A COMPARISON OF INVOLUNTARILY DETAINED MENTALLY DISORDERED INDIVIDUALS, CIVIL V.S. CRIMINAL HOLDS

by

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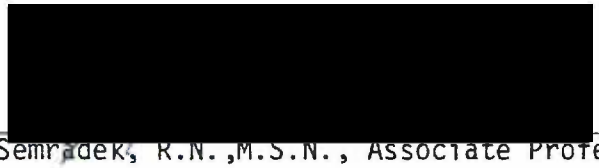

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CHAPTER I

INTRODUCTION

Introduction to the Problem

Recent studies of jail populations around the nation are identifying a high incidence of psychiatric illness in newly arrested prisoners (Petrich, 1978; Swank, 1976) and higher arrest rates for former state mental hospital patients than for the general population (Rappeport & Lassen, 1965; Steadman, Cocozza & Melick, 1978; Zitrin, Hardesty, Burdock & Drossman, 1976). Locally, this investigator's experience as a county jail nurse has included frequent encounters with psychotic inmates. Often these individuals have had misdemeanor charges such as criminal mischief or trespassing. Some have returned to the jail numerous times over the past five years.

Several authors (Abramson, 1972; Bonovitz & Guy, 1979, Petrick, 1978; Stone, 1975 & 1977; Bloom & Shore, Note 1; Shore, Breakey & Arvidson, Note 2) suggest that this apparent increase in arrests among former mental hospital patients may be the effect of new mental health legislation around the nation which has reduced the number of individuals subject to involuntary civil commitment. A mentally ill person may become psychotic and unruly or disorganized and behave in a bizarre manner; however, if he is not dangerous, civil commitment may not be possible. Abramson (1972) notes that when communities lack alternative resources and find it difficult to obtain involuntary commitment to provide treatment for these individuals, they resort to having such persons arrested and jailed.

Other factors undoubtedly contribute to the apparent increase in arrests of former mental hospital patients. Some authors (Becker & Schul-

berg, 1976; Deni, 1979; Schuckit, Herrman & Schuckit, 1977; Swank, 1976) note that the current community treatment programs have put more persons who are at risk for arrest into the community. Acute symptoms of the mentally ill patient can now be fairly well controlled with drugs, and hospitalized patients are quickly returned to the community for rehabilitation. As a result of the community mental health movement which started in the late 1950's and early 1960's, mentally ill patients have been returned to the community, and the resident population of large mental hospitals around the nation has been reduced by two-thirds. Many sections of the Oregon State Hospital have closed down as the resident population has decreased from 3,474 patients in 1958 to 1,334 patients in 1968 to about 500 patients in 1978.

Test and Stein (1976) point out that many of these individuals who have been returned to the community have limited problem-solving ability and have persisting difficulties with work habits, socialization, and leisure time activities. At the same time many communities lack adequate resources to treat these impaired individuals. While living in the community, some of these markedly impaired individuals exhibit behavior which is socially deviant. Their appearance and sometimes bizarre behavior may disturb the neighborhoods; they are usually shunned and often feared. The ex-mental-hospital patient may become despondent, disorganized, or violent under stress, and yet may be unwilling or unable to seek treatment. Lacking other alternatives, the community may take steps to have the individual involuntarily removed.

There are two systems in our society by which this removal can be accomplished - the civil system and the criminal justice system. If detained civilly, the patient may go to a hospital or other mental health service; however, if detained on a criminal hold, the patient most likely will go to jail. Both alternatives are successful in removing the individual from the community for varying lengths of time, but may result in considerable different outcomes to both the patient and the community.

Theoretical Framework

Since early times, cultures have set certain expected standards of behavior. An individual who deviates from these standards or norms often has difficulties living in the community. The community's reactions to deviant behavior is dependent on its tolerance and its judgement of the seriousness of the violation in terms of the magnitude of the overt threat to others (Dohrenwend & Chin-Song, 1967). In Nunnally's (1961) studies of public attitudes toward mental health, he found a strong negative attitude associated with mental illness. People react negatively to the unpredictable actions of a psychotic person. The peculiar behavior of the severely mentally impaired person is often frightening to the families and communities, and hospitalization or incarceration are two alternatives often considered in order to have the person removed from the community.

The choice to involuntarily detain the acutely disorganized mentally disordered person involves not only the specific behavior of the person, but how society perceives the behavior and labels the person. According to the labeling theory of deviance, whether a person is viewed as being

mentally ill or criminal depends upon who the person is, in what ways he is being deviant, and the social context of his behavior. The frame of reference of the evaluator and the community's reactions also come into play in determining how the deviant behavior is viewed. Some will see the deviant behavior as a crime, whereas others may see the behavior as perversion, drunkenness, or mental illness. Norm violations such as sexual perversion, drunkenness, violent behavior, and infringement on the rights of others, are generally labeled criminal, while unusual unexplainable behaviors such as hallucinations, delusions, and mania are generally viewed as being acquired without the individual's wanting to be deviant and are generally labeled as mental illness (Lorber, 1967).

From this perspective, deviance is primarily produced by interaction between a person who commits an act and those who respond to it. Usually the most crucial step in the development of a stable pattern of deviant behavior is the experience of being caught and publicly labeled as deviant. Once a person has been labeled as deviant, the pattern is difficult to break. A self-fulfilling process may be initiated in which others continue to perceive and respond to the person as being deviant (Grove, 1970).

Purpose of the Study

The purpose of this study is to determine what factors lead to an individual's being labeled criminal rather than mentally ill and which subsequently lead to his arrest rather than his hospitalization. Personal characteristics and circumstances surrounding his apprehension will be examined.

Review of the Literature

Specific research to explore why acutely disturbed mentally disordered persons are found within jails around the nation is only now beginning to be conducted. Some of the studies identify specific personal characteristics of the mentally disordered persons as being significant in influencing the decision to have a person jailed, while others address variables within the criminal and mental health system.

Personal Characteristics

A review of the literature shows studies which indicate a higher arrest rate for former mental hospital patients than for the general population. A study done by Steadman, Cocozza, and Melick (1978) concluded that the annual arrest rates of former mental patients have risen steadily over the past 30 years. This conclusion is supported by studies done by Rappeport and Lassen (1969) and Zitrin, Hardesty, Burdock and Dorssman (1976).

Recently in Oregon, Bloom and Shore (Note 1) studied 185 patients who entered the commitment process through the Psychiatric Crisis Service at the University of Oregon Health Sciences Center in January through July, 1976. This group was compared to a group of voluntary patients (95) who were admitted to the same in-patient service during the same time period. Arrest records were reviewed for both groups. Of the involuntary group, 59% were found to have arrest records, while 45% of the control group had a history of prior arrest. Within the involuntary group, there was a significantly greater percentage of psychotic individuals with arrest histories. For the involuntary group, the model diagnostic category was schizophrenia (44%), while only 19% of the voluntary

group was diagnosed as schizophrenic.

Reporting on experiences in providing psychiatric services to the inmates of Denver County Jail in Denver, Colorado, Swank and Winer (1976) indicated that there has been a marked increase in the numbers of seriously ill mentally disturbed individuals entering the jail in recent years. This finding is supported by Gold (1973) and Petrich (1978). In Swank and Winer's study of 545 inmates evaluated, 22% were diagnosed as psychotic and 23% had a history of long-term or multiple hospitalizations. In 1971, in Connecticut, of the 450 mentally disturbed offenders studied, Gold (1973) found 29.6% were diagnosed as schizophrenic and 37.5% were diagnosed as having a paranoid psychosis. Petrich's studies done in 1973-1974 also support these findings. Of the 539 patients studied in the Seattle jails, 49% were diagnosed as psychotic (manic/depressive or schizophrenic) and 10% were diagnosed as depressed with 7% being suicide attempts.

None of these studies specifically identified the type of crime committed with the diagnosis of the patient. The arrests were often for minor crimes such as breach of the peace or vagrancy. Of the patients studied by Gold, about 76% had been arrested for minor crimes e.g. 212 of 450 were arrested for breach of the peace. In Petrich's (1976c) studies, 36% of the patients diagnosed as schizophrenic were arrested on misdemeanor charges. Steadman, Cocozza and Melick (1978) categorized types of crimes committed by ex-mental hospital patients into six groups: violent crimes (murder, manslaughter, assault); potentially violent crimes (robbery, arson); sex crimes (rape, sodomy, sexual abuse); drug

crimes; crime against property (burglary, larceny, forgery); and minor crimes (vagrancy, public intoxication). Only 9% of the 1,920 ex-patients in the 1968 group were arrested for violent crimes and 1.7% were arrested for violent crimes in 1975.

Thus data indicate that former mental-hospital patients are often found in jails, and as a group, they have a higher arrest rate than the general population. It appears that the majority of arrests are for minor crimes.

System Variables

Police historically play a prominent role in the handling of the mentally ill in most communities around the country (Glasscote, 1966). Their services are available 24 hours a day, seven days a week. Liberman (1969) found that families decide to call the police because other, more appropriate resources are not as accessible and will not offer services to uncooperative patients. He found that patients picked up by the police are significantly more reluctant to seek professional help and less willing to go voluntarily to the state mental hospital.

In many communities, jails are used to detain the unwilling patient. To demonstrate the extent of this problem, Glasscote cites a survey done in Indiana in which it was found that 1,258 patients spent an average of seven days in jail during 1959 and 1963, most awaiting disposition to psychiatric treatment facilities. Glasscote also noted similar situations were found in Virginia, Texas, and Florida.

In light of the above data, it is also important to consider that recent changes in mental health legislation in most cities have made it

more difficult than previously to have a mentally ill person committed to a hospital. Critics of these laws (Abramson, 1972; Stone, 1975 & 1977) suggest that the use of the police and jails to detain the mentally ill has increased.

Prior to the mid 1960's, commitment laws for involuntary hospitalization of deviant persons were fairly general. Persons could be committed to mental hospitals and held for long periods of time if they were found to be so mentally ill that they were in need of "care, treatment, or custody". The vague standard did not adequately define the boundaries of these terms and many individuals were involuntarily committed for years. The new statutes of the '60's and '70's are more specific. Some showing of dangerousness or inability to meet basic human needs is required for commitment. In many states, a pre-commitment screening procedure has been set up to divert people out of the system, and to try to find some other way of helping them without forcing them into an institution. The rights of the mentally ill patient are clearly delineated, including the right to legal counsel, cross-examination of witnesses, and the presence of examiners at the commitment hearing. The length of commitment has also been limited.

In contrast, to be arrested and taken to jail, a person only needs to display deviant behavior and be charged with a crime. The nature of the crime or charge can be anything from criminal mischief (a misdemeanor) to attempted murder. There is a law which will cover nearly any type of deviant behavior. Thus, if a mentally disordered person doesn't appear to fit the criteria for civil commitment, it becomes fairly easy for the

deviant to be relabeled as criminal and removed from the community by having the individual arrested.

Urmer (1975), in discussing the impact of implementing the new mental health statutes in California, states that experience is showing that the mental health system is frequently used to house socially incompetent individuals, and that alternative systems such as criminal detention are developed when this system becomes unavailable. Before the new law in California, a significant proportion of individuals had been civilly committed because of their bizarre behavior and because they were a nuisance to society. Urmer contends that these individuals, who are not dangerous, but are a nuisance, are now ineligible for commitment. Instead, their behavior comes to the attention of law enforcement agencies, and these individuals are now put into jails.

A recent research project has been conducted to explore the contention that the restrictive mental health laws are the cause of the increase in numbers of mentally disordered persons in jails. Bonovitz and Guy (1979) were interested in seeing if the 1976 change in the commitment laws in Pennsylvania would impact the use of psychiatric services in the prison system. To test this hypothesis, an exploratory study was done in a forensic unit of a Philadelphia prison. The number of requests for psychiatric consultation and the admission rates for the 12 month period before and after the implementation of the act were compared. It was found that the number of requests from prison staff for psychiatric consultation involving mentally ill prisoners rose substantially during the 6-7 months after implementation of the act. Bonovitz and Guy also found

that more schizophrenic patients were entering the prison. Subjects admitted to the psychiatric unit after implementation of the act were less likely to have committed a violent crime, and there was a marked increase in such crimes as disorderly conduct, trespassing, and making terrorist threats.

In Oregon, the mental health legislation of 1973 has substantially reduced the number of individuals subject to involuntary civil commitment in Oregon's mental institutions. In the late 1960's and early 1970's, more than 2,100 people a year were involuntarily committed to the state's psychiatric facilities. By 1978, that number had dropped to 1,136 - and about 250 of those commitments were to alternative facilities rather than to the three major psychiatric hospitals (Smith, 1979b).

Table 1 illustrates the involuntary movement in Oregon State Hospital from 1962 through 1978. Since readily accessible data are not available for the years 1969 through 1973, it is difficult to draw accurate conclusions about the effect of the 1973 legislation. The data show that the number of patients civilly committed had decreased to roughly one-half of the pre 1968 numbers; however, more patients were admitted to Oregon State Hospital by way of police holds, emergency commitments, and court ordered examinations. Some individuals on police holds or emergency commitments were later civilly committed. There are no data identifying the numbers of individuals who were taken to jail prior to the commitment.

Table 1

Number of

Involuntary Patients Admitted to

Oregon State Hospital from 1962 through 1978

by Type of Commitment

Type of Commitment	Fiscal Year*				Calendar Year**				
	'62-63	'63-64	'66-67	'67-68	1974	1975	1976	1977	1978
Civil Court	594	506	573	548	326	270	294	226	245
Emergency	12	31	15	27	63	99	113	134	170
Police Hold					165	256	418	397	374
Court Ordered Examination	85	50	173	235	162	167	158	159	168

* From Oregon State Board of Control Reports, Note 2.
**From Computer Services Print Outs - Department of Human Resources, Mental Health Division, Salem, Oregon.

Specific data from the study county prior to 1973 are difficult to obtain. Data from 1973 to present indicate some changes in the handling of the involuntary patients; however, it would be difficult to conclude that these changes were due to the impact of the 1973 Mental Health legislation. Table 2 shows the breakdown in involuntary patients from the study county for the years 1973 through 1979.

Table 2

Number of
Involuntary Patients Admitted to
Oregon State Hospital from the Study County
(Calendar Years 1973 - 1979)
by Type of Commitment

Type of Commitment	1973*	1974	1975	1976	1977	1978	1979
Civil	31	64	65	57	24	29	31
Emergency	0	5	29	50	61	66	106
Police Holds	0	2	12	29	20	14	35
Court Ordered Examination	1	5	8	14	14	25	12
Criminal	3	31	18	12	14	17	18

* Year reflects July 1-December 1, 1973
From Computer Services Print Outs - Department of Human Resources, Mental Health Division, Salem, Oregon.

Justification for the Study

With the increasing number of acutely disturbed mentally disordered persons being found in the jails around the country, one wonders why the individual has been arrested rather than detained on a civil hold and hospitalized. An obvious factor which may account for the increased arrests would be that the individuals break the law; however, the literature is suggesting other possibilities. At this time, the possible variables are not clearly identified to account for the fact that some acutely disturbed persons are taken to the hospital while others are arrested. Current studies have not specifically addressed the personal characteristics of the individual or specific aspects of the criminal and mental health systems which may influence the decision to involuntarily remove the

mentally ill person from the community by use of the criminal rather than the civil route. Perhaps there are certain characteristics of the mentally disorganized person which influence the decision to consider the deviant behavior of the individual criminal rather than an illness, or possibly there are practices within the criminal or mental health system which influence the decision to have this individual jailed rather than hospitalized.

While it is beyond the scope of this study to examine all the variables in depth, this exploratory and descriptive approach will yield some preliminary data impacting on this problem. It will examine specific individual characteristics (personal variables), specific local system variables in one Oregon county which may influence the decision to choose one route of involuntary detention over the other by comparing subjects who are civilly detained to subjects who are criminally detained. In this way, some local system variables may be identified which impede the hospitalization of the acutely disorganized mentally disordered person, and specific gaps in the community's knowledge of the local mental health crisis system may be identified. The identification of specific variables which influence the choice of the system by which a person is involuntarily detained can help lay the groundwork for future research in this area.

Definition of Concepts

For the purpose of this study, mentally disordered individuals are defined as those individuals who display patterns of behavior which are judged to be maladaptive, inappropriate, or undesirable on the basis of

various pyschological and social norms. The psychological and social components both must be present.

Psychological Disorganization

Psychological disorganization is defined as behavior which is unpredictable as a result of deficient reality testing, such as:

1) Mental disorganization - e.g. speech disorganization; retardation or lack of emotion; inappropriate affect, appearance or behavior;
2) Delusions or hallucinations;
3) Suspicions of persecution;
4) Grandiosity.

Social Deviance

Social deviance is defined as deviant behavior which violates society's norms, such as:

1) Attempts at suicide or self-destructive behavior, such as head banging, body mutilation, or emaciation due to a failure to eat;
2) Homocidal or other violent behavior and serious physical harm to other persons;
3) Disrobing or exposing self;
4) Sexually disturbing or disrupting others;
5) Stealing or hoarding;
6) Antisocial disposing of excreta;
7) Destroying property;
8) Constituting a fire hazard;
9) Verbally abusing others.

Civil Detention

Civil detention is the involuntary confinement of an individual under the criteria of the civil commitment laws. In Oregon, this can be accomplished by a civil commitment procedure and three emergency commitment procedures. Under the civil commitment process, two persons must file a petition that a person is mentally ill and in need of treatment. An investigation is conducted and when there is probable cause, a court hearing is held. If the court finds that the mentally ill person is dangerous or unable to meet his basic needs, the person is committed to the State Mental Health Division. The commitment can last up to 180 days.

The three emergency procedures are:

1) Peace Officer Hold: If a peace officer has reasonable cause to believe that a mentally disordered person is dangerous or is in need of immediate care, custody, or treatment, he may take the person in custody and transport him to a hospital or holding facility where the person can be legally held up to 5 days.
2) Physician Hold: Two physicians may have a person detained for 5 days if they believe a person is dangerous and is in need of emergency care or treatment for mental illness.
3) Emergency Hold: If an emergency exists, a person can be detained at a state mental hospital for up to 15 days if a judge in a county is not available to hold a commitment hearing immediately and the mentally ill person is in need of immediate hospitalization.

Criminal Detention

Criminal detention is the involuntary confinement of an individual under the criminal laws. The person must be charged with a crime, either misdemeanor or felony. A misdemeanor is the breaking of a municipal ordinance and the penalty is usually a fine or short imprisonment in a local jail. A felony is a major crime and carries a greater punishment. The penalty is generally imprisonment in a penitentiary.

Research Questions

The following research questions were formulated to identify and describe the variables which may have an influence on whether an acutely disordered mentally ill person is arrested or detained on a civil hold:

1) Is there a relationship between the personal characteristics of the acutely disordered mentally ill person and the type of detention?
    a) Is there a relationship between the personal attributes of age, sex and race and the type of detention?
    b) Is there a relationship between independent living and social skills and the type of detention?
    c) Is there a relationship between deviant behavior exhibited, psychological disorganization, degree of dangerousness, anti-social behavior, or drug involvement and type of detention?
    d) Are prior hospitalizations and prior arrests related to type of detention?
2) Is there a relationship between local system variables and the type of detention?

a) Is there a relationship between the place where the incident occurred and the type of detention?

b) Is there a relationship between who files the complaint which starts the process to involuntarily detain the mentally disordered person, and the type of detention?

c) Is there a relationship between time of the incident and type of detention?

d) How often will attempts to detain individuals on a civil basis be unsuccessful, and ultimately result in the filing of a criminal charge?

e) How many initial contacts for help for the acutely disorganized mentally ill person will be calls to mental health agencies or other community resources rather than to law enforcement agencies?

CHAPTER II

METHODOLOGY

Design

An exploratory ex-post facto field study was conducted over a six-week period in an Oregon county to compare two groups of mentally ill individuals on a number of independent variables to determine which factors might influence an individual's involuntary detention in either the criminal system or the civil system. A variety of approaches was used to get as complete a picture as possible of the subjects' behavior at the time of the incident which consequently led to the detention. Likewise, data about the circumstances surrounding the detention were gathered. These data were gathered from agency records, informal interviews with the agency staff having the most contact with the subjects, and by direct observations.

Subjects and Setting

The subjects for this investigation were all acutely disturbed mentally disordered persons from an Oregon county, who were held on an involuntary basis, either at the county jail or at the State hospital, during a six-week period from August 4, 1980 through September 14, 1980.

Diagnoses of alcoholism or organic brain syndrome were criteria for exclusion from the study. Both diagnoses are likely to influence the decision to jail or hospitalize an acutely disturbed person in specific ways. Alcoholics are not often labeled mentally disordered and thus may be sent to jail, whereas mentally disordered persons with organic brain syn-

drome are likely to be civilly committed. Since these individuals were not representative of the target population, those whose primary diagnosis was alcoholism or organic brain syndrome were excluded.

Twenty-six mentally ill individuals met the study criteria and were grouped according to type of detention: those who were hospitalized and those who were arrested.

The first group of subjects (N=16) included all persons in the county who were involuntarily hospitalized on a civil basis during the study period. By law, these individuals were judged to be dangerous to themselves or others or unable to provide for their basic personal needs and were not receiving the care necessary for their health and safety. These included persons on physician hold (N=1), emergency commitments (N=14), and civil commitments (N=1). No peace officer holds occurred during the study period.

The second group of subjects (N=10) included all persons detained in the county jail on criminal charges who had been identified by jail personnel within 24 hours of arrest of being so mentally disorganized that special housing was required. In general, such inmates were identified as being so confused or depressed at the time of booking that, if left alone or with other prisoners, a likely possibility of their being harmed or harming themselves existed.

Variables and Measurement

The instrument for this study was designed to systemize the gathering of information relevant to factors which might influence the decision to remove the acutely disturbed mentally ill person from the community

through either arrest or by having a civil hold placed on the individual. To facilitate an understanding of the various factors which might be significant in the decision making, the independent variables were divided into two general categories - personal variables and system variables.

Personal variables were defined as 1) personal attributes: age, sex, race, and physical functioning; 2) living skills: level of education, employment status, occupation, marital status, living situation, support systems, personal care skills, and interpersonal skills; and 3) deviant behaviors: psychological disorganization, dangerous behaviors, socially unacceptable behaviors, and prior arrest and hospitalization for mental disturbance.

The data sheet (Appendix D) was designed by the investigator to gather information related to the personal attributes, living skills, prior arrests and hospitalizations. In order to identify the nature of deviant behavior exhibited by each subject, an observation tool (Appendix E) was developed by the investigator which included five scales of deviance: psychological disorganization, dangerousness, ability to provide for basic life sustaining needs, antisocial behaviors, and drug involvement.

Three sections of the developed observational tool were taken from previously developed scales. The Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962; Overall & Klett, 1972) was used to rate the subjects' manifest psychopathology, or psychological disorganization by use of 18 system rating constructs (Appendix E, Section I). The scale which identified 14 antisocial behaviors (Appendix E, Section IV) and the scale with three indicators of drug involvement (Appendix E, Section V) were adapted from New York State's Department of Mental Hygiene Level of Care Study.

The scales for dangerousness and ability to provide for basic life sustaining needs were developed by the investigator especially for the research project. Dangerousness was defined to be consistent with the recent trend of the courts to define dangerousness as the likelihood of a substantial risk of physical harm to the person himself or to other persons (Frederick, Note 4). The behavioral events which were counted as evidence of dangerousness were identified as threats or attempts at suicide or self mutilization, and threats, attempts or infliction of physical harm to other persons (Appendix E, Section II). Ability to provide for basic life sustaining needs was identified as the degree of assistance the subject required to meet basic needs for hygiene, dressing, eating, and medical care (Appendix E, Section III).

Except for drug involvement, these variables represent the legal criteria by which a person can be involuntarily detained. Before a person can be civilly detained, there must be evidence of mental disorder as exhibited by psychological disorganization. The law has identified the necessity to prove that an individual is dangerous or unable to provide for basic life sustaining needs before he or she can be civilly committed. To be criminally held, a person must demonstrate antisocial behavior. Involvement with illegal drugs may be a significant factor in determining the arrest of an individual rather than the detention of the individual on a civil hold.

System variables were identified as factors within the local mental health and law enforcement systems which might influence the decision regarding detention. It was beyond the scope of this research to study these two complex systems and control for all the extraneous variables;

however, information relevant to certain factors was gathered to determine if local trends could be identified. To answer the research questions relevant to system variables, the following information was obtained:

1) Location of the incident leading to the detainment,
2) Source of the complaint,
3) Law enforcement agency involved,
4) Initial contact to gain service for this incident,
5) Time of day and day of week,
6) History of prior attempts to gain mental health services within the local system, and
7) History of prior attempts to have the individual civilly committed.

The data sheet (Appendix D) was also used to record the above information related to the system variables.

Data Collection

During the six weeks of the study, the investigator reviewed state hospital medical records on each subject who was hospitalized. Similarly, inmate files and medical records at the jail were reviewed on each subject who was arrested. In addition, records kept by the emergency services team of the county mental health clinic were examined. The combination of information from these sources yielded data related to the circumstances of the detention, demographic data, and specific psychological and sociological assessments and evaluations made by the social workers, nurses, psychologists, and psychiatrists from these three agencies.

In keeping with ORS 179.495 (Appendix B) and ORS 179.505 (Appendix C) written permission was obtained from the local Mental Health Division,

the local Corrections Division and Oregon State Hospital to access client records during the study period. (See Appendix A). To insure confidentiality, the subject's true name was not entered on the tool. A fictitious name was assigned to each subject for purposes of discussion.

The necessity of obtaining written consent from clients for this study was considered, and determined to be unnecessary for the following reasons:

1) During the course of this study, no client was subjected to any treatment, procedure, or environmental circumstance different from those ordinarily imposed by civil authorities and health care professionals during a civil or criminal commitment procedure;
2) The health care professional performing the data collection was a licensed and experienced individual, cognizant of the legal and ethical boundaries and restrictions in obtaining, recording, and assessing health data;
3) All data collected was either public in nature, or was within the scope of information normally accessed by health care professionals in order to accurately determine health problems and provide for adequate medical and nursing care;
4) Reporting of study results focused only on aggregate data scores. Individuals were not identified in any way, and only group scores were used for purposes of comparison.

Informal interviews were conducted with correction officers, nurses and the jail psychologist to gather additional information related to specific behaviors and the level of functioning of individuals who had

been arrested. Similarily, aides, social workers, and nurses at the state hospital were interviewed informally to gather additional information. Unfortunately, staff were not consistently available, so the investigator relied heavily on data which was recorded in the subject's file.

To obtain direct information, the investigator was on call to the emergency services team and the jail during the study period. The investigator was to accompany the emergency services team when they responded to a call from the hospital for a possible emergency commitment and when they made an investigation for a possible civil commitment. Direct observations of the subjects' behaviors at the time of detention were to have been made. Unfortunately, during the course of the study, the investigator was seldom called by the team; therefore, direct observation was possible with only one subject in the civil group.

When a subject was brought to the jail, the jail staff contacted the investigator within the first 24 hours of arrest. The investigator completed the initial history and medical screening as part of the normal routine for inmates. This provided the investigator an opportunity for first hand observation of each subject in the criminal group. These observations were later recorded on the study instrument (Appendix D, E).

Recognizing that the staff reporting of the subjects' behaviors reflect varying levels of observation and recording skills, the investigator studied the data compiled from these sources, made an interpretation, and recorded the findings on the study instrument.

In addition to the previously listed information sources, numbers of prior arrests for each subject were obtained from the county's regional criminal justice data system. Numbers of prior hospitalizations for each

subject were also obtained from subjects' files at the jail, the state hospital, and the emergency services section of the county mental health clinic.

Analysis of Data

The two groups were first compared on each identified personal variable on the data sheet to see if any patterns emerged. Likewise, the two groups were compared for possible differences in the systems data.

Since the investigator was not able to directly observe each subject, the observation tool was used not to measure the degree of deviant behavior, but only to identify its presence.

To indicate the presence of psychological disorganization, the total number of the possible 18 symptoms was noted for each subject and recorded on Section I of the tool as the individual's score for psychological disorganization.

Four syndrome factors (thinking disturbance, hostility-suspiciousness, withdrawal-retardation, and anxiety-depression) were also scored by recording the presence or absence of the three symptoms which were used to represent the syndrome (Appendix F - Use of the Brief Psychiatric Rating Scale).

Again, since direct observation and assessment were not always possible, the investigator found that the tool, as designed was not useful in identifying the specific degree of dangerousness or the specific degree of ability to provide for basic life sustaining needs. In order to indicate the relative dangerousness of each individual, a subject was given a score of one if he or she had actually made a suicide attempt, had placed himself in a life threatening situation (e.g. jumped in front of a moving train),

had inflicted self harm, or had demonstrated a physical act of violence towards another person. The investigator recognizes that other indicators of potential dangerousness, such as threats of suicide or violence, were not counted, leading to a possible error of underrating potential dangerousness; however, the investigator felt that this approach gave a reliable indication if not a precise measurement, of a subject's dangerousness.

To assess an individual's ability to care for self, a score of one was given if there was documentation that the individual had severely neglected personal hygiene, had not been eating properly, and that the neglect was severe enough that there was a threat to the individual's health.

The variables of "antisocial behavior" and "drug involvement" were also recorded as merely the presence or absence of each of the indentified behaviors. No attempt was made to rate the degree to which the behavior interfered with functioning. A total score for each of these two variables was tabulated by the total number of behaviors which were documented in the subject's record.

Each subject was given an overall rating on independent living and social skills. The findings of three or more of the following were seen as indicators of difficulties with independent living and social skills:

1) Unemployment,
2) Less than a high school education,
3) No marital relationship,
4) One or less identified support system, or
5) Unstable living situation.

The evaluator chose to not rate the subject as deficient in living and

social skills unless three of the identified factors were present to allow for the possibility of transient circumstances. For example, an individual may be recently divorced and also unemployed, but not necessarily deficient in living and social skills. Again, this leads to a possible error of overrating the subject's living skills, but the investigator felt the assessment would be more reliable using a conservative approach.

CHAPTER III

RESULTS

Description of the Sample

Of the 26 acutely disturbed mentally disordered persons who were involuntarily detained during the study period, 62% (16) were hospitalized at the state hospital and 38% (10) were incarcerated in the county jail. The police were found to have been called for help with nine of the 16 individuals who were hospitalized. Since the police play a key role in the decision to incarcerate or hospitalize an acutely disorganized mentally ill individual, the civil group was divided into two groups - those who were taken to the emergency room by the police (N=9) and those who were taken to the emergency room by friends or family (N=7).

There were some similarities seen in these 26 subjects. All but two of the subjects were white. Adults, ages 20 to 39, comprized 85% (23) of the total group. Four in the civil group were in the 42-56 age range. There were 13 male subjects and 13 females. Most of the subjects were unemployed 92% (24) and 85% (23) were single, separated, divorced or widowed.

Every individual in the study displayed four or more symptoms of psychological disorganization on the Brief Psychiatric Rating Scale (BPRS) and all but three had documented prior psychiatric hospitalization. Half of the individuals had had one or more arrests prior to this detention. Sixty-five percent of the subjects were diagnosed as schizophrenic. Of those who were diagnosed as schizophrenic, there was documentation that 75% had stopped or had refused to take prescribed antipsychotic drugs.

Civil Group

All but one of the 16 subjects in the civil group were taken to the hospital on an emergency basis during the study period. Only one was hospitalized by use of a civil commitment. The justification to hold nine (56%) of the subjects in this group was "inability to care for self". The remaining seven were considered dangerous. Four of those subjects had made serious suicide attempts. Two had inflicted wounds to themselves, and one had threatened his mother with a butcher knife.

Table 3 illustrates the differences in the justification for the hospitalization between those who were taken to the emergency room by family or friends and those taken by the police. More of the individuals who were considered unable to care for themselves were detained by the police.

Table 3
Number of Individuals Hospitalized by
Method of Hold and Justification for Hold

Justification	Method of Hold	
	Without Police (N=7)	With Police (N=9)
Unable to Care for Self	3 (43%)	6 (67%)
Danger to Self or Others	4 (57%)	3 (33%)

Of the 15 subjects who were detained on an emergency basis, those who were brought in by the police tended to be hospitalized for a longer period of time. (See Table 4).

Table 4
Number of Individuals Hospitalized
by Method of Hold and Disposition

Disposition	Method of Hold	
	Without Police (N=7)	With Police (N=9)
Discharged Within 5 days	4 (57%)	0
Discharged Within 14 Days	0	2 (22%)
Converted to Voluntary Stay of Over 14 Days	0	3 (33%)
Court Committed for 30 to 180 Days	3 (43%)	4 (44%)

Criminal Group

All but two of the 10 subjects who were arrested were charged with a misdemeanor crime. Three of these were charged with being disorderly. The others were charged with: theft of a bicycle, shoplifting, indecent exposure, and drinking on an unlicensed premise. Two of the subjects who were arrested were charged with a felony. A 20 year old female who was in jail had taken a car from a car lot for a test drive. She was arrested 100 miles from the car lot and was charged with unauthorized use of a motor vehicle. A 21 year old male was arrested on a warrant from Idaho for a burglary II charge. Four of these individuals were subsequently hospitalized for mental illness. (See Table 5). During the six weeks of the study, three subjects were released from jail, then later rearrested on another misdemeanor charge.

Table 5
Disposition of Arrested Individuals

Disposition	Total Numbers
Hospitalized for Mental Illness	4
Released on Bail	1
Released After 5 Days or Less	2
In Jail Serving 100 Days	1
In Jail Awaiting Trial	2
TOTAL	10

Discussion

This study set out to answer specific questions related to personal and system variables to determine what factors may have an influence on whether an acutely disordered mentally ill person is arrested, or detained on a civil hold. The three groups were found to have several similarities and several differences. To answer the research questions, the findings have been divided into two sections: one to describe and compare the three groups on the personal variables, and one to describe and compare the three groups on the system variables.

Impact of Personal Variables on Method of Detention

Attribute variables. Question: What is the relationship between the personal attributes of age, sex, and race and the type of system used to involuntarily detain the acutely disordered mentally ill individual?

The number of non whites in the sample (2) was insufficient to allow analysis of the relationship between race and detention.

Table 6 relates the age and sex to type of detention. Subjects in the two civil groups showed a similar age pattern with a range from age 20 to age 56. Of those in their 20's, 53% were on criminal hold whereas only 29% of those in their 30's and none of those over 40 were on criminal hold. Similarly, a higher proportion of males than females were criminally detained. Over half of the females were handled without police involvement, but none of the males were. There is a relationship or association, but it may not be a causal relationship, i.e., younger people may be out on the streets more and thus more likely to be apprehended by police.

Table 6
Number of Individuals Involuntarily Held
by Age, Sex and Type of Detention

	Type of Detention		
	Civil Without Police	Civil With Police	Criminal
Age			
20's	3 (20%)	4 (27%)	8 (53%)
30's	2 (28.5%)	3 (43%)	2 (28.5%)
40-50's	2 (50%)	2 (50%)	0
Sex			
Male	0	5 (38%)	8 (62%)
Female	7 (54%)	4 (31%)	2 (15%)

Independent living and social skills. Question: What is the relationship between independent living and social skills and type of detention?

Skills in independent living and social skills varied somewhat between the groups. (See Table 7). All subjects in the civil groups had completed high school while four in the criminal group had not completed a high school education. With the exception of one person in the civil group, all were unemployed. A substantial difference was found between the groups in the numbers of local support persons available. Individuals in the criminal group tended to have fewer available support persons and many were transient. As a whole, this group was less stable when contrasted with the civil groups. Note that eight of the ten subjects in the criminal group were considered deficient in social and living skills.

Based on the fact that most of the individuals in both broups were unemployed, not married, and were not well educated, one might say that these individuals lack independent living and social skills. While these factors can only serve as indicators of possible difficulties with social and living skills, it would appear that as a group, the acutely disordered mentally ill person who is involuntarily removed from the community is deficient in social and living skills, and the individuals who are arrested may be more deficient in these skills.

Table 7

Number of Individuals Deficient in Independent Living and Social Skills by Type of Involuntary Detention

	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Educational Level			
Less than High School	0	0	4 (100%)
High School	3 (23%)	5 (38%)	5 (38%)
Some College	4 (67%)	1 (16%)	1 (16%)
Unknown	0	3 (100%)	0
Marital Status			
Never Married	1 (9%)	4 (36%)	6 (55%)
Divorced, Separated Widow	4 (36%)	3 (27%)	4 (36%)
Married	2 (50%)	2 (50%)	0
Living Situation			
Stable	7 (41%)	7 (41%)	3 (18%)
Transient	0	2 (22%)	7 (78%)
Local Support System			
No Known	0	0	7 (100%)
One or More	7 (37%)	9 (47%)	3 (16%)
Deficiency of Living and Social Skills			
Not Deficient	7 (47%)	6 (40%)	2 (15%)
Deficient	0	3 (27%)	8 (73%)

Family support. Question: What is the relationship between family support and type of detention?

Information related to the availability of family support was limited for some individuals. The investigator found it necessary to rely on documentation in the subject's record. This leads to the possibility that a subject had a family support person which was not accounted for. With this limitation in mind, in light of the available data, it appears that a mentally ill person with an established local support system might be more likely to be hospitalized rather than jailed when acutely disorganized.

Of the individuals with family support, 81% (13) were involuntarily detained on a civil basis during the study period, as compared to 19% (3) who were detained on a criminal basis.

Deviant behaviors. Question: What is the relationship of deviant behavior and diagnosis to the type of detention?

Previous data indicate that for this small group, more mentally ill individuals who were arrested, were charged with a misdemeanor rather than a felony. As shown in Table 8, there was more difference in the specific deviant behavior which led to the detention of the acutely disturbed mentally disordered individual between the two civil groups than between the civil group who had been detained by the police and the criminal group. The primary behavior which led to the hospitalization of the non-police involved civil group was a suicide attempt or self abuse, while the two groups who were detained by the police were mainly disruptive and fighting or were displaying some bizarre behavior. Of the schizophrenics detained, 82% (14) were picked up by the police with equal numbers

in the civil police and criminal groups. (See Table 9). In contrast, nonschizophrenics were more likely not to be arrested.

Table 8

Number of Individuals Involuntarily Held by Type of Involuntary Detention and Behavior Leading to Detention

Behavior Leading to Detention	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Suicide Attempt/ Self Abuse	5 (83%)	1 (17%)	0
Disruptive/Fighting	0	5 (56%)	4 (44%)
Bizarre/Withdrawn	2 (29%)	3 (43%)	2 (29%)
Illegal Behavior (theft)	0	0	4 (100%)

Table 9

Number of Schizophrenics by Type of Involuntary Detention

Psychiatric Diagnosis	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Schizophrenic	3 (18%)	7 (41%)	7 (41%)
Non Schizophrenic	4 (44%)	2 (22%)	3 (33%)

Psychological disorganization. Question: What is the relationship of psychological disorganization and the type of detention?

As mentioned previously, the investigator was able to interview each subject in the criminal group; however, data on subjects in the two civil groups were collected entirely from secondary resources. Because of the need to rely heavily on the recording of behaviors by others, the reliability of the information is limited. Given these circumstances, the following observations were made.

More than half of all the involuntarily detained individuals had eight to 12 symptoms of psychological disorganization as recorded on the BPRS and none had less than four. (See Table 10). Those with more symptoms were more likely to be involved with police (80.5%) than those with fewer symptoms (60%). (See Appendix G, Table A for the individual subject's score on the BPRS).

Table 10
Number of Individuals Showing Symptoms of
Psychological Disorganization by Type of Detention

	Type of Detention		
Total Number Symptoms	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
4 - 7	4 (40%)	3 (30%)	3 (30%)
8 - 12	3 (19.5%)	6 (37%)	7 (43.5%)

Table 11 categorizes the symptoms of psychological disorganization into four syndrome factors: thinking disturbance, hostility-suspiciousness, withdrawal-retardation, and anxiety-depression. The two police

involved groups had a higher percentage of the individuals with two or three symptoms which indicated a thinking disturbance. Although no difference was seen in the numbers of subjects in each group who demonstrated withdrawal-retardation, a difference between the groups was seen in the other two syndrome factors. Of the two police involved groups, more individuals who were hospitalized showed symptoms of hostility-suspiciousness, while more individuals who were arrested showed symptoms of anxiety-depression.

Table 11

Number of Individuals Exhibiting Symptoms of Syndrome Factors by Type of Involuntary Detention

Number of Symptoms (Range 0 - 3)	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Related to Thinking-Disturbance			
2 - 3	3 (15%)	8 (40%)	9 (45%)
0 - 1	4 (66%)	1 (17%)	1 (17%)
Related to Hostility-Suspiciousness			
2 - 3	5 (28%)	8 (44%)	5 (28%)
0 - 1	2 (25%)	1 (13.5%)	5 (63.5%)
Related to Withdrawal-Retardation			
2 - 3	3 (23%)	5 (38.5%)	5 (38.5%)
0 - 1	4 (31%)	4 (31%)	5 (38%)
Related to Anxiety-Depression			
2 - 3	2 (33%)	1 (17%)	3 (50%)
0 - 1	5 (25%)	8 (40%)	7 (35%)

Dangerousness. Question: What is the relationship of dangerousness and the type of detention?

Even though the subjects varied little in psychological disorganization, a difference was noted between the two groups in their dangerous behavior. (See Table 12). Most individuals who were hospitalized displayed some dangerous behavior, while only three individuals who were arrested demonstrated dangerous behavior. During the apprehension, one woman in the civil group bit an old man in the leg, kicked an officer in the groin, tried to throw another officer off the balcony, then tried to jump off the balcony herself. (See Case Summary Number 1, Appendix H). This is contrasted to a man in the criminal group who kicked a store clerk in the back. Two grocery store clerks were struggling with a shoplifter in a parking lot. The subject interpreted the scene as "the wealthy putting down the oppressed", and jumped into the struggle in an attempt to free the shoplifter from his "oppressors". (See Case Summary Number 2, Appendix H).

Table 12
Number of Individuals Showing
Dangerousness by Type of Detention

	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Dangerous	7 (41%)	7 (41%)	3 (18%)
Not Dangerous	0	2 (22%)	7 (78%)

Ability to care for self. Question: What is the relationship of an individual's ability to care for self and the type of detention?

It is difficult to answer the question of the person's ability to care for self. This factor has a wide range of interpretation. To have a guideline for comparison, the investigator attempted to identify three specific behaviors to be indicators of an individuals ability to provide for life sustaining needs. Data regarding a person's ability to provide for adequate food, hygiene, and medical care were originally identified as possible indicators. These factors proved to not be clearly defined, therefore were not useful.

Evidence of not providing for life sustaining needs was counted if an individual was not eating and was showing some evidence of weight loss. Generally, individuals detained by the police were not deficient in their ability to provide for their life sustaining needs as defined for this study; (See Table 13), however, additional data show that five of the nine subjects in the civil police group were hospitalized on an emergency basis because they were evaluated to be "unable to care for their basic needs". Subjects in the civil group generally had a local place of residence. Only two in this group had no stable living arrangement or identifiable source of income, while six individuals in the criminal group were transient and four had no identified financial resource. (See Case Summary Number 3, Appendix H).

Table 13

Number of Individuals Deficient in Ability to Provide for Life Sustaining Needs by Type of Detention

	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Deficient	4 (50%)	2 (25%)	2 (25%)
Not Deficient	3 (17%)	7 (39%)	8 (44%)

Antisocial behaviors. Question: What are the relationships of antisocial behavior and drug involvement to type of detention?

Again it must be pointed out that the data were collected from secondary resources therefore reliability is limited. Behaviors were only recorded on the study instrument if a staff person had noted the behavior and recorded its presence.

Little difference between the groups was noted in the numbers of individuals with four or more antisocial behaviors. No one individual in either group showed more than seven antisocial behaviors as identified on the observation tool, and over half of the individuals in the two police groups committed only three or less of these identified behaviors. (See Table 14).

Table 14

Number of Individuals Showing Antisocial Behaviors by Type of Involuntary Detention

	Type of Detention		
Number of Behaviors	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
None	2 (40%)	2 (40%)	1 (20%)
1 - 3	1 (10%)	3 (30%)	6 (60%)
4 - 7	4 (30%)	4 (36%)	3 (27%)

Antisocial behavior was displayed at the time of detention by all of the subjects who were picked up by the police; however, there were some differences in the types of behavior shown. Four individuals in the criminal group had stolen something. Six of the individuals in the civil group and four in the criminal group were hostile, agitated, threatening, and generally disruptive. Two individuals in the civil group were found wandering, one in a church, and the other was in someone's front yard. The other individual in the civil group had burned both arms with cigarettes and had jumped through a screen. One individual in the criminal group was sitting nude on a busy street and the other was drinking beer in a park.

Only one mentally disordered individual in these two groups was under the influence of alcohol at the time of detention. This person was arrested and taken to jail. This was the only case where any drug was involved, so given such a small number of subjects, one cannot really determine if there is a difference in the numbers of individuals in each group who are under the influence of a drug at the time of involuntary detention.

Prior hospitalizations and arrests. Question: What are the relationships of prior hospitalizations and prior arrests to type of detention?

Most information related to prior arrests was limited to one Oregon county. Likewise, most information related to prior hospitalizations was limited to one Oregon State Hospital. Consistent information related to arrests or hospitalizations in other counties or states, or hospitalizations at a private hospital was limited. When this information was

available from records, it was included. Recognizing that part of the sample population tends to be transient, it is likely that the past history is undercounted.

All but two individuals in the civil groups and the criminal group had a history of prior involvement with either the state mental hospital system or the criminal justice system. Half (8) of the civil group had had prior involvement with both systems and 70% (7) of the criminal group had had prior involvement with both systems.

A difference was noted between the civil and criminal groups in both numbers of prior arrests and numbers of prior hospitalizations. (See Table 15). The criminal group tended to have a history of more arrests than the civil group. Two of the individuals in the criminal group, each had 15 and 16 prior arrests. This is contrasted with the finding that the civil group had more prior mental hospitalizations than the criminal group. One individual in the civil - non-police group had a history of eight prior hospitalizations and two in the civil - police group each had 10 and 14 prior hospitalizations.

Table 15

Number of Individuals With Prior Mental Hospitalizations and Prior Arrests by Type of Detention

	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Number of Hospitalizations			
None	1 (33%)	0	2 (67%)
One - Three	2 (18%)	3 (27%)	6 (55%)
More Than Three	4 (33%)	6 (50%)	2 (17%)
Number of Arrests			
None	3 (30%)	5 (50%)	2 (20%)
One - Three	4 (36%)	3 (27%)	4 (36%)
More Than Three	0	1 (20%)	4 (80%)

Impact of Local System Variables on Method of Detention

Place of incident. Question: What is the relationship between the place where incident occurred and the type of detention?

The greatest difference noted in the identified system variables was in the place where the incident occurred. The deviant behavior which led to the detention of an individual in the civil group in which the police were not involved occurred in a private place, most often a private home. All individuals whose deviance occurred in a private place were hospitalized, however, of the individuals whose deivance was noticed in a public place, 71% were arrested and only 29% were hospitalized. (See Table 16).

Source of complaint. Question: What is the relationship between who files the complaint which starts the process to involuntarily detain the mentally disordered person, and the type of detention?

The acutely mentally ill person came to the attention of the mental health's emergency services team or the police by various means. The most common route for individuals who were not involved with the police, was through a hospital. Most often, a concerned support person took the disorganized individual to the emergency room of a local hospital where the emergency room staff evaluated the situation. If they determined that an emergency commitment was probably appropriate, they called the emergency services team to help with the process. In two cases, individuals were patients in a local hospital's psychiatric unit. The patients had become difficult to manage on the unit and the psychiatrists requested an emergency commitment to provide for a more secure environment.

Table 16

Number of Individuals Involuntarily Detained by Type of Detention and System Variable

System Variable	Type of Detention		
	Civil - Without Police (N=7)	Civil - With Police (N=9)	Criminal (N=10)
Time of Day/Day of Week			
Monday - Friday 8 a.m. - 5 p.m.	3 (23%)	5 (38.5%)	5 (38.5%)
Weekends, Holidays, After Hours	4 (31%)	4 (31%)	5 (38%)
Known to Emergency Services Team			
Known	4 (25%)	6 (37.5%)	6 (37.5%)
Unknown	3 (30%)	3 (30%)	4 (40%)
Seen by Emergency Services Team During Past Month			
Seen	1 (17%	1 (17%)	4 (66%)
Not Seen	6 (30%)	8 (40%)	6 (30%)
Place of Incident			
Private	7 (58%)	5 (42%)	0
Public	0	4 (29%)	10 (71%)
Source of Complaint			
Local Support Person	7 (70%)	3 (30%)	0
Citizen	0	3 (25%)	9 (75%)
Police Patrol	0	3 (75%)	1 (25%)

Only one individual was detained by means of the civil commitment process. Although this person had concerned family members in the area, the petition was not filed by the family. The owner and the manager of the apartment where the individual resided, filed the petition. The police became involved in the detention when they were called to assist or when they were on patrol and stopped to investigate some unusual situation. For individuals in this study who were picked up by the police, there was a difference in detention according to who reported the deviant behavior. All complaints by family members or friends resulted in hospitalization; whereas, complaints filed by citizens resulted in arrest for 75% of the individuals. (See Table 16)

Time of deviance. Question: What is the relationship between mentally disordered individuals who are behaviorally deviant at night or on weekends and the type of detention?

Of individuals who were deviant during times of low service availability (nights and weekends), 62% were hospitalized and 38% were arrested. A similar pattern was seen for those who were deviant during weekdays; therefore, for this group, there was no relationship between the time of the deviance and the type of detention. (See Table 16)

Attempt to hospitalize rather than arrest. Question: Will an attempt have been made to detain the individual on a civil basis prior to the filing of a criminal charge?

In the pure sense, the question would have to be answered, no. Involuntary hospitalization had not been attempted for any of the subjects who were arrested; however, six of the ten had an open file with the emergency services team, and four of these had been seen by a mental health

health worker from the team during the week prior to arrest. Two had requested voluntary hospitalization; however, the evaluator from emergency services felt hospitalization was not indicated and made an outpatient referral. (See Case Number 4 and 5, Appendix H). It was felt that hospitalization was indicated for a 39 year old veteran. A bus ticket was purchased for him and he was told to take a bus to a community 70 miles away where a VA hospital is located. He was arrested eight days later when found nude, sitting beside a busy street, the bus ticket still with his clothing. (See Case Number 6, Appendix H).

In another case, the father of a 29 year old man had called the emergency services team, concerned because of his son, who had a history of mental illness, was delusional and was physically run down. The process to file a petition for civil commitment was explained to the father. A week later the young man was arrested for spanking a 12 year old boy who was smoking on a downtown street corner. (See Case Number 7, Appendix H). The father had not filed a petition, relating that at one time a psychiatrist had told him to stay out of his son's life.

Initial Contact. Question: How many initial contacts for help for both groups will be calls to mental health agencies or other community resources rather than to law enforcement agencies?

For the group of disorganized mentally ill subjects who were arrested, a complaint was called to the police first in all but one instance. In the one exception, the individual was at a local hospital demanding to be admitted. The emergency room physician called the emergency services team who had been dealing with the individual for the pervious two months. They suggested that the subject be arrested for trespassing if she continued to

refuse to leave. (See Case Number 4, Appendix H).

In the civil situations where the police were called to assist, the mentally ill individual was out of control and had to be physically restrained. Documentation identified that there had been a previous attempt to have the person hospitalized on a voluntary basis in only one instance. (See Case Number 1, Appendix H). For the other cases, hospitalization was initiated only when the acutely disorganized person became out of control and appeared dangerous.

The remaining seven individuals in the civil group were somewhat different. A petition for civil commitment had been filed to obtain hospitalization for one woman who had refused to seek treatment. Three months previously her son had called the mental health clinic and was told that his mother's case was closed. He felt there was nothing further he could do. Another lady was first taken directly to the state hospital by her husband because of her bizarre behavior. The remaining five were taken directly to the hospital because a medical emergency existed (four O.D.'s, one self inflicted wound).

In summary, during the six week study, the police received the initial contact for help with 18 of the 26 subjects.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study looked at specific personal characteristics of the acutely disorganized mentally ill individual who was involuntarily detained, by either arrest or hospitalization, and studied some specific mental health and legal systems variables to identify factors which were influential in determining whether the individual was arrested or hospitalized. The subjects were divided into three groups: those who were arrested, those who were taken to the hospital by the police, and those who were involuntarily hospitalized with no police involvement.

A comparison of the personal variables of the subjects in the study groups showed that overall, the criminal group had more male subjects than the civil group. These individuals were more deficient in living and social skills with a greater number of individuals who were transient with no local support systems as contrasted to individuals in the civil group who all had local support systems. Fewer individuals in the criminal group had actually committed a dangerous act than individuals in the civil groups. Most (80%) were arrested for minor violations of the law.

There was a difference in deviant behaviors which led to the hospitalization of individuals in the civil group not detained by the police and the group of mentally disordered individuals arrested and taken to jail; however, there was not much difference in the specific deviant behavior of the individuals in the civil group who were taken to the hospital by the police and the individuals who were arrested.

There was little difference between the groups in the numbers of antisocial behaviors. Individuals in the civil groups had more prior hospitalizations while individuals in the criminal group had more prior arrests.

The three groups were also compared on several specific system variables, with differences noted in some, but not others. There was no relationship found between the time of detention and the type of detention. Likewise, there was no relationship between individuals who were known to the county mental health emergency service team and the type of detention; however, more persons who had been evaluated by the emergency services team during the month prior to detention were later arrested.

Another finding was that individuals in this study were more likely to be arrested if the incident which led to the detention occurred in a public place and if a citizen called the police. If family members or other support persons called the police, the disorganized mentally ill person was taken to the emergency room of the hospital.

Thus, certain characteristics and factors seem to influence which system is used to detain the acutely disorganized mentally ill person in the study county. In this small sample, the individual who was hospitalized was more likely to be a white, unemployed female with a local support network, and a history of prior hospitalizations, whereas the individual who was arrested was more likely to be a white, unemployed male transient with no local support network and a history of prior arrests. The specific deviant behavior or degree of psychological disorganization appeared to have little influence on the decision whether

to arrest or hospitalize, however, if the deviance was public and no support person was around, the person was more likely to be arrested.

Conclusions

After comparing these three groups of involuntarily detained mentally ill persons on a number of specific personal variables and a few specific local variables, the findings of this study indicate that there is no one answer or single factor which determines the decision to arrest the acutely disorganized person rather than to seek hospitalization. A chain of events occurs which involves a complex interplay of individual characteristics and system variables.

Literature has suggested at least four possible factors which may influence the decision to have an individual who is mentally ill and acutely disorganized arrested and taken to jail, rather than having the person hospitalized. These include restrictive civil commitment laws, illegal behavior, deviant behavior and lack of resources. Do the study data support any of these?

Restrictive Civil Commitment Laws

One factor which is receiving a great deal of attention is the concern that the current strict civil commitment laws have made it difficult to have a mentally ill person involuntarily hospitalized. When mentally ill individuals become acutely disorganized, they are generally unwilling or unable to seek help voluntarily. It has been suggested that the individual may not fit the criteria for civil commitment so the person is jailed (Abramson, 1972). The law requires that before

involuntary action can be taken, the individual must be dangerous or unable to provide for life sustaining needs. Local courts do interpret these in somewhat different ways, particularly what behaviors are necessary to provide for life sustaining needs. Bloom and Shore (Note 1), found that in a large metropolitan area of Oregon, judges operate with stringent interpretations of dangerousness. They found that a high proportion of schizophrenic patients who had been involuntarily hospitalized also had a previous arrest history. They suggest that diversion to the criminal justice system is an unplanned consequence of civil commitment reform.

This study found that out of the ten schizophrenic patients who were involuntarily hospitalized during the six week study period, seven had been arrested in the study county at sometime during the past seven years. This is consistent with Bloom and Shore's finding. The study also supports findings that the chronic mentally ill patient goes back and forth between the two systems. Seven of the ten subjects who were arrested during the study period were diagnosed as schizophrenic. Six of these individuals had documentation of prior hospitalization for mental illness.

To address the issue of whether or not the restrictive commitment laws have caused this shuffling of the chronic mentally ill person back and forth between the hospitals and jails is a more complicated problem. Swank and Winer (1977), Gold (1973), and Petrich (1978) suggest that there has been a marked increase in the numbers of seriously ill mentally disturbed individuals entering the jails in recent years. Although this

finding may be the result of the changes in the commitment laws, one needs to be cautious in interpreting this as a cause and effect. There is the possibility that the findings of Swank and Winer, Gold, and Petrich may be due to a change in reporting standards. Offering psychological services to inmates in jails around the nation is relatively new over the past decade, so perhaps the problems of mentally ill persons in jails are becoming more visible. There seem to be few studies prior to 1970 that look at the numbers of mentally ill individuals in jails to have a baseline for comparison.

To address this issue, this study looked at the events that led up to the detention of the mentally ill person. Involuntary hospitalization had not been explored or attempted as a possible alternative to incarceration for any of the jailed individuals prior to the arrest, even though the person's behavior was disorganized as well as disturbing. Only one person in the study sample was initially sent to the hospital on a civil commitment. The other 16 were sent on an emergency basis. Mental health staff were available 24 hours, any day of the week to facilitate the emergency process, so it does not appear that the restrictive laws hamper the involuntary hospitalization of the acutely disorganized mentally ill person in the study county.

Illegal Behavior

People who have broken the law are generally taken to a jail when their deviance has been discovered. Perhaps more mentally ill persons are found in jails because they commit more crimes than the general public. Again, testing this possibility is difficult. The definition of

illegal behavior, or crime, is not clear cut. When is a behavior "criminal" and when is it a symptom of mental illness? Our culture generally agrees that when someone robs a bank, steals a car, or beats a store clerk, incarceration in a jail is appropriate; however, other behaviors, such as nudity in public are more subject to the evaluation of the observer.

This study took a look at the specific deviant behavior which led to the involuntary detention of the acutely disturbed mentally disordered persons in one county in Oregon. During the six weeks of the study, nine mentally ill persons were taken to the hospital by the police rather than to jail. Was their behavior "less criminal" than the ten individuals who were taken to jail because their behavior was seen as criminal?

Half of the individuals who were arrested had violated specific laws. Four of these were accused of having taken something which belonged to someone else. Another subject, Dick, was fighting with a grocery clerk and kicked him in the back. The other five had displayed behavior which was interpreted to be criminal by the persons filing the complaint. This evaluation was supported by the police officer who then took the person to jail. For example, John (See Case Number 3, Appendix H) was observed out in the street early one afternoon, yelling and screaming profanities. A citizen called the police and signed a complaint against John. In a later situation with Dick (See Case Number 2, Appendix H), an officer was on patrol and observed Dick's unusual behavior. His report noted, "Due to the subject's observed criminal activity and the likelihood of his continued criminal behavior, he was taken into custody".

Not one of the nine individuals who were hospitalized had stolen anything; however, two had actually forced their way into someone's house and were hostile. Another had threatened his mother with a butcher knife. Three others were also hostile and disturbing others. One wonders why their behavior was not seen as criminal.

It appears to this investigator that, for at least half of the cases, the interpretation of the behavior, rather than the specific behavior is a more significant factor in the decision to arrest rather than to hospitalize the individual.

Deviant Behavior

Several factors influence how the deviant behavior is viewed. The most significant include who the person is; in what way the behavior is deviant; what the social context of the behavior is; what the frame of reference of the evaluator is; and what the community's reaction is. Nineteen mentally disorganized individuals in this study were picked up by the police. Nine were hospitalized while ten were arrested and taken to jail.

As shown in the previous section, the specific behavior which led to the detention of half of the individuals who were arrested was very similar to the behavior of the individuals who were hospitalized. Even though the behavior was similar, the study identified several differences in the two situations.

For the individuals who were arrested, the behavior occurred in a public place and in more cases the people bothered by the behavior had asked that the individual be arrested. The deviant person was a stranger

to the complainant, and the behavior was disturbing to a number of people. For example, an individual found hiding in the bushes of someone's front yard at 2:30 in the morning by an officer on patrol was taken to the emergency room of the hospital. No one had noticed this confused and frightened man and filed a complaint. Contrast this to the confused man who was sitting nude at a busy intersection at 6:00 one evening close to the fair which was drawing a large crowd. The police had received numerous complaints and the individual was taken to jail.

Three of the individuals who were arrested had sought voluntary hospitalization a few days prior to the arrest. (See Case Number 4, 5 and 6, Appendix H). One was evaluated by the social worker from the emergency services team as being "not amiable to treatment"; another was seen as being "manipulative"; the third had been left at a bus depot with a ticket to get to the hospital on his own.

During the crisis that precipitates the involuntary detention, the evaluator needs to make an on-the-spot judgement. Very often the police are the ones called in a crisis situation, because few others will respond on site anytime of the day or night and few offer services to resistive, hostile individuals. The officer must base a decision on the information available at the site. Is the behavior merely a norm violation such as violent behavior, and seen as criminal? Or, is the behavior unusual or unexplainable and seen as mental illness?

Except for three people, the mentally disorganized person who was hospitalized was identified as being "crazy" by the complainant. Parents

of two persons, a landlord, a neighbor, a friend, and a mental health worker had called the police for help with six of these individuals. The other three were picked up by the police while on patrol. The one female was hostile and threatening; however, the community was small, and she had a history of ten prior hospitalizations and had previously been labeled as mentally ill. The two men were withdrawn and frightened. Both had a history of several prior hospitalizations. One had been living with his family and the other had the name and phone number of a Veterans Administration social worker in his pocket.

In each instance the evaluator based a decision on a personal frame of reference and the reaction of the community to the disorganized individual's behavior. The police officer views himself as a "keeper of the peace" (Bittner, 1967), not as a mental health worker. In the study county, the information supplied by the complainant appears to heavily influence an officer's decision to take the disturbed individual to the hospital or to jail. A person was more likely to be hospitalized if the officer had clear evidence that the individual was mentally ill.

Lack of Resources

Another factor which has been thought to influence the decision to arrest, rather than to hospitalize the disturbed individual is the lack of available local resources. This study did not specifically address the availability of community resources for this population; however, the study county does not have a holding facility to involuntarily detain an acutely disturbed mentally ill person on an emergency basis. Other than for attempted suicides, the psychiatric unit of the local hospital is

reluctant to accept any involuntary patient, especially if the patient is hostile, abusive, and in need of a protective environment. This had led to the speculation that the acutely disorganized mentally ill person in the study county is taken to jail because the police officer may not have the time and resources to go through the lengthy process of having the individual hospitalized in a community which is 70 miles away.

It is difficult to assess this factor by only reading the police reports; however, it does not appear to this investigator that this is a significant influencing factor in the decision to arrest the mentally disorganized person. During the six week study period, 19 people were involuntarily detained by the police. Nine of these were hospitalized. The disturbed individuals were detained by difference officers, from different agencies, at various times of the day and of the week. The only pattern that was consistent with the individuals who were detained by the police was that persons taken to the hospital had been identified by the complainant as being mentally ill. The persons who were arrested were not known to the complainant and arrest had been requested in most situations. The officer appeared to base action upon the request of the complainant, and the finding or lack of finding obvious signs of serious psychological disorder. This leads the investigator to conclude that in most situations, the decision to arrest was more influenced by the specific incident than the lack of a readily available resource for emergency hospitalization.

In conclusion, it appears the decision to arrest or hospitalize an acutely disorganized mentally ill person depends on an interaction which

takes place between a person whose behavior is seen as deviant and those who are affected by the behavior and respond. For this group of subjects in one Oregon County, the greatest influencing factor does not seem to be primarily restrictive civil commitment laws or lack of a local holding facility. Rather, the influencing factors appear to be what the deviant behavior is, how the deviant behavior is viewed, and by whom.

Deficient Living Skills

Another finding of this study was that certain commonalities emerged in the characteristics of the acutely disorganized mentally ill persons who were involuntarily removed from the community. As a group, these individuals demonstrated poor judgement, little insight, and deficient reality testing. They generally had difficulties with social and living skills. Only one was employed, and many who became involved with the police were transient. Some were without even a source of income.

Nineteen of the 26 study subjects had been picked up by the police. All but two of these had a history of prior hospitalization for mental illness and 12 had been arrested at some previous time. Many had been involved with both systems, some shuffling back and forth between the two systems in a short time span. As many as 14 had been under outpatient treatment but had failed to keep appointments and take prescribed medications.

This leads the investigator to conclude that the problem of involuntary detention of an acutely disorganized mentally ill person is greater than identifying factors which influence the decision of which system is used to detain the disorganized person. A more important issue

than identifying the deviant behavior, involves assessing the specific needs of this population and evaluating the systems which are not working to help these individuals. The mental health and legal systems are spending money to periodically house this population of mentally ill individuals. After release, the individual is returned to the community. The disorganized individual is referred back and forth to various services for help or the individual sits at home until a crisis again occurs and hospitalization or incarceration are seen to be indicated.

Recommendations

The study data identified three characteristics of mentally ill individuals who were arrested. A high proportion of the arrested individuals were male with no identifiable local support system. This is contrasted with the findings that more females were hospitalized than were arrested during the study and all of the hospitalized individuals had a local support system. In addition, the deviant behavior which led to the arrest of the mentally ill individual in each instance occurred in a public place.

These findings suggest the need for future research to test at least the following three hypotheses:

1) Acutely disorganized mentally ill males have a higher rate of arrest than acutely disorganized mentally ill females.
2) Acutely disorganized mentally ill persons who have no local support system will demonstrate a higher arrest rate than acutely disorganized mentally ill persons with local support systems.
3) Acutely disorganized mentally ill persons whose deviant

behavior occurs in a public place will be more often arrested than they will be hospitalized.

The small number of subjects in this study, as well as the limited time frame and specific geographic location of the study prevents the identification of other specific personal characteristics or mental health and criminal system variables which may influence the method of detention. In addition to these limitations, the investigator was not able to study the interrelationships of these various factors. Because of the complexity of the problem and the potential implications for planning community mental health programs, it is suggested that this study be replicated with several modifications.

The "observation tool" (Appendix E) of the study instrument needs to be more fully developed. It is important to quantify the degree of each of the five identified categories of deviant behaviors. The Brief Psychiatric Rating Scale was useful to identify the degree of psychological disorganization and has been tested for reliability; however, the study instrument did not adequately operationalize the degree of dangerousness, ability to care for self, and antisocial behaviors.

Future studies of this population will make the comparison of involuntarily detained mentally ill individuals more precise by excluding individuals who might clearly be labeled as criminal or mentally ill. For this reason, mentally ill individuals who are charged with a felony and those who are involuntarily hospitalized without the involvement of the police should be excluded from the study. Additionally, the study findings will be more generalizable by increasing the sample size, and by conducting the study over a wider geographic area. This will have the additional benefit of controlling ideosyncrasies of specific systems.

In addition to identifying the contribution each variable makes toward the decision to label deviant behavior as criminal or mental illness, analysis of the data in a future study using a multivariate technique would enable the investigator to identify the interrelationships between these variables and evaluate the relative contribution of large numbers of variables in explaining the method of detention used. A multivariate technique also allows the investigator to substitute statistical controls for experimental controls.

In addition to identifying the need for further study, this research project identified a need to evaluate local practice. Most individuals in the two police involved groups in this study had a history of involvement with both legal and mental health systems. Some individuals were well known in the community and presented management problems, such as failure to follow through with appointments and to take prescribed medications. Available family members had few resources available to help with the daily care of the disorganized individual. Other mentally ill individuals were new in the community and were having difficulties meeting basic needs such as food and shelter.

These findings suggest the need to clearly assess the problems of this population and plan programs to address the needs. Issues such as compliance and access to services suggest the need to also research alternative treatment approaches to prevent the crisis situations which lead to the consideration of involuntary removal from the community. This research might include treatment outreach, case management and family therapy designed to meet the specific needs of this population. Most of the mentally ill individuals in this study who utilized the services of both the mental health system and the criminal justice system had difficulties with basic living and social skills. This points to a need for strong interagency communication and cooperation

to develop a multidisciplinary approach to work with the severely disabled mentally ill individual.

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APPENDIX A

LETTERS TO AGENCIES

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

May 12, 1980

Lt. Ben Sunderland
Jail Administrator
Lane County Adult Corrections
101 West 5th
Eugene, Oregon 97401

Dear Lt. Sunderland:

I am currently a graduate student in nursing at the University of Oregon Health Sciences Center, School of Nursing, Portland, Oregon. For my Master's Thesis, I am doing an exploratory study comparing mentally disordered persons in Lane County who are involuntarily detained on a Civil Hold to those who are lodged in the county jail on a Criminal Hold. All mentally disordered individuals who meet the study criteria and who are detained involuntarily during a four to six week period, from June through July, 1980, will be included in the study.

These two groups of mentally disordered persons will be compared on a number of variables to explore what factors may influence their involuntary removal from the community and to determine what behavioral differences exist between the two groups. A copy of the study instrument is enclosed.

Each individual will be assigned a code name on the student instrument. The patient's identity will not be disclosed in any way, in keeping with ORS 179.505 (4)(b).

I would like permission to review records and talk with staff as soon as possible after a mentally ill person is detained in the jail during the study period. I will call you to arrange a time to meet to discuss the study.

Thank you for your assistance.

Sincerely,

Mildred S. Cox, R.N.
398 North 57th
Springfield, Oregon 97477

MSC:ml
Enclosure

LANE COUNTY SHERIFF'S OFFICE

Lane County Courthouse Eugene, Oregon 97401 ★ (503) 687-4141
Adult Corrections/101 W. 5th/Eugene, Oregon 97401

DAVID N. BURKS
★ SHERIFF ★
Director of Public Safety

July 16, 1980

Sue Will, M.S.N., Assistant Professor
University of Oregon
Health Science Center
McKenzie Hall
3181 S.W. Sam Jackson Park Rd.
Portland, Oregon 97201

Re: Proposed research to be conducted by Mildred Cox, Investigator, entitled "A Comparison of Involuntarily detained Mentally disordered Individuals, Civil vs. Criminal Holds"

Dear Ms. Will:

I have reviewed the proposal submitted by Mildred Cox and I am assured that proper precautions to maintain confidentiality will be provided. Please refer to the attached agreement between myself and Mildred, which I have determined is appropriate to allow access to files concerning the acutely disorganized mentally ill inmate during the course of her six week study period. I have asked that Mildred work with our Division's staff psychologist and I understand that she will be conducting interview sessions with persons brought to the facility who fit the criteria of her study. Having evaluated the text and the appropriateness of the request I find no difficulties, and am in fact anxiously awaiting the results and determinations by Ms. Cox. If I can respond to any concerns or questions, please contact me.

Sincerely,

[redacted]

Captain Ben Sunderland, Director
Lane County Adult Corrections

BFS:dco
JA-103
cc: File (2)

To: Lt. Ben Sunderland, Acting Division Director

Lane County Corrections

From: Mildred S. Cox, R.N., investigator

Re: Proposed Study - A Comparison of Involuntarily Detained Mentally Disordered Individuals, Civil vs Criminal Holds

During a 6 week period in the summer of 1980, I, Mildred Cox, plan to conduct an ex-post facto field study to explore what variables influence the decision to arrest an acutely disorganized mentally disordered individual rather than detaining the individual on a civil basis. All mentally disordered individuals who meet the study criteria and who are involuntarily detained at Oregon State Hospital or at the Lane County Jailduring this period will be included in the study. It is anticipated that there will be 15 subjects in each group. Data will be collected from informal interviews with personnel who had contact with the clients, from client records, and from observations made by the investigator.

The client's confidentiality will be protected by not using any names on the study instrument. A code number will be assigned to each client and the write up will refer only to aggregate data.

In order to protect the rights of the clients of the Corrections Division, and in the interest of maintaining professional and ethical standards of confidentiality of individual records pertaining to the treatment of patients in the division, I hereby agree, as an investigator, to abide by the below noted regulations, and I have:

1. Reviewed the statutes on confidentiality, and have accepted the ethical, professional, and moral responsibilities inherent in the review of documents. Any files and treatment plans of clients being treated by the agency will be examined only for the purpose of this specific study.

2. Received for my use a copy of the Handbook on Confidentiality from the Oregon State Mental Health Division, July, 1978.

3. Received and read a copy of the Confidentiality of Alcohol and Drug Abuse Patient Records (General Provisions) Vol. 40, No. 127, Part IV, published July 1, 1975 in the Federal Register, and understand the contents thereof.

4. I further understand that information will be disclosed to me from records whose confidentaility is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit me from making any

further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

PENALTY: Not more than $500 fine for first offense, not more than $5000 fine for subsequent offense.

Investigator [redacted]

Division Director [redacted]

Date 06/18/80

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

May 12, 1980

Dr. Dean Brooks
Administrator
Oregon State Hospital
2600 Center Street
Salem, Oregon 97310

Dear Dr. Brooks:

I am currently a graduate student in nursing at the University of Oregon Health Sciences Center School of Nursing, Portland, Oregon. For my Master's Thesis, I am doing an exploratory study comparing mentally disordered persons in Lane County who are involuntarily detained on a Civil Hold to those who are lodged in the county jail on a Criminal Hold. All mentally disordered individuals who meet the study criteria and who are detained involuntarily during a four to six week period, from June through July, 1980, will be included in the study.

These two groups of mentally disordered persons will be compared on a number of variables to explore what factors may influence their involuntary removal from the community and to determine what behavioral differences exist between the two groups. A copy of the study instrument is enclosed.

Each individual will be assigned a code name on the study instrument. The patient's identity will not be disclosed in any way, in keeping with ORS 179.505 (4)(b).

I would like permission to review records and talk with staff as soon as possible after an involuntary hold is placed on an individual during the study period. I will call you to arrange a time to meet to discuss the study.

Thank you for your assistance.

Sincerely,

Mildred S. Cox, R.N.
398 North 57th
Springfield, Oregon 97477

MSC:ml
Enclosure
cc: Cathy Knox
Director of Nursing Services
Oregon State Hospital

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
MENTAL HEALTH DIVISION
Oregon State Hospital
2600 CENTER STREET N.E., SALEM, OREGON 97310 PHONE 378-2348

August 21, 1980

Mildred Braunstein (Cox)
398 North 57th
Springfield, OR 97477

Dear Mildred:

After careful review of your research proposal dealing with involuntary patients from Lane county, Drs. Pati, Crane and I have approved the project. I am forwarding this recommendation to Dr. Brooks, who makes the final decision.

We understand that your analysis will be based on the review of relevant charts and interviews with 35A staff only, and will not entail personal contact with Lane county patients. We also understand that you are doing the exploratory case study on a maximum of about 25 patients, and will discontinue data collection when you reach that number, or at the end of six weeks.

We are pleased that you are undertaking this kind of study. The determination of factors involved in the differential placement of disturbed or allegedly disturbed persons o is of vital importance to the County and to us.

Sincerely,

[redacted]

William H. Banaka, Ph.D.
Chief Psychologist

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

70

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

May 12, 1980

Mr. Tom Sawyer
Director
Lane County Criminal
Justice Data System
Lane County Courthouse
Eugene, Oregon 97401

Dear Mr. Sawyer:

I am currently a graduate student in nursing at the University of Oregon Health Sciences Center School of Nursing, Portland, Oregon. For my Master's Thesis, I am doing an exploratory study comparing mentally disordered persons in Lane County who are involuntarily detained on a Civil Hold to those who are lodged in the county jail on a Criminal Hold. All mentally disordered individuals who meet the study criteria and who are detained involuntarily during a four to six week period, from June through July, 1980, will be included in the study.

These two groups of mentally disordered persons will be compared on a number of variables to explore what factors may influence their involuntary removal from the community and to determine what behavioral differences exist between the two groups. A copy of the study instrument is enclosed.

Each individual will be assigned a code name on the study instrument. The patient's identity will not be disclosed in any way, in keeping with ORS 179.505 (4)(b).

Literature has suggested that prior arrests may be an important variable. I would like permission to obtain this piece of data from the Criminal Justice Data System.

Thank you for your assistance.

Sincerely,

Mildred S. Cox, R.N.
398 North 57th
Springfield, Oregon 97477

MSC:ml
Enclosure

SERVING LANE COUNTY, OREGON'S:

POLICE
COURTS
PROSECUTION
CORRECTIONS
CRIME PREVENTION

AREA INFORMATION RECORDS SYSTEM

A REGIONAL CRIMINAL JUSTICE DATA SYSTEM

TO: Mrs. Braunstein (Cox)

FROM: Skip Dalros

RE: Research Grant of Access

DATE: 7/25/80

Dear Mrs. Braunstein

I have reviewed your research proposal and data collection instruments. I find then to be acceptable under our research grant of access guidlines.

1. All material released is confidential and is not to be photo copied or reproduced in any fashion other than transposition to your study document titled "Data Sheet" in the form that it appears in your access request package.

2. By accepting the arrest material supplied by the CJDS you automatically assume liability for it's proper use under the federal security and privacy regulations of the Omnibus Safe Streets and Crime Control Act of 1974 as ammended in 1976.

Sincerly,

[redacted]

Bruce A. Dalros
Acting Director CJDS

SERVING LANE COUNTY, OREGON'S:

POLICE
COURTS
PROSECUTION
CORRECTIONS
CRIME PREVENTION

AREA INFORMATION RECORDS SYSTEM

A REGIONAL CRIMINAL JUSTICE DATA SYSTEM

AREA INFORMATION RECORDS SYSTEM
CONFIDENTIALITY ACKNOWLEDGEMENT
FOR RESEARCH PURPOSES

I understand that I am not to release or divulge any information obtained through or contained within the AIRS files to any person, agency, or organization, unless said person, agency, or organization also has a signed agreement with the AIRS system, which authorizes that person, agency, or organization to access AIRS data.

Upon determination that the person, agency, or organization is an authorized recipient of AIRS data, I understand I may release the requested information. I understand that I also must notify the AIRS Project Management of the release for the purpose of documentation.

Since it is imperative that the confidentiality of AIRS not be compromised, I understand that cancellation of the Research Grant of Access may be considered if confidentiality requirements are not strictly adhered to:

SIGNED [redacted]

WITNESSED [redacted]

DATED 7-23-80

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

71

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

May 12, 1980

Mr. Jeff Davis
Director
Lane County Mental Health Division
1901 Garden
Eugene, Oregon 97401

Dear Mr. Davis:

I am currently a graduate student in nursing at the University of Oregon Health Sciences Center School of Nursing, Portland, Oregon. For my Master's Thesis, I am doing an exploratory study comparing mentally disordered persons in Lane County who are involuntarily detained on a Civil Hold to those who are lodged in the county jail on a Criminal Hold. All mentally disordered individuals who meet the study criteria and who are detained involuntarily during a four to six week period, from June through July, 1980, will be included in the study.

These two groups of mentally disordered persons will be compared on a number of variables to explore what factors may influence their involuntary removal from the community and to determine what behavioral differences exist between the two groups. A copy of the study instrument is enclosed.

Each individual will be assigned a code name on the study instrument. The patient's identity will not be disclosed in any way, in keeping with ORS 179.505 (4)(b).

I would like permission to review records and talk with staff as soon as possible after an involuntary hold is placed on an individual during the study period. I will call you to arrange a time to meet to discuss the study.

Thank you for your assistance.

Sincerely,

Mildred S. Cox, R.N.
398 North 57th
Springfield, Oregon 97477

MSC:ml
Enclosure

lane county

MEMORANDUM

DATE: June 18, 1980

TO: Susan Will, MSN, Assistant Professor

FROM: Jeff Davis, Director

RE: Research Proposal - A Comparison of Involuntarily Detained Mentally Disordered Individuals, Civil vs Criminal Holds. Mildred Cox, R.N., Investigator

I have reviewed Mildred's proposed research and am willing to provide her with access to the records of all clients involved in the involuntary civil committment process from Lane County during the six week study period. Measures have been provided for to protect the confidentiality of the client. During this time, Mildred also has permission to accompany the committment team as an observer during their routine investigations.

sg

DEPARTMENT OF COMMUNITY HEALTH AND SOCIAL SERVICES MENTAL HEALTH DIVISION
ALCOHOL & DRUG SERVICES MENTAL HEALTH PROGRAM MENTAL HEALTH SERVICES TO OFFENDERS
1967 WILLAMETTE AVENUE EUGENE, OREGON 97403 (503) 687-4279

To: Jeff Davis, Division Director
Lane County Mental Health Division

From: Mildred Cox, RN
investigator

Re: Proposed Study - A Comparison of Involuntarily Detained Mentally Disordered Individuals, Civil vs Criminal Holds

During a 6 week period in the summer of 1980, I, Mildred Cox, plan to conduct an ex-post facto field study to explore what variables influence the decision to arrest an acutely disorganized mentally disordered individual rather than detaining the individual on a civil basis. All mentally disordered individuals who meet the study criteria and who are involuntarily detained at the Oregon State Hospital or at the Lane County Jail during this period will be included in the study. It is anticipated that there will be 15 subjects in each group. Data will be collected from informal interviews with personnel who had contact with the clients, from client records, and from observations made by the investigator.

The client's confidentiality will be protected by not using any names on the study instrument. A code number will be assigned to each client and the write up will refer only to aggregate data.

In order to protect the rights of the clients of the Mental Health Division, and in the interest of maintaining professional and ethical standards of confidentiality of individual records pertaining to the treatment of patients in the Division, I hereby agree, as an investigator, to abide by the below noted regulations, and I have:

1. Reviewed the statutes on confidentiality, and have accepted the ethical, professional, and moral responsibilities inherent in the review of document. Any files and treatment plans of clients being treated by the agency will be examined only for the purpose of this specific study.

2. Received for my use a copy of the Handbook on Confidentiality from the Oregon State Mental Health Division, July, 1978.

3. Received and read a copy of the Confidentiality of Alcohol and Drug Abuse Patient Records (General Provisions) Vol. 40, No. 127, Part IV, published July 1, 1975 in the Federal Register, and understand the contents thereof.

4. I further understand that information will be disclosed to me from records whose confidentiality si protected by Federal Law. Pederal Regulations (42 CFR Part 2) prohibit me from making any

further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

PENALTY: Not more than $500 fine for first offense, not more than $5000 fine for subsequent offense.

Investigator [redacted]

Division Director [redacted]

Date 6/19/80

APPENDIX B

ORS 179.495, INSPECTION OF INMATE RECORDS

ORS 179.495, INSPECTION OF INMATE RECORDS

179.495 Inspection of inmate records; consent; penalty. (1) Medical case histories, clinical records, X-rays, treatment charts, progress reports and other similar written accounts of the inmates of any state corrections institution listed in ORS 179.321, maintained in such institution by the officers or employes thereof who are authorized to maintain such histories, records, X-rays, charts, reports and other accounts within the official scope of their duties, shall not be subject to inspection except upon permission given by the Corrections Division in compliance with subsection (3), (4), (6), (7), (9), (10), (12) or (13) of ORS 179.505, or upon order of a court of competent jurisdiction. The restriction contained in this section shall not apply inspection of written accounts made under subsection (3) of ORS 179.505 with the consent of the individual concerned, or in case of his incompetence, by his legal guardian.

(2) Except as authorized under subsection (1) of this section, any person who releases or any person who knowingly obtains information from any record referred to in subsection (1) of this section commits a violation.

[1955 c. 452 & 1; 1969 c. 597 & 44; 1973 c. 736 & 3; 1977 c. 812 & 5]

APPENDIX C

ORS 179.505, INSPECTION OF PATIENT RECORDS
(Sections 4 and 5)

ORS 179.505, INSPECTION OF PATIENT RECORDS
SECTIONS 4 AND 5

179.505 Inspection of patient records; consent; exceptions; scope of use; release to others; penalty (Sections 4 and 5). (4) The content of any written account referred to in subsection (2) of this section may be released without consent:

(a) To any person to the extent necessary to meet a medical emergency.

(b) At the discretion of the responsible officer of the provider, which in the case of any Mental Health Division facility or community mental health program shall be the Assistant Director for Mental Health, to persons engaged in scientific research, program evaluation, peer review and fiscal audits. However, patient identities shall not be disclosed to such persons, except when the disclosure is essential to the research, evaluation, review or audit or when the disclosure benefits the provider or patient.

(c) To governmental agencies when necessary to secure compensation for services rendered in the treatment of the patient.

(5) When a patient's identity is disclosed under subsection (4) of this section, a provider shall prepare, and include in the permanent records of the provider, a written statement indicating the reasons for the disclosure, the written accounts disclosed and the recipients of the disclosure.

NOTICE OF DISCLOSURE

With the authorization of Dr. J. H. Treleaven, Assistant Director, Human Resources, Administrator for Mental Health, under the authority of ORS 179.505 (4) (b), this client's chart was reviewed in August or September, 1980 for the purpose of a research study conducted by Mildred S. Braunstein, R.N., graduate student in nursing at the University of Oregon Health Sciences Center, School of Nursing, Portland, Oregon. A copy of the research protocol, titled "A Comparison of Involuntarily Detained Mentally Disordered Individuals, Civil vs. Criminal Holds" is on file with the State Mental Health Division of Oregon.

APPENDIX D

DATA SHEET

DATA SHEET

Code Name: _____ Age: _____ Sex: _____ Race: _____

Date Hold Was Placed: _____ Time of Day: _____ Day of Week: _____

Legal Status:

Civil		Criminal			
Emergency Hold	_____	Violent Crime	_____	Sex Crime	_____
Peace Office Hold	_____	Potentially Violent Crime	_____	Drug Crime	_____
Physician Hold	_____				
Commitment	_____	Minor Crime	_____	Crime Against Property	_____

Place of Incident:

Public	_____
Private	_____

Source of Complaint:

Family	_____	Citizen	_____
Agency	_____	Other	_____
Health Professional	_____		

Initial Contact to Gain Service:

Public Agency	_____
Mental Health Clinic	_____
Hospital	_____
Private Practitioner	_____
Physician	_____
CIRT	_____
Other	_____

Law Enforcement Agency Involved:

Eugene Police	_____
Springfield Police	_____
Sheriff	_____
Other	_____
None	_____

Events Leading to Arrests or Filing of Petition:

_____

_____

_____

Prior Attempts to Gain Mental Health Services:

_____

_____

_____

Prior Attempts to Have the Individual Civilly Committed:

_____

_____

_____

Education Level:

Grade School	_____	College	_____
High School	_____	Trade School	_____

Marital Status:		Employment During Past Month:	
Single	_____	Unemployed	_____
Married	_____	Sheltered	_____
Divorced	_____	Competitive	_____
Separated	_____	Unskilled	_____
Widow(er)	_____	Semiskilled	_____
Unknown	_____	Skilled	_____

Living Stiuation During Past Month:

(Medical) Institution	_____	Independent Setting	_____
Supervised Setting	_____	Transient	_____

Support Systems:

Family	_____	Private Agency	_____
Friends	_____	Church	_____
Public Agency	_____	Other	_____

Number of Admissions to OSH During Past Four Years: _____

Number of Arrests in Lane County During Past Four Years: _____

Diagnosis (if known): _____

Final Disposition:

_____

_____

_____

_____

_____

APPENDIX E

OBSERVATIONAL TOOL - DEVIANT BEHAVIOR

OBSERVATIONAL TOOL - DEVIANT BEHAVIOR

I. PSYCHOLOGICAL DISORGANIZATION	0 Not Present	1 Very Mild	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extremely Severe
1. SOMATIC CONCERNS - preoccupation with physical health, fear of physical illness, hypochondriasis.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
2. ANXIETY - worry, fear, over-concern for present or future.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
3. EMOTIONAL WITHDRAWAL - lack of spontaneous interaction, isolation, deficiency in relating to others.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
4. CONCEPTUAL DISORGANIZATION - thought processes confused, disconnected, disorganized, disrupted.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
5. GUILT FEELINGS - self-blame, shame, remorse for past behavior.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
6. TENSION - physical and motor manifestations or nervousness, over-activation, tension.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
7. MANNERISMS AND POSTURING - peculiar, bizarre, unnatural motor behavior (not including tic).	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
8. GRANDIOSITY - exaggerated self-opinion, arrogance, conviction of unusual power or abilities.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
9. DEPRESSIVE MOOD - sorrow, sadness, despondency, pessimism.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

I. PSYCHOLOGICAL DISORGANIZATION (continued)	0 Not Present	1 Very Mild	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extremely Severe
10. HOSTILITY - animosity, contempt, belligerence, disdain for others.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
11. SUSPICIOUSNESS - mistrust, belief others harbor malicious or discriminatory intent.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
12. HALLUCINATORY BEHAVIOR - perceptions without normal external stimulus correspondence.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
13. MOTOR RETARDATION - slowed weakened movements or speech, reduced body tone.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
14. UNCOOPERATIVENESS - resistence, guardedness, rejection of authority.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
15. UNUSUAL THOUGHT CONTENT - unusual, odd, strange, bizarre thought content.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
16. BLUNTED AFFECT - reduced emotional tone, reduction in normal intensity of feelings, flatness.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
17. EXCITEMENT - heightened emotional tone, agitation, increased reactivity.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
18. DISORIENTATION - confusion or lack of proper association for person, place or time.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

II. DANGEROUSNESS

In the past week, to what degree has the patient:

	Problem Not Present	VERBAL THREAT		ATTEMPT	
		No Plan	Plan	Not Life Threat-ening	Life Threat-ening
	0	1	2	3	4
1. Behaved in a manner dangerous to self:					
a. Self-Mutilization	[ ]	[ ]	[ ]	[ ]	[ ]
b. Suicide	[ ]	[ ]	[ ]	[ ]	[ ]
2. Behaved in a manner dangerous to others:	[ ]	[ ]	[ ]	[ ]	[ ]

	No	Minimal	Moderate	Frequent	Continuous
	0	1	2	3	4
3. Requires close monitoring and supervision for life threatening condition.	[ ]	[ ]	[ ]	[ ]	[ ]

III. ABILITY TO PROVIDE FOR BASIC LIFE SUSTAINING NEEDS

To what degree does the patient require assistance with:	None 0	Minimal 1	Moderate 2	Frequent 3	Complete 4
A. Basic					
1. Hygiene	[ ]	[ ]	[ ]	[ ]	[ ]
2. Dressing	[ ]	[ ]	[ ]	[ ]	[ ]
B. Eating	[ ]	[ ]	[ ]	[ ]	[ ]
C. Medical	[ ]	[ ]	[ ]	[ ]	[ ]

IV. ANTISOCIAL BEHAVIORS	Never	Rarely	Occasionally	Frequently	Often
Does this patient:	0	1	2	3	4
1. Disrobe/Expose Self	[ ]	[ ]	[ ]	[ ]	[ ]
2. Sexually Disturb/Disrupt Others	[ ]	[ ]	[ ]	[ ]	[ ]
3. Sexually Threaten or Assault Others	[ ]	[ ]	[ ]	[ ]	[ ]
4. Steal	[ ]	[ ]	[ ]	[ ]	[ ]
5. Hoard	[ ]	[ ]	[ ]	[ ]	[ ]
6. Antisocially Dispose of Excreta	[ ]	[ ]	[ ]	[ ]	[ ]
7. Destroy Property	[ ]	[ ]	[ ]	[ ]	[ ]
8. Constitute a Fire Hazard	[ ]	[ ]	[ ]	[ ]	[ ]
9. Physically Abuse Self	[ ]	[ ]	[ ]	[ ]	[ ]
10. Physically Assault Others	[ ]	[ ]	[ ]	[ ]	[ ]
11. Exhibit Temper Tantrums	[ ]	[ ]	[ ]	[ ]	[ ]
12. Verbally Abuse Others	[ ]	[ ]	[ ]	[ ]	[ ]
13. Otherwise Disturb/Disrupt Others	[ ]	[ ]	[ ]	[ ]	[ ]
14. Require Physical Restraint for Behavior	[ ]	[ ]	[ ]	[ ]	[ ]

V. DRUG INVOLVEMENT

At this time, what degree do the following interfere with daily activities:	Problem Not Present	PROBLEM PRESENT			
		No Interference	Mild Interference	Moderate Interference	Severe Interference
	0	1	2	3	4
1. Illicit Drug Use	[ ]	[ ]	[ ]	[ ]	[ ]
2. Alcohol Use	[ ]	[ ]	[ ]	[ ]	[ ]
3. Medication Side Effects	[ ]	[ ]	[ ]	[ ]	[ ]

APPENDIX F

USE OF THE BRIEF PSYCHIATRIC RATING SCALE

BRIEF PSYCHIATRIC RATING SCALE

The Brief Psychiatric Rating Scale (BPRS) rates the severity of the patient's psychiatric symptoms on 18 measures. The rater is to rate the patient on the seven point scale provided on the scoring sheet by degrees ranging from "not present" to "extremely severe". The first six scores are based upon observation of the patient, the latter twelve are based upon what the patient says.

Provided below is a description of each of the eighteen constructs, and a guide to their use in the BPRS.

1. SOMATIC CONCERN: The severity of physical complaints should be rated solely on the number and nature of complaints or fears of bodily illness or malfunction, or suspiciousness of them, alleged during the interview period. The evaluation is of the degree to which the patient perceives or suspects physical ailments to play an important part in his total lack of well-being. Worry and concern over physical health is the basis for rating somatic concern. No consideration of the probability of true organic basis for the complaints is required. Only the frequency and severity of complaints are rated.

2. ANXIETY: Anxiety is a term restricted to the subjective experience of worry, overconcern, apprehension, or fear. Rating of degree of anxiety should be based upon verbal responses reporting such subjective experiences on the part of the patient. Care should be taken to exclude from consideration in rating anxiety the physical signs which are included in the concept of tension, as defined in the BPRS. The sincerity of the report and the strength of the experience as indicated by the involvement of the patient may be important in evaluating degree of anxiety.

3. EMOTIONAL WITHDRAWAL: This construct is defined solely in terms of the ability of the patient to relate in the interpersonal interview situation. Thus, an attempt is made to distinguish between motor aspects of general retardation, which are rated as "motor retardation", (13) and the more mental-emotional aspects of withdrawal, even though ratings in the two areas may be expected to covary to some extent. In the factor analyses of change in psychiatric ratings, a "general retardation" factor has emerged in several different analyses, and it has included emotional, affective, and motor retardation items. It is difficult to identify the basis for rating of "ability to relate", (3) however, initial work has indicated that raters achieve reasonably high agreement in rating this quality. Emotional withdrawal is represented by the feeling on the part of the rater that an invisable barrier exists between the patient and other persons in the interview situation. It is suspected that eyes, facial expression, voice quality and lack of variability, and expressive movements all enter into the evaluation of this important but nebulous quality of psychiatric patients.

4. CONCEPTUAL DISORGANIZATION: Conceptual disorganization involves the disruption of normal thought processes and is evidenced in confusion, irrelevance, inconsistency, disconnectedness, disjointedness (blocking, confabulation), autism, and unusual chain of associating. Ratings should be based upon the patient's spontaneous verbal products, especially those longer, spontaneous response sequences which are likely to be elicited during the initial, nondirective portion of the interview. Attention to the facial expression of the patient during the verbal response may be helpful in evaluating the degree of confusion or blocking.

5. GUILT FEELINGS: The strength of guilt feelings should be judged from the frequency and intensity of reported experiences of remorse for past behavior. The strength of the guilt feelings must be judged in part from the degree of involvement evidenced by the patient in reporting such experiences. Care should be exercised not to infer guilt feelings from signs of depression or generalized anxiety. Guilt feelings relate to specific past behavior which the patient now believes to have been wrong and the memory of which is a source of conscious concern.

6. TENSION: This construct is restricted in the BPRS to physical and motor signs commonly associated with anxiety. Tension does not involve the subjective experience or mental state of the patient. Although research psychologists, in an effort to attain a high degree of objectivity, frequently define anxiety in terms of physical signs, in the BPRS observable physical signs of tension (6) and subjective experiences of anxiety (2) are rated separately. Although anxiety and tension tend to vary together, developmental research with the BPRS has indicated that the degree of pathology in the two areas may be quite different in specific patients. A patient, especially when under the influence of a drug, may report apprehension, but give no external evidence of tension whatsoever, or vice versa. In rating the degree of tension, the rater should attend to the number and nature of signs of abnormally heightened activation level such as nervousness, fidgeting, tremors, twitches, sweating, frequent change of posture, hypertonicity of movements, and heightened muscle tone.

7. MANNERISMS AND POSTURING: This symptom area includes the usual and bizarre motor behavior by which a mentally ill person can often be identified in a crowd of normal people. The severity of manneristic behavior depends both upon the nature and number of unusual motor responses. However, it is the unusualness, and not simply the amount of movement, which is to be rated. Odd, indirect, repetitive movements or movements lacking normal coordination and integration are rated on this scale. Strained, distorted, abnormal postures which are maintained for extended periods are rated. Grimaces and unusual movements of lips, tongue, or eyes are considered here also. Tics and twitches which are rated as signs of tension are not rated as manneristic behavior.

8. GRANDIOSITY: Grandiosity involves the reported feeling of unusual ability, power, wealth, importance, or superiority. The degree of pathology should be rated relative to the discrepancy between self-appraisal and reality. The verbal report of the patient and not his demeanor in the interview situation should provide the primary basis for evaluation of grandiosity. Care should be taken not to infer gradiosity from suspicions of persecution or from other unfounded beliefs where no explicit reference to personal superiority as the basis for persecution has been elicited. Ratings should be based upon opinions currently held by the patient, even though the unfounded superiority may be claimed to have existed in the past.

9. DEPRESSIVE MOOD: Depressive mood includes only the affective component of depression. It should be rated on the basis of expressions of discouragement, pessimism, sadness, hopelessness, helplessness, and gloomy thema. Facial expression, weeping, moaning, and other modes of communicating mood should be considered, but motor retardation, guilt, and somatic complaints, which are commonly associated with the psychiatric syndrome of depression, should not be considered in rating depressive mood.

10. HOSTILITY: Hostility is a term reserved for reported feelings of animosity, belligerence, contempt, or hatred toward other people outside the interview situation. The rater may attend to the sincerity and affect present in reporting of such experiences when he attempts to evaluate the severity of pathology in this symptom area. It should be noted that evidences of hostility toward the interviewer in the interview situation should be rated on the uncooperativeness scale and should not be considered in rating hostility as defined here.

11. SUSPICIOUSNESS: Suspiciousness is a term used to designate a wide range of mental experience in which the patient believes himself to have been wronged by another person or believes that another person has, or has had, intent to wrong. Since no information is usually available as a basis for evaluating the objectivity of the more plausible suspicions, the term "accusations" might be more appropriate characterization of this area. The rating should reflect the degree to which the patient tends to project blame and to accuse other people or forces of malicious or discriminatory intent. The pathology in this symptom area may range from mild suspiciousness through delusions of persecution and ideas of reference.

12. HALLUCINATORY BEHAVIOR: The evaluation of hallucinatory experiences frequently requires judgement on the part of the rater whether the reported experience represents hallucination or merely vivid mental imagery. In general, unless the rater is quite convinced that the experiences represent true deviations from normal perceptual and imagery processes, hallucinatory behavior should be rated as not present.

13. MOTOR RETARDATION: "Motor retardation" involves the general slowing down and weakening of voluntary motor responses. Symptomatology in this area is represented by behavior which might be attributed to the loss of energy and vigor necessary to perform voluntary acts in a normal manner. Voluntary acts which are especially affected by reduced energy level include those related to speech as well as gross muscular behavior. With increased motor retardation, speech is slowed, weakened in volume, and reduced in amount. Voluntary movements are slowed, weakened, and less frequent.

14. UNCOOPERATIVENESS: This is the term adopted to represent signs of hostility and resistance to the interviewer and interview situation. It should be noted that "uncooperativeness" is judged on the basis of response of the patient to the interview situation, which "hostility" (10) is rated on the basis of verbal reports of hostile feelings or behavior toward others outside the interview situation. It was found necessary to separate the two areas because of an occasional patient who refrains from any reference to hostile feelings and who even denies them while evidencing strong animosity toward the interviewer.

15. UNUSUAL THOUGHT CONTENT: This symptom area is concerned solely with the content of the patient's verbalization; the extent to which it is unusual, odd, strange, or bizarre. Notice that a delusional or paranoid patient may present bizarre or unbelievable ideas in a perfectly straightforward, clear, and organized fashion. Only the unusualness of the content should be rated for this item, not the degree of organization of disorganization.

16. BLUNTED AFFECT: This symptom area is recognized by reduced emotional tone and apparent lack of normal intensity of feeling or involvement. Emotional expressions are apt to be absent or of marked indifference and apathy. Attempted expressions of feelings may appear to be mimetic and without sincerity.

17. EXCITEMENT: Outer expression of inner excitement. Excitement refers to the emotional, mental, and psychological aspects of increased activation and heightened reactivity. The excited patient tends to be active, agitated, quick, loud, and emotionally responsive. Whereas tension is a construct concerned with physical or motor manifestations of activation, excitement has reference primarily to the mental and emotional areas. Tension usually implies a binding of the physical activation potential, while excitement is the underlying activation potential. The degree of excitement depends on the strength of arousal and heightened affect.

18. DISORIENTATION: This rating construct has been included to provide a place for recording the particular kind of confusion that is evidenced by lack of memory or proper association for persons, places, or times. The disoriented individual may not know where he is, how to relate where he is to other points in the environment, or how to get from one place to another. The identities of persons that should be familiar may be confused. Location in time and place and even personal identify may be confused or unavailable for recall. Distortions in identity such as those that occur in delusional systems should not be rated under disorientation. Disorientation represents the type of confusion that frequently occurs in organic conditions.

From: Overall, J.E. & Klett, J.C. Applied Multivariante Analysis. New York: McGraw-Hill, 1972, 6-10.

BRIEF PSYCHIATRIC RATING SCALE - SYNDROME FACTORS

From: Overall, J.E. & Klett, J.C. Applied Multivariante Analysis. New York: McGraw-Hill, 1972, 12.

Syndrome factor scores are derived as the summ of three separate rating items as follows:

1. Thinking Disturbance
   - Conceptual disorganization
   - Hallucinatory behavior
   - Unusual thought content
2. Withdrawal - Retardation
   - Emotional withdrawal
   - Motor retardation
   - Blunted affect
3. Hostile - Suspiciousness
   - Hostility
   - Suspiciousness
   - Uncooperativeness
4. Anxious Depression
   - Anxiety
   - Guilt feelings
   - Depressive mood

APPENDIX G

SUBJECT'S SCORE ON BRIEF PSYCHIATRIC RATING SCALE

TABLE A

Score on Brief Psychiatric Rating Scale
Civil Hold - Non Police

Subject Number	B-2	B-4	B-8	B-9	B-10	B-17	B-18	
Overall Total Score	10	7	4	5	10	7	11	
Thinking Disturbance	3	1	0	0	2	1	3	
Hostility-Suspiciousness	3	3	0	1	3	2	2	
Withdrawal-Retardation	2	1	2	1	1	1	1	
Anxiety-Depression	0	1	2	1	0	1	1	
Other	2	1	0	0	4	2	4	

Score on Brief Psychiatric Rating Scale
Civil Hold - Police

Subject Number	B-3	B-5	B-6	B-7	B-12	B-15	B-16	B-19	B-20
Overall Total Score	8	7	11	8	10	6	8	6	9
Thinking Disturbance	2	2	2	2	2	2	3	0	3
Hostility-Suspiciousness	3	3	3	3	3	3	1	2	2
Withdrawal-Retardation	3	0	1	0	3	2	0	2	3
Anxiety-Depression	0	0	2	1	0	1	0	0	1
Other	0	2	3	2	2	0	2	2	0

Score on Brief Psychiatric Rating Scale
Criminal Hold

Subject Number	A-1	A-2	A-3	A-4	A-5	A-6	A-7	A-8	A-9	A-10
Overall Total Score	12	11	11	7	9	6	8	10	10	7
Thinking Disturbance	3	3	2	3	2	3	1	3	2	2
Hostility-Suspiciousness	1	3	3	1	3	1	0	3	3	0
Withdrawal-Retardation	3	1	1	1	2	0	3	1	2	3
Anxiety-Depression	2	0	2	0	1	0	2	1	1	1
Other	3	4	3	2	1	2	2	2	2	1

APPENDIX H

CASE SUMMARIES

Case Summary - Number 1

Sally (B-12) is a 37 year old female who was hospitalized on an emergency basis at 5:00 one Thursday morning. She was brought in to the emergency room by the police who had detained her in an apartment. Staff from the community shelter house related to the police that Sally had been staying at the shelter for one week prior to the detention. During this week she had refused to eat and had been sleeping poorly. Staff had encouraged voluntary hospitalization at the state hospital, but had failed. The morning the police were called, Sally had walked into a stranger's apartment and had refused to leave. In the process of removing her, Sally bit an elderly man in the leg, kicked an officer in the groin, tried to throw another officer off the balcony, then tried to jump off the balcony herself. Sally was yelling, screaming, and babbling all the way to the emergency room.

Case Summary - Number 2

Dick (A-3) is a 29 year old transient who was charged with assault and battery. Two grocery store clerks were attempting to detain a shoplifter when Dick approached them and yelled, "let him go" and kicked one of the clerks in the back. The clerk complained of extreme pain resulting from the kick and filed charges against Dick. Three months prior to this arrest, he was arrested two times, once for "unreasonable, loud and raucious noise" and once for having a prohibited weapon.

During the intake interview, Dick stated that two men were beating up another man and he intervened, stating that the clerks were, "ganging up on the poor". Dick expressed many paranoid ideas saying he had difficulty finding a place to live because the "Argentineans were throwing bolos" at him and the government was trying to kill him. He was convinced that the apartment manager had put amphetamines in his water. Most of his communication centered on somatic complaints. Dick said he has "cancer and cystic fibrosis" caused by "beryllium poisoning and exposure to x-rays" and he would die any time.

Case Summary Number 2 (continued)

In two days Dick was released, then one week later he was rearrested. The police report notes that two officers "observed the subject sitting, talking to himself. As two people walked by, the subject yelled 'you hypocrites'. About 45 minutes later he was observed at the fountain. He reached down and pulled out a metal object and yelled, 'I know where this goes'. He walked barefoot four blocks, slammed the metal object down onto a fire hydrant. Then he turned and hit a no parking sign with his closed fist." The officer further noted that "Due to the subject's observed criminal activity and the likelihood of his continued criminal behavior, he was taken into custody". Dick was charged with littering.

During this incarceration, Dick was secluded. He was uncooperative, disruptive and considered unpredictable. He was observed to sit in a corner at times and cry, and at other times he was in a fetal position. Dick yelled at sporatic intervals and talked aloud to himself. He was released after serving two days.

Records show that Dick was referred to the Emergency Services team one month prior to his arrest for having been evicted from a motel because of his agitation and disruptive behavior. He had not eaten for three days. Housing was arranged at an emergency shelter and Dick was given an appointment with the mental health clinic's offenders program. Dick gave a history of difficulties with the police since age 16 with numerous arrests for disturbing the peace, vagrancy, fighting, possession of marijuana..., and in early 1972 he served three and half years in Vacaville, California on an assault charge. By history, Dick had only been hospitalized one time. He was court committed in Florida in 1972.

Dick was seen by the clinic's psychiatric who suggested he take a neuroleptic drug. He became uncooperative and demanded valium, refusing any antipsychotic medication. Two weeks later, and five days prior to his arrest on the assault charge, Dick had been in the clinic, threatening suicide if he did not get valium. The psychologist evaluated Dick to be in no current danger to himself and asked that he leave the clinic.

Case Summary - Number 3

John (A-8) is a 26 year old transient sentenced to 14 days for disorderly conduct. He had been standing out in the street yelling and screaming profanities one afternoon. A citizen called the police and filed a complaint. Jail records show that this was John's third arrest in a little over a month. His first arrest when a citizen called the police to complain that John was taking things from a Goodwill Box. John told the officer he had no money. He was charged with petty larceny and served four days in jail.

During his intake interview at his first arrest, John said that both welfare and social security had refused him assistance. He gave a history of having been hospitalized at University Hospital in San Diego, March, 1979-1980 for schizophrenia. At this time he was friendly, cooperative, nervous and jittery.

John was released from jail without having been seen by any of the program staff. Four days later he was returned to jail, charged with assault and battery, and criminal mischief II. The police report shows that a young lady heard yelling and screaming and went out to check. John called her many "vulgar names" and broke the antena off her car. Other citizens became involved, made a citizen's arrest, and called the police.

At this booking, John appeared to be hallucinating. He was carrying on an argument with a nonexistant woman and became very physical, threatening to kill everyone. During the next week he frequently yelled out and his speech was incoherent. The jail psychologist evaluated him and felt commitment was appropriate; however, John was released with a suspended sentence before the process for commitment was initiated. Eleven days later he was rearrested on his current charge and was quickly sentenced. He had to be secluded because of his hostile behavior. Four days after booking he was seen by the psychiatrist and was started on prolixin. He is being maintained in a special unit within the jail while he serves his time.

Case Summary - Number 4

Jane (A-1) is a 24 year old female who was arrested for the first time. She was charged with trespassing at a community hospital. At booking, Jane was withdrawn, appeared confused, was guarded when questioned and requested to be hospitalized, stating, her "heart was stopping". Jane related that she had gone to the hospital because she was "tingling all over" and had "passed out", but the doctor would not admit her. She had refused to leave the hospital, so was arrested. Jane persisted with her somatic complaints, saying someone was "frying her soul".

A review of the records at the Mental Health Clinic revealed that Jane was well known to the emergency services team. Her first contact was in the fall of 1977 when she was admitted to the state hospital, depressed after an abortion. She was rehospitalized a year later on the psychiatric unit of a local hospital when she was "physically abusing herself". Her next recorded hospitalization was in May, 1980, again at the psychiatric unit of the local hospital.

During the three months prior to her arrest, Jane had had several contacts with the staff of the Emergency Services team. After her discharge from the hospital in May, Jane requested readmission because her "heart was stopping" and "too much energy was coming from her head". She was evaluated as being "manipulative" and "seeking contact and attention". The record shows that the psychiatrist from the psychiatric unit suggested to the social worker that outpatient treatment for Jane was more appropriate, and hospitalization should be avoided if possible, stating that Jane, "had failed to keep her outpatient appointment, was probably a chronic schizophrenic who was resistant to treatment". And he further stated that she "does not cooperater with treatment, e.g. refuses antipsychotic medication, refuses many half-way house or foster home placements; has seen many therapists, but does not follow through; demands treatment, then sabotages it".

Over the course of the summer, a pattern continued where Jane requested hospitalization and the social workers referred her to outpatient treatment. She was taken to the emergency room or the mental health

Case Summary - Number 4 (continued)

clinic eight times by a crisis counselor, her family, and the police, complaining of "hearing thoughts broadcast concerning herself and Jesus". She felt that she had "psychic energy" and was "afraid of coming out of her head and hurting people".

Jane's family was concerned because Jane was so afraid she would not leave her apartment and was calling her family at all hours of the night. The D.A.'s office complained to the Emergency Services staff because Jane had been calling the D.A.'s office "over and over, and over..." Jane also began persistently calling the police who finally, on one occasion, took her to the emergency room.

The social workers repeatedly gave Jane outpatient appointments which she was sporadic in keeping. The clinic psychiatrist prescribed lidone for Jane which she refused to take, insisting that she wanted sinequan which she had been taking earlier in the spring. During the week prior to arrest Jane began wandering around a local hospital. The social worker referred her to a private physician for her somatic complaints and Jane was told she would be arrested if she didn't leave the hospital. She then went to the hospital in a neighboring community. Again she was referred to the mental health clinic. Jane persisted, going to the local police station, then back to the hospital where she continued to wander and disrupt the wards. Finally she was arrested.

The judge sentenced Jane to two days in jail. Within 24 hours of her release, Jane was rearrested, again for trespassing at the same hospital. This time Jane was agitated when booked in the jail, and appeared more confused than previously. During her stay she neglected her personal hygiene and spent long periods of time hiding in the bathroom. The rest of the time, she paced. Any conversation centered around concern that "Forrest was trying to take over" her body. The jail psychologist evaluated Jane to be acutely psychotic and requested that charges be dropped so Jane could be sent to the state hospital on a civil basis. The D.A. refused to drop charges, so one week after arrest, Jane was sent to the psychiatric secure unit of the state hospital on a court order after being found unfit to proceed. A month later, Jane was still at the hospital, not responding to treatment, and

Case Summary - Number 4 (continued)

still psychotic.

Case Summary - Number 5

Bill (A-6) is a 24 year old transient from Washington who was charged with theft of a bicycle. At the time of the initial interview, Bill was cooperative and friendly. Although there was no sign of hallucinations at this time, Bill was somewhat grandious. His thought processes were confused and his speech disorganized. Bill was unable to abstract and his judgement and insight were poor. He told the interviewer that he was arrested for "being a nice person". He had staged a protest to "let the people know what the wealthy are doing". Bill said he was pulling things out of a Goodwill Box, "waiting around to be busted, to protest". He claimed that his arrest would demonstrate that the staff of the Salvation Army take the items of value for themselves.

A review of the arrest report shows that the officer was dispatched on a complaint of theft from a Goodwill Box. Bill was going through property around the box, telling the officer that he thought the property was free. Bill then went to get a bike. Upon questioning, the officer determined that the bike was stolen. Bill even took the officer to the site where the bike had been taken from.

Bill had served three days in jail for disorderly conduct two weeks prior to this arrest. At that time the corrections officer reports he had observed Bill to be quite "crazy". Bill had been jumping around in his cell, talking loudly in an irrational manner, often pounding on the wall.

Records at the mental health clinic show that Bill had been hospitalized on a voluntary basis at the State Hospital four days after his first arrest. At the time of hospitalization, Bill was quite delusional and had a badly infected finger. He had received an injection of prolixin and calmed down somewhat, and in four days he requested to be discharged. He was given a full discharge with no arrangements being made

Case Summary - Number 5 (continued)

for follow-up in the community. Hospital records show that Bill was considered to be a paranoid schizophrenic with a history of three prior psychiatric hospitalizations in Washington since age 15. The second hospitalization was for two years and eight months.

Two days prior to his arrest, and four days after his return from the hospital, Bill was taken by ambulance to the emergency room, complaining of "visual difficulties secondary to marijuana". The social worker from the Emergency Services team referred him to a local crisis center and aide station, who reported to the mental health clinic that Bill was "not amenable to treatment we can offer him."

Bill's attorney posted bail after two weeks and Bill was released from jail. The next day an officer cited Bill for having a "prohibited slugging weapon". The police report notes that the officer "observed the subject sitting on a bench playing a radio and singing. He was wearing a woman's plaid sleevless blouse and a string of multi colored beads around his neck". The officer "noted a white wrapped wooden stick next to him. The subject said the stick was for 'protection against especially gays' and others who might try to assault him". The officer noted he had arrested the subject the previous month for disorderly conduct. Two weeks later, Bill was arrested for failure to appear for the weapon charge and is currently awaiting trial.

Case Summary - Number 6

Herb (A-7) is a 30 year old transient from Florida arrested for public indency. This was his second arrest in the county. Six weeks previously he had served four days in jail for stealing some socks from a grocery store. During the initial interview, Herb answered all questions with "no" and would not respond to open ended questions, frequently asking the questions be repeated. Eye contact was poor, affect was flat, and his voice was soft. During the interview Herb was restless, continually shifting his position.

Case Summary - Number 6 (continued)

A review of records at the mental health clinic found that Herb had been evaluated in the emergency room of the hospital three times within the previous two weeks by a social worker from the Emergency Services team. at the first evaluation, 12 days prior to arrest, Herb came to the hospital complaining that his "heart was skipping beats" and he "had cancer". He was given valium and sent home. The next day he returned to the emergency room, convinced that he had cancer. The record shows that he was found to be "oriented and rational" and was sent home. Four days later Herb was brought to the emergency room by the police where he was treated for exposure, malnourishment, dehydration and blisters. He had been sleeping in the grass and had not eaten for three days. He continued to be preoccupied with somatic concerns. At this time he gave a history of previous psychiatric hospitalizations in Florida. The social worker arranged for a voluntary admission to a Veterans Administration hsopital in a community 70 miles away, purchased a bus ticket for Herb, and left him at the bus depot.

The day of the arrest, an officer was dispatched to investigate a report of a naked man. Herb was found completely naked, sitting in a parking lot close to the fairgrounds, situated such that any traffic would be likely to see him. In his property he had 50¢, $13 of food stamps, and a bus ticket to Roseburg. Herb was sentenced to five days. The jail psychologist arranged for transportation, and upon release from jail, Herb was taken to the Veterans Administration hospital where he was admitted on a voluntary basis.

Case Summary - Number 7

Robert (A-2) is a 29 year old young man who was arrested for disorderly conduct. A local downtown business owner had signed a citizen's arrest because he had been annoyed by Robert's behavior. The police report shows that Robert would approach to complainant and look him up and down. He would then "say an unknown word and start laughing and walk away". This had occurred on a daily basis for four months, with

Case Summary - Number 7 (continued)

Robert "staring and laughing" at several people daily, frequently "saying unknown words", shaking his head. The complainant said Robert continually "tries to intimidate" him. Robert is reported to have spanked a 12 year old boy on the mall for smoking a cigarette.

Records show that this was Robert's fifth misdemeanant arrest. Two previous arrests were in 1978. A month after these arrests he was admitted to a Veterans Administration hospital on a voluntary basis. (Robert was discharged from the service in October of 1970 after having spent 14 ½ months in Vietnam). Two months previous to this arrest, Robert served 16 days in jail on a littering charge. Two weeks later he was arrested on an assault charge. His former wife filed the complaint stating that Robert had "physically forced her into his apartment by dragging her by her shirt collar" after having beat her for four hours. The police report shows that she stated that Robert "punched her while he spoke of being Jesus". Robert was released on his own recognizance and is still awaiting trial on this charge.

Emergency Service records note that Robert's father called one week prior to the arrest, concerned because Robert was delusional, physically run down, and unable to look after his needs. They had been providing him with food. The social worker told Robert's father how to file a petition for commitment.

During the time Robert was in jail, he was very delusional and grandious, stating that he was the "middle man on the planet, taking care of God's stead". After two weeks in jail, Robert was taken to trial. The judge, upon observing Robert's inappropriate behavior, ordered that he be immediately taken to the hospital, where he was emergency committed. A week after his hospitalization, Robert was reported to be missing from the hospital. The next week, Robert's father called the police to alert them that Robert was back in town. He was found at the mall and again sent to the State Hospital on an emergency commitment. Upon arrival at the hospital he was sent to a locked ward.

Case Summary - Number 8

Paul (A-4) is a 29 year old single, unemployed young man with a history of 15 prior arrests for minor charges in the county over a seven year period. He was arrested on a warrant for violating the terms of a release agreement on an arrest for shoplifting which took place eight months ago (he had left the state for a few days). Paul waived trial by jury and was found not guilty of theft II by reason of mental disease or defect. He was ordered to Oregon State Hospital to remain one year or until earlier release by order of the Psychiatric Review Board.

Records at the mental health clinic show that Paul has been seen as an outpatient for several years with his first emotional problems beginning at age 15. In 1976, he spent four months at Oregon State Hospital on a civil court commitment and was diagnosed as a paranoic schizophrenic. This is his only recorded hospitalization for mental illness. Jail records show that Paul was generally maintained on neuroleptics during each of his previous incarcerations.

According to mental health records, Paul lived by himself with his parents and four brothers in the area. At one time, he had worked with his father in the mill. On file with the emergency services team were two recent police reports. The first, dated four months prior to Paul's arrest, was an investigation of a report that a neighbor was being bothered by Paul. The neighbor related that Paul was a "mental case, who up till now had not posed an immediate threat to himself or others; but who now was becoming more and more aggressive". The officer contacted Paul who appeared very confused. The report notes Paul "admitted to me his hallucinations of many and varied types; hearing voices, seeing things, and talking with people who were not there". Further, Paul told the officer, "he thought that many people were 'out to get him' including, the government, the Mafia, some of his doctors, and the neighbor". The officer notes that he suggested that Paul see a doctor or obtain some professional help with his problem, and Paul "appeared receptive to his idea". The officer also contacted Paul's mother by telephone and advised her of Paul's condition. She said she would try to get help

Case Summary - Number 8 (continued)

for Paul immediately. The officer also sent a copy of the report to the emergency services team.

The second police report was two months prior to Paul's arrest. A different officer investigated a report of Paul trespassing. Another neighbor had been awakened by noises coming from the rear of her residence. She observed Paul standing on the back porch of her residence. The complainant related that she has become "terrified" of Paul because "he has in the past entered her residence with no reason other than to 'just be there'". The officer contacted Paul at his residence and advised him that his neighbor did not want him on her property and that "should he repeat that activity, he would be arrested for trespassing". The officer further noted, "It is my opinion that Paul should be re-evaluated by mental health services if this behavior continues". The report then was sent to the emergency services team. Although both reports were in Paul's file, there were no notes by a social worker related to either of them.

ABSTRACT

AN ABSTRACT OF THE THESIS OF

MILDRED SHARON BRAUNSTEIN

For the MASTER OF NURSING

Date of Receiving this Degree: June 12, 1981

Title: A COMPARISON OF INVOLUNTARILY DETAINED MENTALLY DISORDERED INDIVIDUALS, CIVIL V.S. CRIMINAL HOLDS

Approved: _____

Susan Will, R.N.,M.S.N., Assistant Professor, Thesis Advisor

During a six week period an exploratory ex-post facto field study was conducted in an Oregon county to determine what individual characteristics and what aspects of the civil and criminal systems influence the decision to arrest the acutely disorganized mentally disordered person rather than detain the person on a civil hold. All mentally disordered individuals in the county who met the study criteria and who were detained involuntarily during the study period were included. Specific data related to personal characteristics and local mental health and law enforcement systems were gathered on each subject by reviewing agency records, interviewing subjects at the jail, and informal interviews with agency staff.

Twenty-six mentally ill individuals met the study criteria and were grouped according to type of detention: those who were hospitalized (N=16) and those who were arrested (N=10). Of those who were hospitalized, nine were detained by the police. Adults ages 20 to 39 comprized 85% of the total group with 13 male subjects and 13 females. Most subjects were

unemployed and were single, separated, divorced or widowed. Seventeen were diagnosed as schizophrenic. The group who were arrested had more male subjects than the hospitalized group and were more deficient in living and social skills with a greater number of individuals who were transient with no local support systems. There appeared to be little difference in the deviant behaviors of these groups. More individuals who were arrested had a history of prior arrests while those individuals who were hospitalized had more prior hospitalizations. Individuals in this study were more likely to be arrested if the incident which led to the detention occurred in a public place and if a citizen called the police whereas the police took the mentally ill person to the hospital when a family member or friend had called for help.