to the jurors' natural sense of equity as reflected in how they

voted when not given any instructions. Furthermore, she found that at least half of the uninstructed and Durham juries took the defendant's ability to distinguish right from wrong, the hallmark of the M'Naghten instructions, into consideration during their deliberations. This seems to support the assertion that the Durham rule added to the scope of the discussions generated by the M'Naghten standard, which contained only one aspect of what juries consider appropriate in reaching conclusions on the question of a defendant's insanity. Simon also found evidence that refuted the charge that the Durham rule would result in jurors abdicating their decision-making responsibility, blindly following the conclusions of the mental health professionals. She found that the Durham juries deliberated significantly longer than did the M'Naghten juries, suggesting greater juror involvement and responsibility, while the lack of a significant difference in the proportion of hung juries was taken to suggest that it was no more difficult for them to reach consensus.

However, it should be noted that Simon's study also partially substantiates the conclusions reached by both Pasewark et al. (1979b) and Elwork et al. (1982). Namely, Simon's determination that the Durham instructions produced almost the same results as no instructions at all in one trial, in the other trial produced similar results, and that even the M'Naghten instructions produced only a 12% difference, reinforces the contention that jurors are relying on their own sense of justice, whether this be out of ignorance of the law, a willful avoidance of the law, or because the standards have successfully captured the community sense of justice in such cases rather than relying on some other distinctions dictated to them by the law. If these points are valid, one must question the amount of time and money being spent on the various reform efforts to alter the insanity plea."

One other study provides indirect evidence that the particular legal standard chosen has little influence on the outcome of NGRI trials. Arens and Susman (1966) studied trial transcripts of NGRI cases in Washington, D.C., between 1960 and 1962. Based on their content analysis, they concluded that the change from a M'Naghten standard to the Durham rule in that jurisdiction made no appreciable difference in the wording of judges' instructions to juries on the insanity plea in such cases. Instead, there was a tendency to retain the language of the M'Naghten instructions. Arens and Susman suggest that this intransigency is due to trial judges' dislike of the insanity defense in general, and their disapproval of the Durham rule in particular.

Finally, two things in reviewing this literature should be kept in mind: (1) Not all NGRI pleas are decided by a jury. Thus, the proportion of NGRI cases in a jurisdiction that are decided by a judge

and the percentage by a jury may affect the importance of the phrasing of jury instructions and their incomprehensibility to jurors. (2) In light of the findings discussed earlier by Steadman et al. (1983), that the controlling factor in NGRI adjudications is whether the pretrial forensic examiner found the NGRI defendant insane, how either the jury or the judge interprets the insanity standard may be irrelevant, with the impact it has on the forensic examiner being decisive. Only Sauer and Mullens (1976) assess the standards from this aspect, and, as noted in note 9, there are reasons to remain wary of their conclusions.

DISCUSSION

Our review of the research suggests that it is relevant to some public policy issues. For example, laypersons may argue that the insanity defense should be abolished, since they believe offenders regularly invoke it and often win. Research documents the existence of these perceptions and their inaccuracies. The defense is rarely invoked and less often won. Some of this research can also speak to policy in ways that have not received wide recognition. Data on frequency of pleading, frequency of acquittal, and characteristics of those who plead and win, for instance, should be used to address questions about the need for centralized court clinics to evaluate defendants for insanity, the type of staffing these clinics should have, and the size, type, and staffing of facilities that are needed to evaluate and treat acquittees. In fact, only recently have we seen any programmatic study of these system issues (Keilitz, forthcoming).

But although these data have some policy relevance (see, for example, National Commission on the Insanity Defense, 1983), they are typically insufficient for policymakers to use as a disposition. The studies that exist are limited to a few locations at different periods of time, most often without specificity as to the legal constraints that may affect each study's outcome. Thus it should not be surprising that in some instances, findings across states are inconsistent. There is a need to implement cross-jurisdictional research that will allow clear determinations of whether variations in findings are due to artifacts in prior work or to factors not yet thought to be relevant. Indeed, finding the cause for this as yet unexplained variation may be one of the more interesting opportunities in the empirical study of the insanity defense (Wexler, 1983).

But even if this research was entirely consistent across jurisdictions, it would still be of limited value, since it has not addressed the

issues that are the focus of legal policy debates. Consider two recent proposals to modify the defense. The American Medical Association's (AMA) proposal would effectively eliminate it except insofar as mental state goes to *mens rea*, on the assumption that this change would severely limit the number of mentally disordered offenders who would be found not guilty. Yet there is no research on how juries, or judges for that matter, reach decisions regarding *mens rea*, what information they use, or what standard they apply. And once this information is known, we would still need research to assess whether this decision-making task would be different from that represented in juries who were instructed that the insanity defense was available to defendants in their jurisdictions. As noted in research on sentencing, juries are more prone to acquit when only the severest sentence with no lesser options is available for them to impose (see, generally, Elwork et al., 1981). Perhaps similar processes may work in juries considering *mens rea* when no exculpatory option is available. Clearly, research should assess the AMA's assumption. Given the conceptual importance of *mens rea* in the definition of most crimes, this work could also add valuable insight into a mental health criminal justice interaction that has been almost completely overlooked to date.

The second proposal, the recent position on the insanity defense adopted by the ABA, contains several proposed modifications, with each based on assumptions that require empirical verification or refutation. The first part of the proposal would modify the current American Law Institute Model Penal Code (ALI) provision, which reads:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law.

to read:

> whether the defendant, as a result of mental disease or defect, was unable to appreciate the wrongfulness of that defendant's conduct at the time of the offense charged . . .

The ABA modified the ALI version by deleting (1) the word "substantial," on the assumption that jurors and juries are not able to make distinctions beyond presence or absence of capacity, and (2) the phrase "or to conform his conduct to the requirements of the law," on

the assumption that clinicians cannot reliably or validly differentiate an irresistible impulse not resisted. As to the first assumption, there are no studies addressing whether the decision makers (for example, jurors) are capable of differentiating "substantial capacity" from presence or absence of capacity. Similarly, to the best of our knowledge there is no empirical verification of the assumption about clinicians' inability to detect irresistible impulse, when compared to postdicting other aspects of prior mental state.

As noted in the introduction to this chapter, the second part of the ABA position would shift the burden of proof, depending on whether the jurisdiction adopted the ABA insanity defense standard or some equally stringent criterion. But no research has been conducted to assess the validity of the assumptions underlying this part of the proposal.[10]

Moreover, the available research is not only of limited relevance to the current proposals on the insanity defense but also to the fundamental legal issues relating to the defense—the language of the standard, its procedural implementation, and the disposition of those acquitted by reason of insanity. For instance, the ALI standard is currently the most widely used test for insanity, with its creation being prompted by a number of perceived problems in the M'Naghten, Irresistible Impulse, and Durham rules (the other available standards). Yet to the best of our knowledge, there have not been studies that reliably (see note 9) probed the impact that this different standard has had on jurors and juries, or on mental health professionals who supposedly should be altering some focus of their evaluations due to the different requirements of the ALI standard.

Related to the actual standard are the procedures that jurisdictions currently use to implement it. Will the prosecution have the burden of proving sanity, or will the defense have the burden of proving insanity? The decision that jurisdictions have made on this point are typically not normative, but rather empirical, based on the assumption that shifting the burden to one side or the other will directly affect the difficulty of prosecuting and defending the case. Yet, as noted in our discussion of the ABA proposal, research has not directly addressed whether the empirical assumption is a valid one, and if so, to what extent.

Beyond the issue of burden is the standard of proof to which the side having the burden will be held. Will the defense have to prove the defendant's insanity by a preponderance of the evidence, or by some greater standard? Will the prosecution have to prove the defendant's sanity beyond a reasonable doubt, or by a lesser standard? Clearly, there are legal grounds for arguing that the prosecution should be held

to the highest standard of proof in all phases of the trial. But even this argument is based on empirical assumptions of the difficulty of meeting this standard—that is, whether attorneys prepare and/or argue cases differently and whether jurors and juries decide cases differently because a different standard has been imposed on the side with the burden of proof is in need of empirical testing. There are other procedural issues surrounding the trial of an insanity defense (for example, impact of alternate verdict wording—nonresponsibility versus insanity; bifurcation of the trial to consider the insanity issue separate from the evidence on the *actus reus*; and impact of the testimony of mental health professionals) that also require empirical testing but that we will not discuss further because of space limitations.

After the acquittal of a person because of insanity, the law typically imposes rules for the evaluation, detention, and treatment of these persons. Some research, as we have seen, has addressed this stage in the process, focusing on the length of postacquittal detention, recidivism and hospitalization rates. From the public's point of view, information gained from these studies is essential, since they fear that insanity acquittees are only detained briefly after acquittal and have high recidivism rates. Although such data are important, the research has failed to address many of the critical legal policy issues that are inherent in state laws. For instance, states basically use three approaches for postacquittal detention: civil commitment; automatic commitment for a brief period for a mental health evaluation with subsequent disposition being dependent on the resultant findings; and mandatory commitment for some length of time, which in some states can be indefinite.

Numerous empirical questions need to be asked about the actual operation and impact of these differing approaches, if states are to create more rational legal policies surrounding issues of postacquittal detention and release. For example, in jurisdictions that use mandatory commitment for some length of time, does the imposition of this disposition influence the frequency of the use of the plea, or the probability that a jury will acquit a defendant when compared to what happens in jurisdictions using alternate approaches? And given the differing assumptions implicit in the three approaches about the continuing mental illness and dangerousness of the acquittee, does the treatment provided to these individuals significantly differ across these categories? If we assume that postacquittal detention is justified because of the need for evaluation and subsequent treatment, the mechanism for achieving it (civil commitment, automatic commitment for evaluation, or mandatory commitment for a period of detention) should not impact on the quality of care. Whether it does is

an empirical question that needs to be carefully assessed. Moreover, these are but some of the questions that need to be addressed in the future.

Research on this topic will not be simplistic by any means, since there are other procedural issues that interact with it. For example, who will have the burden of proof in release proceedings for persons committed under each of the three approaches, and how will that impact on the probability that the person will achieve release? What will the standard of proof be for the party having the burden? Variations in jurisdictions are substantial and may in some cases actually deny an insanity acquittee a reasonable opportunity for release. And how do the criteria for postacquittal disposition, including both commitment and release, impact on the decision making of the hospital administrators and staff responsible for these decisions? For example, in the case of release, some states following postacquittal commitment use phrases like "restored to sanity" and "cured," whereas others use less stringent criteria. These criteria may affect both the information that the hospital administrator/staff will seek out in reaching a decision as to release, as well as how they weigh that information in reaching a decision. Clearly, that is the intent of the drafters of such legal policies, but we have no data to evaluate how these criteria are used by decision makers and the appropriateness of their behavior.

Finally, although we have not reviewed research dealing with conditions of confinement, this is no less an important area for legal policy. For example, as already noted, what is the treatment provided and types of treatment available? What is the comprehensiveness of treatment? What is the appropriateness of the environmental setting for therapy? What procedures are available for the granting of privileges?

These questions are by no means exhaustive of those that should guide future research. There are numerous others. For example, when states use a civil commitment procedure for postacquittal detention of an insanity defendant, does this in some way alter the processing of the "regular" civil committee? And what is the impact of these procedures on the victim, the victim's family, or on society's perception of fairness in the criminal justice system and their consequent support for the implementation of certain legal policies on this topic? To catalogue all of the relevant issues and to set priorities among them in order to generate the factual foundation on which to build rational legal policies in this area is perhaps a critical intervening step that researchers, law professors, and legal policymakers should take together. For, as is often the case, the quality of the data generated is dependent on the quality of the questions asked.

NOTES

1. In light of the great weight given such evaluations, those switches could be seen as the defense attorney's attempt to plea bargain down to the most favorable terms for the defendant rather than an acknowledgment that the defendant was sane all along.

2. Also see Criss and Racine (1980), who note that 17 percent of the NGRI homicide acquittals in Michigan were for uxoricides, suggesting that society may take a similar view toward intrafamily violence in general. The number of women receiving NGRI acquittals when charged with killing a spouse was twice that which would be expected when compared to the total percentage of women facing such charges.

3. The M'Naghten standard as originally formulated read:

> [T]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it that he did not know he was doing what was wrong [M'Naghten's Case, 1843].

This standard was criticized for being too narrow in that it ignored findings by mental health professionals that while the mentally ill might be able to distinguish right from wrong, they might still be unable to control their wrongful actions (Hagan, 1982).

4. The "irresistible impulse" test excuses those who knew an act was wrong but were unable to stop themselves from carrying it out. However, this approach has been criticized in turn because of mental health professionals' great difficulty in differentiating an irresistible impulse from an impulse not resisted.

5. The Durham rule asked if the criminal act was "the product of a mental disease or defect." Designed to allow for the inclusion of more material concerning the alleged insanity of the defendant, it proved too general and an insufficient guide to juries and judges. In addition, the testimony of psychiatric experts was felt to usurp the decision-making function of the judges and juries under this rule, as experts inevitably, despite the courts' attempts to prevent it, provided answers to questions that were beyond their expertise, and which juries and judges found impossible to ignore in reaching their decisions (Hagan, 1982).

6. Intended to be broader and open to a greater spectrum of evidence concerning the alleged insanity, yet narrower in scope than the Durham rule, the ALI test states:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law [American Law Institute, 1962].

This approach has been applauded for incorporating the modern view that the mind is a complex entity whose function may be impaired in various ways (Hagan, 1982). The ALI formulation is said to differ from the M'Naghten rule in three respects: (1) by using the term "appreciate," it introduces an affective, emotional understanding of the defendant; (2) it does not require a total lack of appreciation by the defendant of the nature of his or her conduct, only that the defendant "lacks substantial capacity" to do so; and (3) it includes a volitional element, making the defendant's inability to control his or her actions an independent criterion for insanity (The Insanity Defense, 1983).

7. The burden of proof is currently placed on the defendant in 26 states, the District of Columbia, and in the federal courts (The Insanity Defense, 1983). Since the party that bears the burden operates from a considerable disadvantage, it is believed by

some to make a finding of NGRI more difficult to obtain. Its proponents justify this by arguing that it eliminates the state's difficult and unfair task of proving someone sane, instead placing the burden to generate the relevant evidence on the insanity issue with the party most likely to have such evidence and most able to focus the scope of the controversy: the defendant. Opponents of this approach argue that the burden rightfully belongs with the state, which should have, as in every other criminal charge, the burden of proving each and every element of the crime, including that the defendant was sane at the time of the crime. In addition, it is asserted that the state has superior resources to undertake this investigation and has initiated the legal steps that necessitate this investigation and that threaten to seriously infringe upon the defendant's liberty. This approach actually has a long history but has received revived attention in the recent drive to "tighten up" the insanity laws.

8. Under this approach, which is currently being utilized in thirteen states (Melton, 1984, personal communication), a defendant found GBMI receives the same sentence as a defendant found sane. Following an evaluation, if it is determined that the defendant continues to need mental health treatment, he or she is committed to the appropriate mental health facility. When and if it is decided that the individual is no longer mentally ill, the individual will be transferred to a prison to complete the remainder of his or her sentence, and the time spent in the mental health facility will be deducted from the original sentence.

This approach was at least partially motivated by concerns about the early discharge given some NGRI acquittees, allowing them to return to society. Critics of this compromise approach assert that it improperly allows juries and judges to avoid coming to terms with the difficult moral issues involved in insanity cases, such as the societal standards to be used in assigning responsibility and nonresponsibility. This is especially felt to be the case in states that use GBMI to supplant insanity, but it is also germane in states where it supplements the defense. In these latter states, it is feared that jurors and juries will opt for the GBMI verdict even if a defendant met the test of insanity.

9. Another study also contends that the statutory language used for deciding insanity pleas has a significant impact. Sauer and Mullens (1976) probed the impact in Maryland of the June 1, 1967, change from the M'Naghten rule to the ALI test. They compared the results of mental examinations conducted at the Maryland hospital that was charged with evaluating males accused of a felony who had entered insanity pleas or were believed by the court to be incompetent. The results of these tests for two-year periods were analyzed. In Fiscal Year 1966 there were 278 pretrial mental examinations, while in FY 1973 there were 380. Comparing the two years, a statistically significant increase in the percentage of individuals evaluated as not responsible for their actions appeared: 22 (8%) under the M'Naghten rule in FY 1966 and 73 (19%) under the ALI test in FY 1973—a proportional increase of 143%. The authors found no differences in the evaluations themselves for the two time periods, nor was there an appreciable difference in the staff at the hospitals or in the frequency of the psychological or psychiatric labels applied.

There are troublesome aspects to the Sauer and Mullens study. Perhaps the most significant is that it attempts to deduce a trend from single data points on either side of the legal change. Their approach fails to eliminate the possibility that some factor other than the change in statutory language may have been responsible for the reported difference. For instance, a highly controversial insanity case may have been decided in Maryland just prior to or during FY 1966 which led to artificially low numbers of such evaluations for that year. Alternatively, the figures for FY 1973 may be high not because of the change in legal standard but because throughout the nation there had been a trend of greater acceptance of insanity pleas, and Maryland simply reflected that trend. Without a series of data points both preceding and following the legal

change with a break in the general trend at that point, it is highly speculative to conclude that a particular legal rule has been responsible for a change in a trend.

The need for such an analysis increases in importance in light of other studies that claim to have determined that the legal standard utilized does not alter the nature of the NGRI verdicts reached. For example, two studies conducted in Wyoming at different times under different rules did not reveal a significant difference in the number of persons entering an NGRI plea and the proportion that were successful (Pasewark, 1981). The first study examined the years 1970 to 1972, when Wyoming used a M'Naghten rule with an "irresistible impulse" addendum. The second study considered 1975-1977, when the ALI test governed. Between 1970 and 1972, 102 defendants entered NGRI pleas, with one being successful, while for 1975-1977, 114 pleas were entered. Of the 100 defendants for whom dispositions were know, four were successful (X^2 (1) = 1.54, $p > 0.20$).

Of course, it could be argued that the "irresistible impulse" addendum made the M'Naghten rule more comparable to the ALI test. Furthermore, it could be contended that the Wyoming data were headed in the same direction as those for Maryland (both showing an increase in the percentage of successful pleas following a shift to the ALI rule), even though the Wyoming data were not significant. Finally, the small number of cases and the resultant reliance on a single data point on either side of the legal change make any conclusions about general trends highly speculative.

10. ABA also recommended that the guilty but mentally ill verdict form not be used to supplant or supplement the insanity defense. Once again, the recommendation was based on assumptions about how this alternate form would affect the implementation of the insanity defense (see, for example, note 8). Among others, fears include the belief that juries would not acquit by reason of insanity if the GBMI verdict were available; jurors would vote for the GBMI form on the mistaken belief that the defendant would receive needed treatment; and that legislators would quickly supplant the insanity defense with the GMBI verdict. Although we considered the GBMI verdict beyond the scope of our review, there has been some research assessing its impact (see Criss and Racine, 1980; Smith and Hall, 1982).

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Chapter 12

IDENTIFYING AND TREATING THE MENTALLY DISORDERED PRISON INMATE

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"Mentally disordered offenders" can be considered as an umbrella term embracing four distinct legal categories: defendants who are incompetent to stand trial or not guilty by reason of insanity, persons adjudicated as "mentally disordered sex offenders," and convicted prisoners who are transferred to mental hospitals (Steadman et al., 1982; Monahan and Steadman, 1983a, 1983b). Public attention has focused on the first three of these categories, perhaps because of a belief that they constitute a form of "beating the system." That is, the offenders in these cases committed what would popularly be considered a crime, yet have escaped criminal conviction. Notorious cases that have raised these issues (although not always successfully), such as John Hinckley, Patricia Hearst, David Berkowitz, and Mark Chapman, no doubt contribute to this public attention.

The media, the public, and legislators, however, have yet to show comparable interest in the fourth category of mentally disordered offenders—persons first convicted of a crime, incarcerated, and later found to be in need of transfer to a mental health facility. It is likely that this lack of interest in mentally disordered inmates reflects the

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fact that these individuals did not "get away" with their crimes since they have already been convicted and sentenced to prison. Social scientists have also, for the most part, limited their research efforts to "incompetency" (Roesch and Golding, 1980; Mowbrey, 1979; Steadman, 1979) or "insanity" (Rogers and Bloom, 1982; Petrila, 1982; Pasewark et al., 1979; Pasewark and Lanthorn, 1977; Steadman, 1980; Cook and Sigorski, 1974; Morrow and Peterson, 1966) and "mentally disordered sex offender" status (Konecni et al., 1980; Sturgeon and Taylor, 1980). Researchers rarely study the less publicized situation where the prisoner's mental health problems were not manifest, or at least not identified, until after placement in prison (Gearing et al., 1980; Halleck, 1961).

Despite the meager public and research attention garnered by mentally disordered inmates, they constitute the largest category of mentally disordered offenders in the U.S.—54% of all mentally disordered offenders, and 68% of all *male* mentally disordered offenders admitted to mental health facilities in the United States in 1978 (Steadman et al., 1982). In fact, 10,831 inmates were transferred from state prisons into separate mental health units or facilities in 1978 (Steadman et al., 1982). This number does not include those inmates who were experiencing mental health problems but received care (or at least remained) in the general prison population.

It also appears that for at least two reasons, the number of mentally disordered inmates may increase in coming years. First, there is a movement in a number of states to do away with the insanity defense in favor of a "guilty but insane" verdict, which may have the effect of mandating mental health services for specified inmates who previously would have been acquitted by reason of insanity. Second, current trends in criminal sentencing seem likely to result in placing more offenders into state prisons for longer periods. In 1981, the largest annual increase in U.S. history in the number of prison inmates (41,292) was recorded (Gardner, 1982). Thus, even if the proportion of inmates who were mentally disordered remained constant, the absolute number of inmates requiring care would have skyrocketed. Using a low estimate of the proportion (15%) of inmates who are mentally disordered there would have been nearly 6200 more inmates needing mental health services in U.S. prisons in 1982 than in 1981.

The level of management problems that these mentally disordered inmates pose has been demonstrated by Uhlig (1976). Examining a group of 356 offenders throughout New England prisons who had been identified as special management problems, he found that 195 (53%) were diagnosed as having current psychiatric disturbances.

Clearly, a major source of conflict in volatile prison settings are mentally disordered inmates. These inmates present problems with which prison officials usually are not prepared or trained to cope. Further, these inmates would appear to create additional management problems for prison officials by generating disruptive behavior among inmates who do not know how to respond to the unusual and inappropriate behavior displayed by the mentally disordered, and who tend to victimize these more vulnerable inmates. It is also important to note that an additional series of problems results from those inmates who are withdrawn or excessively depressed but who may not be disruptive or create management problems (Hartstone et al., 1982).

Programmatic responses to mentally disordered inmates in the United States have been cyclical: (1) responsibility for mentally disordered prison inmates repeatedly has shifted back and forth from corrections to mental health departments; and (2) the appropriateness of mixing convicted mentally disordered persons in civil mental hospitals has been viewed very differently from one era to another (Steadman and Cocozza, 1974). The experiences in New York illustrate these long-standing issues.

The first move in New York to separate civil mental patients from mentally disordered persons charged with or convicted of crimes occurred in 1782. An "Act Respecting Lunatics" was passed that prevented the overseers of the poor, who were responsible for the mentally disordered, from housing the mentally disordered in jails or "in the same room with any person charged or convicted of an offense" (N.Y. Laws 1827, Ch. 294, Sec. 2). They could be kept only in poorhouses.

When the state's first asylum for the mentally disordered was opened in 1842 in Utica, however, the legislative provisions allowed for the mixing of mentally disordered convicts, those confined under indictments or criminal charge, those acquitted by reason of insanity, and patients committed under any civil process. Thus, the mental health system, rather than the more general social welfare system or corrections, came to care for mentally disordered inmates.

By 1855, there was movement again toward separating patients who were convicted or alleged criminals from civil patients. This movement culminated with the 1859 opening of an Asylum for Insane Convicts at Auburn Penitentiary, the first institution of its kind in the United States. In 1861 the state legislature directed that all mentally disordered male prisoners be transferred from Utica to Auburn. In 1869, Auburn was directed to house those persons acquitted because of insanity as well as defendants charged with murder, attempted

murder, or arson who became mentally disordered prior to trial or sentencing. Thus, convicted and unconvicted patients were again confined in the same facility, separate from civil patients, as they had been before Auburn Asylum opened.

A legislative commission established in 1886 located a site in Matteawan to replace the Auburn Asylum, which would be large enough to allow for the separation, within a single facility, of unconvicted patients awaiting trial from mentally disordered convicts. As a *New York Times* article reporting the opening noted, "The two classes of patients differ widely, the criminals giving the officials much anxiety at times. They are frequently dangerous and destructive." As had happened with Auburn soon after its opening, the number of patients at Matteawan quickly increased. While the patient population continued to burgeon at Matteawan, pressure also built for the separation of the "convict insane" from the other criminally insane patients, such as insanity cases. In 1894, the State Lunacy Commission noted that separate institutions were beneficial because the presence of insane convicts "was very objectionable to the ordinary inmates" of state hospitals.

A new facility, Dannemora State Hospital, opened in northern New York in January, 1900, under the auspices of the Department of Corrections. By this time, Matteawan was overcrowded with 719 patients in a building whose capacity was 500. All inmates in the state who were determined to be mentally disordered after a felony conviction would be housed in Dannemora. All other convicted patients and pretrial cases would go to Matteawan. Between 1900 and 1966, the patient population at Matteawan and Dannemora climbed steadily, with Matteawan reaching a patient census of over 2000 in the early 1960s. At the same time, Dannemora reached a peak of about 1400 patients. However, in these 66 years little changed in either the statutes or the two facilities.

Throughout the late 1960s and early 1970s, there was a dramatic decrease in the patient census at Matteawan and Dannemora, and a gradual shift for all mental health treatment for all classes of mentally disordered offenders to the Office of Mental Health (OMH). Dannemora was closed in 1972 and Matteawan in 1977, removing the Department of Corrections (DOC) from any direct mental health care responsibilities. Instead, the OMH opened a maximum-security hospital for incompetent defendants and defendants not guilty by reason of insanity in 1972 and one for mentally disordered inmates in 1977. Thus, over this 150-year period, care of mentally disordered inmates in New York shifted from welfare, to mental health, to corrections, and back to mental health.

History appears to be again repeating itself as states continually tinker with their treatment arrangements for mentally disordered inmates, sometimes charging departments of mental health with the responsibility, either by themselves or in concert with departments of corrections, and sometimes mandating treatment by the departments of corrections themselves. Based on our 1978 national survey (Steadman et al., 1982), there appears to be little consensus on the most appropriate arrangements for mentally disordered inmates. This survey revealed that 16 states transferred most (at least 75%) of their mentally disordered inmates into mental health facilities or units administered by the DOC;[1] 28 states transferred the majority into hospitals or units run by the DMH; and six states utilized a combination of DOC and DMH units.

It may be that the lack of consensus across states on how to handle mentally disordered inmates reflects in part a lack of empirical data. There are no data on whether there is a type of arrangement that is optimal for both inmates and facilities, what such an arrangement might look like, and under what circumstances one arrangement is to be preferred over others. As prison populations climb, as the number of beds in state mental hospitals continues to be limited, and as legal rights to minimum health and mental health treatment are confirmed by the courts, more information is needed to facilitate the development of appropriate programs for mentally disordered inmates.

In an effort to provide some empirical data on the needs of these inmates and how the correctional and mental health systems respond to them, this chapter utilizes data from 67 interviews with a wide range of correctional staff in five states. Specifically, these data focus on the placement options available for mentally disordered inmates, the adequacy of procedures used to identify the inmates and transfer them to mental health facilities, and the extent to which the procedures used meet the needs of these inmates.

METHODS

Our data are drawn from a national study of the movement of offenders between prisons and mental hospitals funded by the National Institute of Justice. As part of this effort, six states—Arizona, California, Iowa, Massachusetts, New York, and Texas—were identified for an intensive examination of the confinement and criminal careers of inmates and mental patients, and of the practices and processes of transferring prison inmates to mental health facilities. Five of these six states (New York excluded) were found to use Department of

Corrections (DOC) mental health settings as the main placement for mentally disordered inmates. It is these five states with their use of *intra*-agency transfers for mentally disordered inmates that are the focus of this chapter.

While approximately two-thirds of the states in the United States transfer most of their mentally disordered inmates to state departments of mental health (DMH), since the larger states tend to use DOC options, 71% of all prison inmates transferred for mental health services in 1978 were placed in DOC-operated mental health facilities. Any effort to generalize from the data reported here should be limited to those states that transfer the majority of their inmates to DOC mental health settings. The issues discussed here focus only on procedures for dealing with male inmates, since 95.8% of all inmates transferred in our 1978 study were males. Women's programs require specialized study for what are often more haphazard, less formal service arrangements.

Structured interviews were conducted with a wide range of DOC personnel in the five target states between October 1, 1980, and January 31, 1981. The interviews were primarily open-ended, with some Likert-type items, and averaged 90 minutes. A two-person interview team completed interviews with 67 persons employed by the DOC. Interviews were conducted at the DOC central office, the state prison transferring the most inmates, and the mental health setting receiving the most inmate transfers. At the DOC central office, the DOC Commissioner (or Deputy Commissioner) and the mental health treatment director were interviewed. At the prison transferring the most inmates in each state, we interviewed the warden, the treatment director, two direct clinical service providers, and a correctional officer. Hospital or Treatment Center interviews consisted of the facility or unit director, the chief of security, two clinical staff members, and a line staff representative. In instances where there were a number of people in a particular position, we interviewed the person nominated by the facility director. Thus, the information obtained from the interviews reflects a wide range of staff locations and job responsibilities.

SCOPE OF MENTAL HEALTH PROBLEMS IN PRISONS

The first issue of interest was the perception of the various DOC staff of the scope of the problem and how their estimates compared with prior research. All respondents were asked what percentage of the DOC inmates they believed to be either seriously mentally disordered (that is, psychotic) or suffering from a psychological problem

that warranted mental health treatment. The mean responses, separated by staff location, are presented in Table 12.1. It is clear that a sizeable number of state prisoners were suffering from serious mental health problems. As seen in Table 12.1, the respondents in our five target states estimated on average that 5.8% of state DOC inmates were "seriously mentally ill," and that an additional 37.7%, while not psychotic, were suffering from a psychological problem that would significantly benefit from mental health treatment. This table also shows that, when compared to central office administrators, the people actually working in the institutions (that is, prisons and DOC mental hospitals) thought considerably more DOC inmates were psychotic (6.1% versus 4.3%) or experiencing other psychological problems (38.7% versus 30.6%). While the differences may appear at first glance to be small, one must consider that given the size of the total prison populations in these five states, this translates into a difference of 6389 inmates defined as in need of mental health services.[2]

In general, the overall estimates of the respondents are similar to the best estimates of true prevalence of mental disorder that Monahan and Steadman's (1983a) literature review found:

> One is left from these studies with true prevalence rates for serious mental illness (i.e., psychoses) among offenders incarcerated in prison or jails varying from 1 percent (Guze, 1976) to 7 percent (Bolton, 1976). True prevalence rates for less severe forms of mental illness (nonpsychotic mental disorders and personality disorders) vary greatly, ranging up to 15-20 percent (Roth, 1980).

When staff were asked whether they believed there had been any change over the past ten years in the percentage of inmates suffering from a "serious mental illness," 43% of the staff said they believed the percentage of disordered inmates had gone up. In contrast, only 7% of those responding said the number had gone down. Those prison and correctional mental health facility staff persons who felt this problem was becoming increasingly severe offered a variety of explanations. Most respondents cited one of three factors: conditions in the prison, the deinstitutionalization movement in state mental hospitals, and general societal conditions. A prison guard concerned that the prisons themselves were generating the problem stated:

> The environment here in prison is changing for the worse. It is becoming more and more crowded, causing a lot of problems. There are now three to four inmates in one cell; they are in the cell for 12-14 hours at a stretch.

Table 12.1 Percentage of Inmates in State Prisons Perceived as Having Mental Health Problems (by staff location)

	Mental Health Need			
	Seriously Mentally Ill		*Psychological Problem Warranting Treatment*	
Staff Location	*Mean %*	*(N)*	*Mean %*	*(N)*
DOC central office	4.3	(9)	30.6	(8)
Mental health facility to which inmates were transferred	6.2	(25)	42.3	(29)
Prison from which inmates were transferred	5.9	(23)	34.4	(24)
Total	5.8	(57)[a]	35.7	(61)[b]

a. Missing data for 10 cases
b. Missing data for 6 cases

A clinician at a DOC-operated mental hospital blamed the problem there on DMH deinstitutionalization of mental hospitals:

> The main cause of deinstitutionalization by (DMH). A lot of these persons are getting criminalized. It is easier for a cop to take John Doe to a lock-up—end up here—than to send him to a state hospital.

A social worker in a state prison stated that she felt there were mental health problems in prison because of general societal conditions:

> There has been an increase in societal population, a breakdown of the families, a pressure packed society. It is a societal problem.

Due to these perceived problems, DOC staff expressed concern that there are sizeable numbers of inmates in the DOC who are experiencing serious psychiatric or psychological problems warranting some form of clinical intervention. The remainder of this chapter examines what is happening to those prison inmates who are mentally disordered—where can they receive treatment, and are they identified and placed in the designated mental health settings?

PLACEMENT OPTIONS AND PROCEDURES

While all five state DOCs treated mentally disordered inmates within the agency, these agencies did not all have the same philosophy regarding mental disorder, nor did they establish the same placement options. California had substantially more beds available and trans-

ferred more inmates than any of the other states. Within the California Department of Corrections, two major placement options were used for inmates suffering mental health problems. The California Medical Facility at Vacaville (CMF) received those inmates who were most disordered and dangerous, and the California Men's Colony (CMC) utilized one of their prison quandrants usually for less disordered and less violent mentally disordered inmates. Over 3000 inmates are transferred into either the CMF or CMC annually. Prior to 1980, some inmates were transferred to DMH's Atascadero State Hospital, but DOC staff said that since January 1980 it was practically impossible to get an inmate into Atascadero. As indicated by the number of DOC beds that were available for mental health care, the California DOC approach clearly reflects a philosophy that stresses the importance of recognizing the mentally disordered offender and placing such inmates in a separate facility or unit for treatment.

In three states (Arizona, Iowa, and Massachusetts) there was a single DOC-operated mental hospital. In these three states, the hospitals admitted all categories of "mentally disordered offenders" (transfers, insanity acquittals, and incompetency cases). The hospitals varied considerably in size and transfer admissions. There were 442 beds at Bridgewater State Hospital (Massachusetts), 80 beds at the Iowa Medical Facility, and 40 beds at Alhambra (Arizona). The Massachusetts and Iowa hospitals both admitted approximately 225-275 transfers annually, while the Arizona facility admitted fewer than 15.

The Texas Department of Corrections (TDC) operated with the philosophy that all TDC inmates are TDC's responsibility and should, whenever possible, be maintained in the general population. While a maximum security unit at Rusk State Hospital (operated by DMH) was a potential placement option, the use of this unit decreased from 65 inmates in 1978, to 37 in 1979, to 9 in 1980. Typically, when an inmate's condition caused the TDC to move an inmate out of the general population, the inmate was transferred to the Huntsville Treatment Center (HTC), located within the Huntsville prison. This unit contained 90 beds, an average census of 67, and admitted 20-25 inmates each month. The HTC was used primarily for short-term stabilization and medication, followed by the inmate's immediate transfer back to the general population. On rare and extreme occasions, inmates have been transferred from the HTC to Rusk State Hospital. The number of inmates placed in either the HTC or Rusk State Hospital seems particularly low given the large number of inmates (approximately 30,000) residing with the Texas Department of Corrections.

In all five study states, the initial identification of the mentally disordered inmate usually resulted from observations made by a correctional officer and a referral to a prison psychologist or psychiatrist. At that point, however, considerable procedural variations occurred in the role of the prison, the mental hospital, the DOC central office, and the courts in determining which inmates were transferred. In only one state (Massachusetts) was judicial approval required. In two states (Arizona, California), transfer decisions were routinely made or approved by representatives of the DOC central office. The mental health receiving facility had an active role in the transfer decisions in two states (Iowa and Arizona), while in Texas the prison psychologist's recommendations were followed without any review. Whatever the means used to review recommendations made by the prison clinician (such as the court or DOC central office), the review appeared to be perfunctory and virtually all inmates recommended for transfer were, in fact, transferred.

An examination of available placement options and transfer procedures implemented in our five study states reveals that, although each of these states transferred most of their inmates into facilities operated within the DOC, variation occurred in the type of placements available, the extent to which they were used, and the procedures implemented for transferring an inmate to one of these facilities.

ADEQUACY OF IDENTIFICATION AND TRANSFER PROCEDURES

Identification

In order to ascertain which inmates were selected for transfer to mental health facilities, we asked all respondents whether transfers occurred primarily for clinical reasons (that is, mental health difficulties) or behavioral reasons (management problems), and what types of inmates were identified for referral to mental hospitals. The majority of our respondents (52.6%) reported that persons were identified for behavioral reasons, 33.3% felt that identification was usually brought about due to clinical reasons, and 14% stated that identification could occur for either reason. In only one state (California) did more respondents attribute identification to clinical reasons (52.6%) more often than to behavioral reasons (36.8%). In each of the other four states, 50% or more of the respondents said inmates were primarily identified for behavioral reasons.

Table 12.2 Reasons Why Inmates Are Transferred to Mental Health Facility

	Staff Work Location							
	Central Office		*Mental Health Facility*		*Prison*		*Total*	
Reason for Transfer	*%*	*(N)*	*%*	*(N)*	*%*	*(N)*	*%*	*(N)*
Psychotic	25.0	(6)	15.4	(10)	14.0	(8)	16.4	(24)
Other mental illness[a]	45.8	(11)	66.2	(43)	72.0	(41)	65.1	(95)
Management problem: violent	25.0	(6)	15.4	(10)	10.5	(6)	15.1	(22)
Other	4.2	(1)	3.0	(2)	3.5	(2)	3.4	(5)
Total							100.0	(146)

a. Other mental illness includes (1) DSM II diagnostic classifications that do not fall under the heading of psychotic; (2) more general references to mental illness (for example, crazy, flaky, bizarre, mentally ill, unstable); and (3) "mentally ill and dangerous."

When asked for specific reasons why inmates were identified for referral to mental health facilities, the respondents focused primarily on mental health problems. As presented in Table 12.2, our 67 respondents produced 146 responses: 16.4% of the responses referred to psychosis, 65.1% referred to other mental health reasons, and 15.1% focused solely on violence or mangement problems. The fact that behavior was felt to be a more important determinant than clinical factors in deciding whether an inmate was identified for transfer would seem to indicate that some inmates who were mentally disordered were not identified because their behavior was not particularly visible or disruptive, and that other inmates may have been identified for transfer due to behaviors which were unacceptable, but not necessarily indicators of real clinical symptomatology. However, given the high percentage of responses citing mental health problems as a reason for transfer, it appears that, while the initial identification may have been precipitated by behavior, the transfer decision typically was based on mental health problems. Thus, while it would seem that there may be some inmates transferred who are only behavior problems (not mentally disordered), the potentially more important problem is the lack of early identification of those mentally disordered inmates whose behavior does not either annoy the DOC staff or disrupt prison operations. It seems likely that there are a number of disordered inmates who go unnoticed and, therefore, untreated.

This interpretation is supported by responses to questions about the appropriateness of the number of inmates transferred and the major weaknesses in the identification of inmates for transfer. Staff were asked how they felt about the number of inmates transferred to a

Table 12.3 Staff Perception of the Appropriateness of the Number of Inmates Transferred (by staff location and state)

	Number of Inmates Transferred					
	Too Few		*Just Right*		*Too Many*	
Staff Location	%	(N)	%	(N)	%	(N)
Central office	30.0	(3)	60.0	(6)	10.0	(1)
Mental hospital	41.1	(12)	48.3	(14)	10.3	(3)
Prison	62.5	(15)	33.3	(8)	4.2	(1)
			State			
A	20.0	(2)	70.0	(7)	10.0	(1)
B	62.5	(5)	25.0	(2)	12.5	(1)
C	70.0	(14)	25.0	(5)	5.0	(1)
D	30.8	(4)	69.2	(9)	0.0	(0)
E	41.7	(5)	41.7	(5)	16.7	(2)
Total	47.6	(30)	44.4	(28)	7.9	(5)

mental health facility or unit. Table 12.3 shows the staff responses by staff location and state. As seen in the table, almost half of the staff members responding felt that "too few" inmates were transferred (47.6%). This compares to the small number of staff (7.9%) who felt that "too many" were transferred. Staff in three states[3] clearly were quite concerned that too few mentally disordered inmates were placed in mental health settings. When examining responses by work location of staff responding, it is interesting to note that while concern over underidentification occurred in all three locaitons (prisons, 62.5%; mental hospitals, 41.4%; and central office, 30.0%), the percentage of prison staff who felt that not enough inmates were transfered more than doubled the percentage of central office administrators who had that concern. While it is unclear whether this distinction reflects a lack of first-hand knowledge by the administrative staff or the lack of mental health expertise of the prison staff (or both), it is apparent that the prison staff felt they were handling inmates whom they were incapable of treating in the general prison population.

Respondents also were asked to name what they perceived to be the major strengths and weaknesses in the identification of mentally disordered inmates. While most respondents did find some strengths, frequently the strength cited was merely a reiteration of the fact that the system did exist and did identify and place mentally ill inmates. More meaningful strengths that were cited with some regularity by the corrections staff were the quality of the clinical staff, the ability of staff to work together, and the efforts made by prison guards.

Table 12.4 Major Weaknesses in Identifying Inmates for Transfer

Weakness	*% of Responses*	*(N)*
Miss some mentally ill inmates	30.0	(27)
Lack of clinical staff in prison	17.8	(16)
Seek to transfer management problems	11.1	(10)
Inadequate training of prison staff	8.9	(8)
Manipulation of staff by inmates	5.6	(5)
Lack of mental health assessment	4.5	(4)
Other	22.1	(20)
Total	100.0	(90)

Efforts to specify weaknesses in identification were more informative. As seen in Table 12.4, many of the responses dealt directly with the problem of prisons "underidentifying" mentally disordered inmates (miss some mentally disordered inmates, 30%; insufficient number of clinical staff, 17.8%; lack of mental health assessment, 4.5%). Additional responses (such as the lack of clinical training of prison staff) at least indirectly dealt with the same concern. Some examples of responses noting the "underidentification" of mentally disordered inmates were:

> There are not enough professional staff; I fear the quietly crazy are not identified. That is what concerns me [prison psychologist].
>
> Problems of spotting someone who needs to be there. We have only 30-40 correctional officers for 2000 inmates. Not enough of us to keep up on what's going on. Inmates usually have to show exceptional behavior before being identified. They could have problems, and not be identified [prison correctional officer].
>
> We primarily have a disturbance identification process rather than a patient need identification [process] [Correctional mental hospital psychiatrist].

Procedures

Once an inmate was identified by the prison staff as being mentally disordered, each state had formal procedures for reviewing the transfer of the inmate to a mental health facility. All respondents were asked how well they thought the procedures were working. Almost 85% of those interviewed said the procedures were working either "very well" or "well," and in only one state was there considerable concern over how these procedures were operating (33% said "poorly" or "very poorly"). However, a significant difference was revealed in

how staff at different locations (central office, mental hospital, prison) assessed the effectiveness of these procedures. Only one respondent across the five states working either at the central office or the mental health facility said the procedures were operating "poorly" or "very poorly" (2.6%). On the other hand, 36% of the prison staff interviewed viewed the operation of transfer procedures as so problematic as to define them as operating "poorly" or "very poorly." This view was found to be limited to two states. Some of the specific criticisms made by prison staff in these two states were:

> No one's going anywhere. There are a lot of mentally ill people here, but they are not housed as if they're mentally ill. Not treated any differently than other inmates [prison psychologist].
>
> Bedspace problems at (the CMH) and their unwillingness to take our inmates. If they are both psychotic and management problems, they [CMH] keep them only a short period of time and say the inmate is only a management problem and send them back [prison administrator].
>
> Takes too much time! Courts' fault, always getting involved when they know nothing about it. Afraid we will put people there (the CMH) for punishment. Delay in getting hold of "shrink" and taking care of paper work. Delay is at central office . . . [the mental health facility] sends them back too soon, when they shouldn't be housed here at all. The inmates go back and forth [correctional officer].

While DOC staff from the other three states typically stated that procedures were operating well overall, staff in these states frequently said there were still some major weaknesses in the procedures. In one state the concerns frequently focused around the extent to which the procedures protected inmates from being transferred inappropriately:

> Procedures are not terribly tight, staff could conspire to place a person who is not mentally ill into a mental hospital. Lack of legal safeguards. Not forced to confront the man and say he is crazy [corrections administrator].
>
> [The Supreme Court] requires there should be an independent review of hospitalization. We don't have this. A good law requires judicial commitment. We don't have this [corrections administrator].

In another state, the issue involved the decision-making process. As seen below, some DOC staff (usually prison staff) felt too much

decision-making control was left in the hands of hospital staff. Others (typically hospital staff) felt that too much control was given to the prison and DOC central office.

> If _____ [the CMH director] doesn't want someone he doesn't have to take him. He is scared and doesn't want to be bothered by this type of person. He fears they will be disruptive to their program. His power to make this decision is the major weakness in the procedures [correctional officer].
>
> Formal decision is left in the hands of a lay person [central office]. This is a medical facility and he [DOC director] has the ultimate authority . . . Not a real problem, as long as mental hospital director has right to discharge.

Despite the specific concerns noted above, the respondents were, in general, satisfied with the transfer procedures. The respondents also expressed satisfaction with the receptivity displayed by the DOC mental health facilities to mentally disordered inmates referred by the prison. Almost 90% of the staff interviewed defined the state correctional mental health facility or facilities as either "very" or "somewhat" receptive. The prison staff were considerably more likely to define the mental health facilities as "somewhat" or "very" nonreceptive (22.7%) than the staff at the mental health facilities (3.3%). Almost 75% of the staff responding in each of the five states defined the correctional mental health facility as receptive.

Thus, in general, DOC staff appear to be satisfied with the procedures for inmate transfers from the general prison population into mental health facilities and the receptivity of these facilities to mentally disordered inmates.

One area that generated little concern by the prison staff, DOC central office staff, or mental health staff was the inmate's ability to prevent transfer through procedural safeguards. When asked whether inmates prevented transfer too frequently, as often as they should, or not often enough, 92% of the DOC staff responding said "as often as should be the case." In no state did a sizable percentage of staff express concern that inmates either prevented too many transfers or were unable to prevent transfers often enough. It is not clear whether these responses reflect procedures that gave inmates an optimal amount of input into this decision or whether it more accurately reflects the frequently stated belief of DOC staff that "inmates have no control over these decisions and they shouldn't."

CONCLUSION

This chapter has used 67 interviews conducted with DOC staff in five states to describe the process of identifying state prisoners suffering from mental disorders and the transferring of these inmates into designated DOC mental health facilities. The major conclusions drawn from these interviews are:

- DOC staff perceive a sizable number of state prisoners to be suffering from a serious psychotic mental disorder (5.8% of all inmates) or psychological problems warranting treatment (37.7%).
- Different states operate with different philosophies on how to handle mentally disordered inmates and therefore identify widely divergent percentages of their inmates as warranting placement in a mental health facility.
- Once the prison psychiatrist or pschologist recommends that an inmate be transferred, it is the rare exception when a review system (prison, DOC, court) reverses that decision.
- Inmates are typically identified in the prison for behavioral management reasons, thereby making it likely that a sizable number of mentally disordered inmates remain in the general population because their behavior is insufficiently visible, annoying, or disruptive.
- A sizable percentage of staff (47.6%) stated they felt "too few" inmates were transferred to mental health settings.
- Staff typically felt that the procedures used to transfer those inmates identified as mentally disordered were working well (84.4%) and that the DOC mental health facilities were receptive to these inmates (85.5%). However, staff working at the prisons were considerably less satisfied with both the procedures and the receptivity of the mental health facilities than were the staff at either the DOC central office or the DOC mental hospitals and treatment centers.

As prison populations continue to burgeon, the problem of mentally disordered inmates will only be exacerbated. Even if the proportion of the inmate population with mental disorders remains constant, the scope of the problem within any given growing prison system will become more acute in terms of absolute human service needs (see Monahan and Steadman, 1983a). While the descriptive work discussed in this chapter is a major first step toward building knowledge in this area, it is essential that more research be devoted to studying mentally disordered inmates. Further research is needed both on inmates themselves and on the system and agencies responsible for their care and treatment.

More information is needed on the prevalence, causes, and correlates of mental disorders within the state prison inmate population. A systematic, multistate study is needed that utilizes an objective instrument across states to assess the extent to which prison inmates suffer from mental disorders. Inmates identified as mentally disordered should be studied for purposes of examining causes and correlates of both the criminal behavior and mental disturbance. Included in this assessment should be an examination of how incarceration and prison conditions contribute to inmate mental health problems and in what ways the prison experience may combine with preprison factors to generate serious inmate symptomatology.

NOTES

1. According to 1978 admission data, there were 16 states in the country which transferred most (at least 75%) of their mentally disordered inmates to mental health settings within the DOC. They are California, Idaho, Illinois, Iowa, Massachusetts, Michigan, Missouri, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Texas, Utah, and West Virigina. In addition, Arizona changed the agency responsible for the mental hospital treating mentally ill inmates from DMH to DOC at the end of 1978.

2. Information contained in the Bureau of Justice Statistics Bulletin (Department of Justice, 1982) showed that at the end of 1980 the state prison censuses in the five states discussed in this chapter were as follows: Arizona, 4,372; California, 24,569; Iowa, 2,513; Massachusetts, 3,191; Texas, 29,892; total: 64,537.

3. Throughout the remainder of this chapter, we do not identify any of the states by name. We felt that to do so would betray both the confidence and trust the states had in us and risk the anonymity we promised to individual respondents.

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Chapter 13

CONDITIONAL RELEASE ON PROBATION AND PAROLE
Implications for Provision of Mental Health Services

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The criminal justice system altered its philosophy from punishment and deterrence to include rehabilitation during the decades at the end of the nineteenth century and the beginning of the twentieth. This constituted an endorsement of the particularly American beliefs that people are perfectable and that government has a responsibility to bring this about. Thus, the criminal justice system has attempted to educate, "correct," rehabilitate, reform, and reintegrate criminals.

Parole and probation were the centerpieces of the rehabilitative approach, the purest embodiments of the new ideals. Probation is considered "America's contribution to progressive penology" (Goldfarb and Singer, 1973: 209). Criminals would be treated instead of punished, guided back into society instead of isolated. The parole and probation processes included the provision of mental health, vocational, and educational services to criminals, using resources within and outside of the criminal justice system.

Despite its noble aims, the rehabilitative approach has faced a torrent of criticism for the past decade. This criticism is based on an alarming crime rate, the pessimistic conclusions of researchers that "nothing works" (Martinson, 1974) to rehabilitate offenders, and an increasingly conservative view among the public that rehabilitation means leniency, and leniency is felt to be a major cause of the growing crime rate.

The purpose of this chapter is to take a careful view of probation and parole, to understand how these systems function, what they do with

offenders, and the problems offenders have faced in seeking rehabilitation. We propose that policymakers and the public need to know these things in order to make wise choices about the allocation and use of resources by the criminal justice system. We feel that there is reason to hope that rehabilitation *can* work, but not if we continue to make conflicting and scientifically unsound demands on an overburdened criminal justice system.

PROBATION AND PAROLE

Probation and parole are forms of conditional release after conviction. Probation is a judicial sentence usually in lieu of incarceration but sometimes in combination with a short sentence (sometimes called a "split sentence"). The judge, in assigning a probationary sentence, has thereby decided that the offender should be supervised in the community subject to the conditions of probation. Parole is also a conditional release but is a decision made by a parole board (part of the executive branch of government) to release an offender from prison prior to the completion of a judicially assigned sentence. The rationale for having a parole release mechanism as well as probationary release is to allow for release as a function of monitored progress within the institution, information that is unavailable (of course) at the time of sentencing.

Probation and parole are conditional releases in the sense that the released offender is under supervision and surveillance according to the terms of a contract between the releasing authority and the offender: the offender will be released only if he or she agrees to specified conditions and is subject to imprisonment should the contract be broken. The conditions of release include mandatory conditions set by law, such as those for probationers in Illinois: (1) must not commit a crime, (2) must report regularly, and (3) must not possess a firearm or other dangerous weapon (Illinois Criminal Law and Procedure, 1982). Additional conditions, called special conditions, are those tailored to the individual by the releasing authority in order to achieve desired goals. These involve various functions: (1) monitoring and control—the offender may be told not to move, travel, or marry without prior permission, as well as when and how to report to a probation or parole officer, or be subject to regular urinalysis tests for drug use; (2) prescribed and proscribed behaviors—the offender may be required to maintain a job, support dependents, make restitution to victims, or avoid alcohol, drugs, or criminal associates; and (3) rehabilitation—the offender may be required to pursue

educational or vocational training, drug or alcohol programs, or other types of counseling or therapy.

Failure to comply with any of the conditions of the probation or parole contract is called a violation. The commission of new offenses is called a criminal violation, whereas failure to comply with other conditions is called a technical violation (these are like status offenses in the sense that they are "crimes" only for those on probation or parole). Violations result in a sequence of administrative and court proceedings that could terminate the contract and put the offender in prison, or leave the offender on release with the same or altered conditions (for example, to report more often).

Offenders on probation or parole are supervised in the community by field staff. All federal and over 80% of state-level parole staff supervise a mixed caseload consisting of some combination of parolees, probationers, work release, pretrial release, and other possibilities (Flanagan et al., 1982: 123). County-level supervision is typically for probationers who have less serious offenses and criminal records.

Use of Probation and Parole

More than one-half of all criminal sentences are to probation (President's Commission, 1967). They are most frequently used with juveniles, first offenders, and those who commit minor crimes. By statute, probation may not be granted for certain serious offenses (for example, rape, armed violence, armed robbery, and murder) or to offenders with a prior felony conviction (Killinger et al., 1976). Conditional release from prison is the most typical form of release, although in some states it is rare. In 1979, 80% of offenders released from state and federal prisons went out on conditional release, 72% of these on parole, 4% on probation, and 22% on supervised mandatory release (released early by the prison for "good time").

The number of people under supervision is staggering: 1.25 million under state or local probation supervision, 200,000 under state or local parole supervision (Hindelang et al., 1981: 472), and another 60,000 under federal supervision (Flanagan et al., 1982: 451). The Cook County Probation Department (Chicago) has a caseload in excess of 30,000. In comparison, there are slightly over 300,000 prisoners in state and federal prisons (Flanagan et al., 1982: 474) and another 150,000 in local jails (1982: 461).

Supervising the conditional releases are the vastly outnumbered parole and probation officers. Depending on jurisdiction and nature

of caseload (for example, juvenile versus adult), probation officers have caseloads ranging from 40 to well over 100 probationers. In the 1960s, the typical adult caseload was over 100 (President's Commission, 1967). There has been some progress: From 1972 to 1980, federal caseloads were reduced from 147 per officer to 45 (Flanagan et al., 1982: 125). Cook County caseloads are currently about 120 per officer, down from 160 only six months before, after 40 new officers were hired. Assuming that probation officers do nothing other than contact probationers, that would give each Cook County officer less than one hour per month with each probationer. Parole caseloads are somewhat lower, typically 50 to 80 (President's Commission, 1967).

Use of Mental Health Services

Field supervision of probationers and parolees is based primarily on a "caseworker" modality (Nelson et al., 1978). The *Manual of Correctional Standards* of the American Correctional Association states that "the goal of treatment is to help the offender understand his/her own problems and enable him/her to deal adequately with them." This fits in with the desire of many officers to act as social workers or counselors (McCleary, 1978).

The most common methods of therapy in probation are vocational counseling (Phillips, 1975), group and individual psychotherapy (Marx et al., 1969; Olsson, 1975), and drug rehabilitation (Dole and Herman, 1970). According to Allen et al. (1979), the common thread running through these different treatment modalities seems to be an attempt to engender a positive self-concept in the probationer and to counteract the low self-esteem and diminished self-confidence that many probationers share. It is assumed that an improvement in the offender's self-image will reduce his or her tendencies toward criminal activities. This view is closely allied with the psychogenic model of criminology, which posits that the acquisition, severity, and maintenance of antisocial behavior is either a manifestation of unconscious urges and conflicts or the result of faulty learning experiences (Bartol, 1983).

We have already mentioned that caseloads (and other duties such as presentence investigations, court duties, field investigations, and report writing) make such intensive treatment difficult. Being responsible for the supervision of large numbers of offenders may force officers into a paradoxical situation in which severely troubled clients are actually avoided because of their nettlesome nature and problematic or bizarre behavior (see Lurigio, 1981).

The provision of effective services is further complicated by the fact that officers often have little training for their caseworker function (Goldfarb and Singer, 1973: 249-250). Despite recommendations that a master's degree in social work be considered the preferred qualification for probation officers (President's Commission, 1967), this standard is not and could not be met (Joint Commission on Correctional Manpower and Training, 1969). Probation officers with college degrees are generally considered desirable. However, this criterion does not stipulate that the degree be in a field germane to probation work. Consequently, the backgrounds of probation officers "range from majors in home economics to accounting without requiring any training in psychology and sociology" (Stratton, 1973: 14). Although many probation officers actually have degrees in these areas, relatively few have had specific education or experience in counseling theories or techniques. For this reason, Stratton (1973) refers to the group as the only unlicensed paid therapists in the country. As expressed by one California officer, "If our workloads were to be reduced . . . my lack of skill would be apparent. . . . Our new probation officers are assigned a full caseload with little or no training. What training we do have emphasizes department policy and procedures" (California Board of Corrections, 1965: 30-33).

An obvious solution is to have the field officers do triage and facilitate the use of services available from other agencies. There is a growing trend to view probation and parole officers as "resource brokers" (Smith and Berlin, 1979). As noted by a former director of probation, "The probation or parole officer may be doing his best work when he gets someone else to do his work for him" (Keve, 1967: 7). However, there is resistance to these efforts: offenders do not seek help voluntarily and hide their thoughts from agents, and social agencies feel uncomfortable working in a court setting or dealing with troublesome cases who may not benefit from services (Goldfarb and Singer, 1973; National Advisory Committee on Criminal Justice Standards and Goals, 1973). Further, mental health services in surrounding communities may be difficult to obtain, limited in availability, highly costly, or of dubious quality and effectiveness (Foelker et al., 1983).

A study of the use of resources in Cook County revealed that a paucity of services in the area sorely limits the range of officers' supervisory responses. As one agent remarked:

> I don't pay attention to a guy's (probationer) so-called psychological problems because at this point there just aren't many places where I could send him. So if he isn't causing trouble, I'd

prefer to ignore those aspects. Unless the judge orders him to see a shrink I can't force him to go to therapy anyway.

The use of outside mental health services by probation and parole staff varies tremendously across jurisdictions. Unfortunately, we have been unable to find any published studies of the frequency with which various services are utilized. In-house reports from various jurisdictions could provide a valuable source of information about service provision. The best we have been able to do is to obtain some suggestive instances. Cook County (Chicago) probation officers, supervising 120 clients each, refer only a little over 1 percent to mental health services (psychiatric assessment, alcohol and drug rehabilitation, or outpatient psychotherapy). In contrast, in the Milwaukee region of Wisconsin, 35%-40% of all active cases are seeking mental health treatment in one of the above forms (Milwaukee Regional Chief Marge Kelley, personal communication, November 1983). This activity and the average caseloads of 50 express a totally different relationship to offenders than in Chicago.

Probation and Parole Decisions

It should by now be evident that we view probation and parole personnel as central to the rehabilitative approach. They must decide who gets conditional release, what conditions apply, and how to implement those conditions. Even though judges assign probation and its conditions, they do so by relying on the probation staff who prepare presentence reports (Carter and Wilkins, 1967; Ebbesen and Konečni, 1981).

It is important to note that it is relatively rare for persons who are severely mentally disordered to be put on either probation or parole. Typically, persons exhibiting symptoms of mental illness are either incompetent to stand trial or are found not guilty by reason of insanity. Similarly, parole consideration is substantially delayed in cases where a convicted offender is transferred to a mental hospital from a prison. Apparently, parole boards take the attitude that an individual who is unable to function in a prison would certainly not be able to live within the community. The more common practice in such cases is to wait until the individual has returned to the correctional setting (Churgin, 1983). Although at least one state court has ruled against this policy, it is likely that this practice continues on an unofficial basis. Thus, the mental health problems of probationers and parolees are primarily nonpsychotic and are limited to character disorders,

substance abuse, and "problems of living" such as inadequate education, job skills, marital problems, and so on.

In making probation and parole decisions, staff must balance a variety of goals including individual treatment, community protection, fairness, deterrence, and their own preferences among clients. To some extent these goals are conflicting, such as when a person would be best treated in the community yet has committed a serious crime demanding prison time as retribution. In the last section of this chapter we will discuss these conflicts. Insofar as individual treatment is a central goal of decision makers, they will engage in a diagnostic task attempting to identify client problems in order to determine whether conditional release is appropriate and, if so, to assign appropriate treatments. In the next section we investigate how those determinations are made.

DECISIONS BY DIAGNOSIS

Schemas of Probationers

The process of diagnosis can be considered as the development and use of a set of diagnostic categories representing different types of cases. Cantor et al. (1980) have demonstrated that the most useful diagnostic categories (such as schizophrenia) are at a middle level of abstraction wherein members of the same category share many features with each other and few with other categories. However, category boundaries are "fuzzy," in that diagnosis is made by examining the overlap of features shared by client and diagnostic category rather than by identifying a simple set of features that must be present for the client to be diagnosed in a category.

Lurigio and Carroll (1983) identified ten categories or "schemas" reported by at least one-third of the sample of probation officers in Cook County (Chicago). One example is the burglar: a male in his early 30s, married, intelligent, an expert professional at his trade, with an extensive burglary record. His prognosis is very poor due to a set lifestyle. Each schema contains information about criminal behavior, physical and personality descriptions, social histories, attributions about the causes of the probationer's criminal involvement, a summary of an appropriate supervision/treatment strategy, and a prognosis for rehabilitation. Cases that fit any one of the schemas are evaluated for treatment more rapidly and supervision recommendations are made more confidently than for cases not fitting a schema. Thus, the availability of these categories guides the processing of case information and controls the formulation of super-

visory strategies and the selection of treatment modalities. To the extent that these schemas are valid, they offer an efficient way of handling parts of a caseload and a nucleus for the future classification of parolees. However, the schemas may be inaccurate or overapplied to cases that do not actually fit. If so, attempts to develop assessment devices should recognize that they are competing with subjectively developed diagnostic strategies that may be very compelling to users.

In the domain of parole case supervision, McCleary (1978) has written a rich description of how parole officers create parolee types. Three classes of types with important supervision implications are identified: "dangerous persons," "criminals," and "sincere clients." Dangerous persons are not necessarily violent but are unpredictable and cannot be controlled by the usual threats and promises. They are dangerous because they make trouble for their parole officer. Labelling a parolee "dangerous" to supervisors allows use of strong sanctions, such as revoking parole for technical violations. Criminals are people who have no excuses for crime; in contrast, noncriminal types have personal problems underlying crime such as addiction, vocational or educational handicaps, or psychopathological violence. In our own experience with the Pennsylvania Board of Probation and Parole, officers distinguish "criminal addicts" from "addict criminals." The former use drugs as an aspect of their criminal lifestyle, but the drugs do not cause crime, whereas the latter are addicts who turn to crime as a means to support their habit (Carroll, Galegher, et al., 1982). Finally, sincere clients are those who share the goal of rehabilitation. They accept the parole officer as a counselor or therapist and thus allow him or her to carry out the role they most desire: caseworker.

Causal Reasoning in Parole Decisions

Central to the diagnostic process is the imputation of a cause—a mechanism or "problem" that makes a meaningful story of a criminal's life and answers questions about why a crime has occurred. Research has shown causal reasoning to be central to the decision process. Carroll and Payne (1977) observed five expert parole decision makers examining actual parole case files who were instructed to "think out loud" during this process. Their remarks were tape-recorded, transcribed, and coded. Causal attributions were found to represent the single largest category of statements going beyond the factual information being read. In all, 22 percent of all coded statements were attributions. Thus, causal theories do appear prevalent in expert judgments.

As an illustration, one expert described the events around a crime of breaking into a food market and stealing 37 cartons of cigarettes in the following way:

> OK, you know, what he did was so, was done so impulsively, man. He was out. He had been drinking with this cat and, uh, they were drunk, and they needed cigarettes. And he went into this place and he got the cigarettes.

This offender had a prior record but no problems for ten years prior to this crime. The expert felt that "the difficulties that the guy had in the past—the records would show that it was due to alcoholism, you know." He stated that "the guy has the ability to be stable out there," referring to his ten years of staying straight and an expectation of a possible future. And why the reemergence of an alcoholism problem? "He indicated to the counselor that when he found himself out of work that he started hitting the bottle, which is, you know, that's his, you know, reason for doin' it. For going to the alcohol, as to why, why there would be some alcohol abuse."

This expert decision maker was concerned not only with the crime but also with the causes of the crime. He gradually built a picture of the offender as a person who had controlled an earlier alcohol problem but was set off by frustrations over losing his job. This causal attribution provided a consistent way of interpreting the crime, the criminal record, and participation in Alcoholics Anonymous in the institution, and even directed the preparation of treatment plans: "I think the area that we're gonna be concerned with, or the parole agent should be concerned with, is that of his alcohol problems."

Carroll (1978) asked Parole Board members from Pennsylvania to answer a questionnaire immediately after each of over 200 interviews for parole release. Among a series of questions was one asking for an opinion about the cause of the offender's crime. Responses to this question were coded on three dimensions: how much the crime was due to something internal to the offender versus external, in the offender's environment, how much the cause was stable and long-term versus unstable and short-term, and how much the cause was intended versus unintended. Results showed that cases with more stable causes were considered worse risks, less likely to be rehabilitated, and more likely to be denied parole.

In a later analysis of these causal statements, Carroll, Galagher, et al. (1982) found that dividing the causal statements into categories was more useful than coding them on dimensions. Causes were grouped into five categories: drugs, alcohol, person, money, and environment. This classification of causes was more strongly related to release

recommendations than were the dimensional codes previously described. Crimes attributed to person, drugs, and alcohol received less favorable recommendations. Further analyses revealed that causal category influences recommendations through its impact on assessments of the risk of future crime and of prognosis for supervision. In short, release recommendations are based on predictions of future behavior (crime and rehabilitation) that are made through causal analysis of past behavior.

In general, causal categorization seems to be based on intuitively reasonable attributes in the case material. Crimes are most likely to be attributed to the offender's personality when there is a negative psychiatric diagnosis. Alcohol attributions are most likely to occur when there is a history of alcohol abuse or when offenders have been convicted of an assaultive crime. Crimes are likely to be attributed to drugs when there is a history of drug use or when the offender has been convicted of robbery or burglary. Although alcohol and drug causes may seem similar as instances of substance abuse, the patterns of relationships for these causes are quite different. Alcohol problems are associated with assaultive crimes and interpersonal conflicts, whereas drug problems are associated with property crimes and with being black. Environment attributions are made most frequently for murders ("environment" frequently refers to other people), while money attributions tend to be associated with property crimes or drug crimes.

These results suggest that prediction is a result of the diagnostic process involving causal reasoning. Like clinical psychologists who diagnose clients by sorting them into "fuzzy categories" (Cantor et al., 1980), parole decision makers identify criminals as "types" who have a pattern of criminal and social behavior, causes for this behavior, and treatments for the causes. In essence, drug problems are referred to drug treatment, alcohol problems to alcohol treatment, personal problems to psychological counseling, money problems to job training, and environment problems to social support, coping strategies, and new environments.

It is interesting that the above diagnostic categories are response-driven; that is, they reflect available treatment opportunities. This could occur in two ways: first, over time treatment programs are developed to address categories of need and, second, over time diagnostic categories are shaped to fit treatment programs. There is some evidence for the use of the latter strategy, a kind of "working backward." Generally, working backward is a broadly used and powerful heuristic for problem solving (Newell and Simon, 1972). In diagnostic judgments, Batson et al. (1979) found that the availability of person-

oriented treatment resources (such as a mental hospital or clinic) rather than situation-oriented resources (such as career centers or community coalitions) induced diagnoses that clients' problems were due to personal factors that necessitated more person-oriented treatment. In short, treatment resources generated consistent diagnoses justifying use of those resources. In a study of juvenile justice agencies, Mulvey (1983) found that those with fewer resources saw punishment as more beneficial. In parole supervision decisions, McCleary (1978: 142-143) found that available programs for drug and alcohol treatment were used by field staff to remove unpleasant clients from their caseloads: "The general attitude among POs is that the special treatment programs are an alternative to reimprisonment . . . for the cases that cause them trouble."

Predictive Accuracy

Insofar as parole and probation experts seek to predict what parolees and probationers will do in the future in order to determine appropriate treatment, it is possible to evaluate the quality of these predictions. Research indicates that experts have a very difficult task in predicting recidivism (Carroll, Wiener, et al., 1982; Gottfredson et al., 1978; Hakeem, 1961) or dangerousness. Scientific attempts to predict recidivism using background information on criminal history, age, and so forth have been shown to be more valid than expert judgment, but even these actuarial predictors are only moderately accurate (Gottfredson et al., 1978). Studies of recidivism have generally found several factors to separate successful from unsuccessful cases, including prior record, crime type, age, drug and alcohol use, employment, and marital status (Carroll, Wiener, et al., 1982; Gottfredson and Gottfredson, 1980).

It is unfortunate that attempts to predict future behavior or to assess the outcomes of correctional programs have relied almost exclusively on recidivism as the criterion. It is possible that mental health services on probation and parole are benefiting many offenders and helping them lead better, more productive lives, yet the rates of recidivism might not demonstrate any improvement. This could occur because different people are being helped than are committing crimes, or because improved mental health reduces crimes only in a minority of criminals for whom that problem was the principle cause of criminal behavior. The research to address these issues simply has not been done (Gottfredson and Gottfredson, 1980: chap. 7).

ROLE CONFLICT

Parole and probation authorities are given immensely difficult tasks to perform. They must punish the wicked, protect society, rehabilitate those that can be salvaged, and maintain the integrity of criminal justice institutions. Even if a probation officer was adequately trained as a change agent, highly skilled in applying clinical techniques and licensed by the state to practice psychotherapy, the constraints of the officer-probationer relationship would still place severe limitations on how effectively officers could treat the psychological problems of the offenders. The legal requirements of an officer's job inhibit open communication and full confidentiality, and thereby hinder the development of a therapeutic alliance. In a very real sense, the probation officer is a double agent, representing both the probationer as a provider of services and assistance, and the court as an agent responsible for monitoring the offender's compliance with the conditions of release. The dilemma that arises out of this situation is captured in the following statements by Vogt (1971: 47) regarding group psychotherapy with probationers:

> In some respects, it is like a kind of free discussion between friends who want to take the time to hear each other out and get each other's opinion. . . . Your group leader, a probation officer, acts as guide and moderator in the discussions. . . . The group leader's attitude toward a probationer getting into unlawful activity or breaking the rules of probation would have to be the same whether he heard about it in the group or privately. On the other hand, he is not running the group to check up on anybody.

These conflicts are dealt with in different ways. Guidelines systems, such as those pioneered by the U.S. Parole Commission (Gottfredson et al., 1978), encourage a policy decision explicitly weighing or trading off between goals. McCleary's (1978) study of parole officers is consistent with a strategy of partitioning case loads according to goals; some will be rehabilitated, some carefully watched and controlled, others ignored.

A different approach is to recognize that individuals or departments of probation and parole may resolve these conflicts by preferring one style, approach, or set of priorities. Several very similar typologies of probation officers have been constructed (Glaser, 1964; Jordan and Sasfy, 1974; Keve, 1962; Klockars, 1972; Ohlin, 1956; Tomaino, 1975). We summarize their implications for mental health services as follows:

The Punitive or Law Enforcement Officer. This type is concerned with the preservation of community safety through the control of

probationers and a strict adherence to the stipulations of a sentence. Probation is conceptualized as a privilege, not a right. The probationer is usually perceived as a criminal who should be continually monitored and closely supervised—that is, as a danger to society. The law enforcer frequently reminds his or her cases that probation will be revoked, without exception, if conditions are violated. This style of supervision emphasizes firmness, formality, legal authority, and rule abidance. The punitive officer finds satisfaction in upholding the law for its own sake, irrespective of whether the best interests of the probationer have been addressed.

If the department and the court system which it serves view probation solely as a punishing or monitoring function, then it is not likely that mental health treatment will become an explicit condition of the sentence, or that officers will consider the diagnosis and amelioration of psychological distress as a priority. In general, the mental health components of a case are disregarded in the setting of conditions. Basically, this occurs because judges, lawyers, and probation officers are simply not trained or knowledgeable enough to recognize or be sensitive to behavior pathology. For example, Cook County (Chicago) probation officers generally take their education in criminal justice or law. Their primary motivation is to expedite the case through the system, and to be attentive to its legalistic and judicatory aspects. Therefore, unless a psychiatric disturbance has (a) played a major role in the conduct of a crime, (b) entered explicitly in the rendering of a disposition, or (c) manifested itself blatantly or unmistakably during the trial, hearing, or custody period, the mental health needs of a probationer may be considered nonessential or nonexistent. Hence, the less obviously or seriously distressed client is frequently neglected (President's Commission, 1967).

The Welfare-Therapeutic Officer or Social Worker. The second type of officer is almost the opposite of the rule enforcer. The social worker, who strives to rehabilitate and reintegrate offenders into the community, regards the conditions of probation as hindering or blocking an offender's progress. The probation period is a time for a diagnosis of problems, an assessment of the probationer's life situation and resources, and a remediation of underlying pathologies and intrapsychic conflicts. The offender is seen as disturbed or troubled, a victim of circumstances, socially disadvantaged or psychologically deprived. The social worker cultivates a personal relationship with offenders in order to formulate a suitable treatment plan that will assist them in avoiding future criminal activity and in making their lives more productive. The officer's overriding motivation is grounded in the assumption that individuals are fundamentally good and will

choose appropriate, legal behavior once they are helped to understand themselves.

In a jurisdiction such as Wisconsin, where treatment is paramount, officers conduct extensive social history and intake evaluations that detail such topics as the probationer's interpersonal and familial relationships, his or her typical adjustments to stressful situations, the client's use of drugs and alcohol, and the extent to which personality traits and psychological forces led to the commission of crime. The results of these assessments are then explicitly incorporated in the development of a supervision plan. In contrast, in other jurisdictions where mental health concerns are deemed unimportant, presentence investigations and intake forms may provide little space for reporting on the client's mental health status, or may merely request a summary of the offender's prior psychiatric institutionalizations. If mental health information is not solicited at intake, it becomes less probable that it will be collected during subsequent supervisory contacts (Lurigio, 1981). Consistent with this approach to probation, a large percentage of Wisconsin's probation officers are well versed in assessment and psychotherapeutic techniques.

The Passive Time-Saver or Civil Servant. The probation officer who adopts the role of civil servant exhibits little concern for the welfare of the community or the probationer; the job is considered a sinecure, demanding a minimum of effort and personal commitment. This type of officer directs energy toward ascending the probation bureaucracy with the ultimate goal of retirement, pension, or entry into another field such as law or police work. Consistent work attendance, proper and prompt completion of paperwork, and the kind of self-enhancement that results in salary increases are characteristic strategies. Their conduct on the job contributes to the smooth flow of office functioning; however, all responsibilities are met minimally and mechanically. Although contact with offenders is regular, it is often conducted via mail-in or telephone reporting. The civil servant perceives his or her duties as instructing and advising probationers concerning failure to conform, apprising the court of the offender's criminal behavior or lack thereof, and operating as an observer of progress rather than an initiator of behavior change.

The Protective/Synthetic Officer. The final style reflects a desire to satisfy the basic orientations of both the rule enforcer and social worker. In doing so, the officer is coming to grips with the fundamental dilemma of reconciling the conflicting tensions arising from the legal and social service dimensions of probation work. The protective officer seeks to integrate concerns for monitoring and rehabilitation by conducting a separate evaluation of each case to determine which

particular strategy will best protect the safety of the community while concurrently meeting the needs of the offender. This type of officer is most likely to develop a working relationship with community resource agencies and local police departments.

IMPLICATIONS FOR MENTAL HEALTH SERVICES

Although it is desirable and morally imperative to rehabilitate offenders, this noble attempt faces an uphill battle. Not only are there severe resources constraints and a lack of demonstrably successful techniques, but well-intentioned programs may have unbidden consequences that undermine their own goals. These are the "Catch-22's" of rehabilitation.

Coercion

Most offenders are forced into treatment programs as part of their sentence or conditional release, or are coerced into treatment with implied promises of leniency. This lack of voluntary treatment creates a barrier to rehabilitation: People are unlikely to change their attitudes unless they perceive a free choice (Cross, 1971). Forced treatment creates a negative reaction to being controlled. Progress in the program is attributed by the offender and others to the program, rather than the person, thus undermining personal responsibility and pride. The stronger the surveillance and control in the program, the less the person can internalize change, and the more likely that change will be fleeting. Voluntary involvement in rehabilitation may reach fewer people but should be more effective and will avoid wasting resources in a "treatment game."

Surveillance

Efforts at rehabilitation involve increased contact between change agents and offenders and more requirements of conduct placed on offenders. The result is that there are more ways to fail or get caught. Supervisors are more likely to learn about problems, drug use, fights, crimes, and to experience more instances of broken appointments and other lapses. This could be why reduced caseloads do not improve measures of postrelease conduct: Any improvements in conduct are offset by increased access to negative information (Greenberg, 1975).

Expectations

Rehabilitative programs create rising expectations that, when unmet by an unfavorable environment, may leave people even worse off. The surprising results of the Cambridge-Somerville Project (McCord, 1978) show that the provision of intensive caseworker services to delinquents leads to no improvement in indices of criminal behavior, mental or physical health. If anything, those given this "help" were worse off—higher rates of alcoholism, serious mental illness, early death, stress-related disease, lower-prestige jobs, unsatisfying work, and commission of two or more crimes.

Does Anything Work?

The National Academy of Sciences Panel on Research on Rehabilitative Techniques was unwilling to conclude that "nothing works." Rather, it concluded that existing studies are insufficient for providing knowledge of what can work (Sechrest et al., 1979). Major problems exist in the use of puny interventions and programs that did not deliver the promised services. "Why would one expect that one hour per week of group therapy with a poorly trained leader and unwilling participants would produce a major behavior change in incarcerated felons?" (Martin et al., 1981: 9). There are some promising new directions, but we are far from knowing how to rehabilitate.

We are faced with an ailing criminal justice system and a fading dream of rehabilitation. Prisons are overcrowded, treatment programs lack resources, and no one wants to spend money on criminals. There is a strong movement to scrap an unwieldy system, to simplify everything by providing justice—determinate sentencing, curtailed treatment services, and a harsher attitude toward criminals. The alternative to simplification is to amplify the attempt to rehabilitate, if not with greatly increased resources, then by focusing on a few targeted problems with concentrated attention. If we are to salvage rehabilitation, we must base it above all on knowledge of how treatment programs are built and run, and how they fit into the criminal justice system and into society.

In the area of probation and parole, there is tremendous need for research on very basic questions. First, we need to survey probation and parole authorities to determine what mental health needs they perceive among their clients and what services they provide in-house or through referrals to outside agencies. Essential information on the relationships of client population, case load, supervision costs, officer training, role orientation, community resources, and provision of services could be obtained through personal interviews, telephone

interviews, or mailed questionnaires. Second, we need to know what works not only to reduce recidivism, but just as importantly, what serves to improve the mental health status of probationers and parolees. Carefully designed projects with evaluation of both service delivery (were the services provided as stated?) and outcome effectiveness (did it work?) are needed. Finally, or perhaps primarily, we need to encourage policymakers to face decisions regarding the expenditure of scarce resources. Should we try to rehabilitate? If so, inside or outside prison? What target populations, problems, and impacts are of top priority? Research can help structure these decisions and provide essential information about the availability and consequences of policy choices. We hope that this chapter has identified and drawn attention to some of the issues in the matrix of mental health concerns in probation and parole.

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