

1975

Indefinite Commitment in a Mental Hospital for the Criminally Insane: Two Models of Administration of Mental Health

Aldo Piperno

Follow this and additional works at: <https://scholarlycommons.law.northwestern.edu/jclc>

 Part of the [Criminal Law Commons](#), [Criminology Commons](#), and the [Criminology and Criminal Justice Commons](#)

Recommended Citation

Aldo Piperno, Indefinite Commitment in a Mental Hospital for the Criminally Insane: Two Models of Administration of Mental Health, 65 J. Crim. L. & Criminology 520 (1974)

This Criminology is brought to you for free and open access by Northwestern University School of Law Scholarly Commons. It has been accepted for inclusion in Journal of Criminal Law and Criminology by an authorized editor of Northwestern University School of Law Scholarly Commons.

INDEFINITE COMMITMENT IN A MENTAL HOSPITAL FOR THE CRIMINALLY INSANE: TWO MODELS OF ADMINISTRATION OF MENTAL HEALTH

ALDO PIPERNO*

Several states have enacted legislation providing for the indefinite commitment of the mentally ill, psychopathic or sexual psychopathic offender. This commitment is frequently in state facilities entitled "mental hospital for the criminally insane."¹ The statutes permitting such commitment also provide for the identification, classification, hospitalization and eventual release of the offenders. Although differences exist in the language of these statutes, there are similarities in their characterization of the offender and in their statements of the purpose of the statutes. The offender is identified as a person who exhibits criminal

* J. D., Research Associate, Center for the Study of Crime and Delinquency, Ohio State University.

¹ See, e.g., CAL. WELF. & INST'NS CODE §§ 5500 to-22 (1966); COLO. REV. STAT. ANN. §§ 39-19-1 to-10 (1963); CONN. GEN. STAT. ANN. §§ 17-244 to-257 (1958); D. C. CODE ANN. §§ 22-3501 to-13511 (1967); FLA. STAT. ANN. §§ 917.12 (Supp. 1964); ILL. REV. STAT. ch. 38, §§ 105-1.01 to-12 (1954); IND. ANN. STAT. §§ 9-3401 to-3412 (Burns 1956); IOWA CODE ANN. §§ 225 A.1 to-15 (Supp. 1966); KAN. STAT. ANN. §§ 62-1534 to 1537 (1964); MASS. ANN. LAWS. ch 123A, §§ 1-11 (1965); MINN. STAT. ANN. 526.09 to-11 (1945); MO. ANN. STAT. §§ 202.700 to-770 (1959); NEB. REV. STAT. §§ 29-2901 to-2907 (1964); N.H. REV. STAT. ANN. §§ 173.1 to-16 (1964); N.J. STAT. ANN. §§ 2A. 164-3 to-13 (1953); OHIO REV. CODE ANN. §§ 2947.24 to-29 (Supp. 1964); ORE. REV. STAT. §§ 137.111 to-119 (Supp. 1964); S.D. CODE §§ 13.1727 (Supp. 1960); TENN. CODE ANN. §§ 33-1301 to-1305 (Supp. 1966); UTAH CODE ANN. §§ 77-49-1 (Supp. 1965); VT. STAT. ANN. tit. 18, §§ 2811-16 (1959); VA. CODE ANN. §§ 53-278.2 to-4 (1958); WASH. REV. CODE ANN. §§ 71.06.010 to-260 (1962); W. VA. CODE ANN. §§ 2666(1), (2) (1961); WIS. STAT. ANN. §§ 959.15(1) (1958); WYO. STAT. ANN. ch. 7, §§ 348-57 (1957).

For studies focusing on the sociological, medical and legal problems inherent in these statutes, see S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* 341-75 (1971); N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 169-209 (1971); R. QUINNEY, *THE SOCIAL REALITY OF CRIME* 82-86 (1970); Sutherland, *The Sexual Psychopath Laws*, 40 J. CRIM. L.C. and P.S. 543 (1950); Swanson, *Sexual Psychopath Statutes*, 51 J. CRIM. L.C. and P.S. 215 (1960).

tendencies and constitutes a menace to society. The purpose of the statute is described as the control of the possible "predicted" occurrence of behavioral events which endanger society.²

While the statutes focusing on the control of "predicted" dangerousness seek the protection of society, recent court decisions have progressively emphasized concern for the procedural protection of the mentally ill or psychopathic offender. This concern has arisen through the theory of an institutionalized right to treatment. For example, Judge Bazelon of the Court of Appeals for the District of Columbia stated that "[t]he purpose of involuntary hospitalization is treatment, not punishment. . . . Absent treatment, the hospital is transformed into a penitentiary. . . . Absence of treatment might draw into question the constitutionality of this mandatory treatment."³

The possible unconstitutionality of the commitment statutes represents only one aspect of the problem of indefinite commitment. There are also serious problems relating to the implementation of the statutes. In *Pearson v. Probate Court*,⁴ the Supreme Court recognized the due process problems inherent in the administra-

² See, e.g., COLO. REV. STAT. ANN. §§ 39-19-1 (1963): "[A]ny such person . . . [who] constitutes a threat of bodily harm to members of the public or is an habitual offender . . ."; FLA. STAT. ANN. §§ 917-12 (Supp. 1964): "[A]ll persons . . . coupled with criminal propensities to the commission of sex offenses and who may be considered dangerous to others"; IOWA CODE ANN. §§ 225A.1 (Supp. 1966): "[A]ll persons . . . having criminal propensities . . . and who may be considered dangerous to others"; OHIO REV. CODE ANN. §§ 2947.24 (Supp. 1964): "[A]ny person . . . who exhibits criminal tendencies and who by reason there of is a menace to the public . . ."; ORE. REV. STAT. §§ 137.111 (Supp. 1963): "Any person . . . who has mental or emotional disturbances, deficiency or condition predisposing him to the commission of a crime to a degree rendering the person a menace to safety of others."

³ *Rouse v. Cameron*, 373 F.2d 451, 452-53 (D.C. Cir. 1966) (footnote omitted).

⁴ 309 U.S. 270, 276-77 (1939).

tion of such statutes. More recently, the Court of Appeals for the Fourth Circuit held that the Maryland indefinite commitment statute was "facially constitutional," but directed the district court to determine whether the statute was being constitutionally applied.⁵ The court noted that a statute, although fair on its face and impartial in appearance, "may be fraught with the possibility of abuse in that if not administered in the spirit in which it is conceived it can become a *mere device for warehousing the obnoxious and antisocial elements of society.*"⁶

This study analyzes one aspect of the implementation of this legislation: the factors which impinge on the mental hospital staff's decision to continue or terminate the offender's indefinite commitment. The mental hospital is viewed as that part of "community screening" which separates, officially labels and processes the mentally ill or psychopathic offender. In this sense, the mental hospital's relevance for research as the major structure of the system of mental health administration is derived from, and parallel to, the criminal court as the major structure of the system of criminal justice administration.⁷ This study adopts an organizational perspective which suggests that control agencies (the mental hospital for the criminally insane in this case) operate in ways that minimize the strains and maximize the rewards for the organizations.⁸

THE METHOD

The data for this study were collected from the records of a mental hospital for the criminally insane located in a midwestern state. The mental hospital records included the criminal and mental health history of the patient and certain socio-biographical variables. Information concerning the institutional life of the patient (in cases where an indefinite commitment has been recommended and authorized by the

court) includes: records of the prescribed therapy and the patient's performance; notations of any unusual incidents during the institutionalization and the action taken by the staff; records of medical examinations; and lists of all contacts of the patient with individuals outside of the hospital.

The research population consisted of a ten per cent random sample of the records of all male patients committed for an indefinite period under the provisions of the state psychopath law during the period 1965-71, but released prior to August 1, 1973 (N=103). Additional information on the problems relating to the enactment of psychopathic offender statutes was obtained from the proceedings of several statewide seminars in 1972 and 1973 in which hospital doctors, judges and other professionals participated.

Correlation and multiple regression analyses were used to analyze the data.⁹ Although several variables are nominal in nature, dichotomizing and treating them as dummy variables makes regression analysis appropriate.¹⁰ The Pearson correlation coefficient provides a measure of the strength of the association between each independent variable and the dependent variable. Multiple regression analysis provides a measure (unstandardized partial regression coefficient *b*) of the degree of variance in the dependent variable accounted for by each independent variable, while all other independent variables are held constant. Multiple regression analysis also provides a measure in standard units of the direct effect (standardized partial regression coefficient or path coefficient) of the various independent variables on the dependent variable. This permits comparison of the relative effects exerted by the independent variables. The independent variables have also been grouped in sets (socio-biographical, legal, mental health, institutional) in order to assess the regression effect of every set or factor on the dependent variable.

⁹ The .10 level of probability has been reported due to the small size of the sample. For a discussion of the significance level of partial regression coefficients, see Heise, *Problems in Path Analysis and Causal Inference* in E. BORGATTA (ed.), *SOCIOLOGICAL METHODOLOGY* 60-61 (1969).

¹⁰ See Bohrnstedt & Carter, *Robustness in Regression Analysis* in H. COSTNER (ed.) *SOCIOLOGICAL METHODOLOGY* B1-B7 (1971).

⁵ *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964).

⁶ *Id.* at 516 (emphasis added).

⁷ The importance of focusing on the criminal court in the study of criminal justice administration is indicated in A. BLUMBERG, *CRIMINAL JUSTICE IX-X* (1967). See also Feeley, *Two Models of the Criminal Justice System: An Organization Preference*, 7 *LAW & SOCIETY REV.* 407 (1973).

⁸ W. CHAMBLISS & R. SIEDMAN, *LAW, ORDER AND POWER* 261-70 (1971).

The variables considered in relation to their possible effect on the dependent variable are grouped according to four factors:

(1) *Socio-biographical factor*: age of the patient (at the time of commitment); race (white/non-white); marital status (divorced or widowed, single, married); socio-economic status (as measured by Hollingshead two-factor index); and nature of the county of commitment (urban/rural).

(2) *Legal factor*: severity of punishment (as represented by the maximum term of the sentence in years); type of crime (non-violent/violent); prior criminal involvement of each patient. A prior criminal involvement score was obtained by weighting all previous criminal activities followed by dismissal, fine, probation, workhouse or prison.¹¹

(3) *Mental health factor*: diagnosis upon commitment (mentally ill, psychopath, sexual psychopath) and length of previous hospitalization (number of days).

(4) *Institutional factor*:¹² patient's performance in therapy (measured on a Likert type

¹¹ Prior criminal involvement for each patient was ascertained from the criminal report which constitutes part of the hospital file. All previous criminal activities were coded according to the official action which was taken:

1. Number of offenses followed by dismissal;
2. Number of offenses followed by fine;
3. Number of offenses followed by probation;
4. Number of offenses followed by workhouse;
5. Number of offenses followed by prison.

The sequential numbers from 1 to 5 were assumed to constitute a Likert scale. The weights were then used to multiply the raw score of each patient and summed for the five indicators. For a detailed discussion of several techniques used in the calculation of prior criminal involvement scores, see J. Scott, *An Examination of the Factors Utilized by Parole Boards in Determining the Severity of Punishment*, May, 1972 (unpublished doctoral thesis, Department of Sociology, Indiana University).

¹² The following variables were first coded for every patient: performance in therapy; contacts between physician and patient; number of positive psychiatric and behavioral remarks; number of negative psychiatric and behavioral remarks; recommendation at the time of release; number of days in seclusion; upward mobility; downward mobility; contacts between patients and individuals outside the hospital; contact between staff and individuals in relation to the patient. The variables were factor-analyzed using a principal factoring method. An oblique rotation was performed in order to obtain a simpler factor structure which resulted in four factors. See H. HARMAN, *MODERN FACTOR ANALYSIS* 314-341 (1970). The following four variables were selected as representing the

scale on the basis of staff ratings); physician contact with patient (a weighted score obtained by averaging the number of contacts between physician and patient as represented by the medical notes in the "Psychiatric Progress Note," divided by the length of hospitalization); downward mobility (number of ward changes following negative behavior by the patient and considered as demotions in the patient's institutional career); pressure from individuals outside the hospital (as represented by a weighted score of the number of letters to the patient and to the staff, plus the number of visits from family, divided by the length of hospitalization).

The dependent variable (length of commitment) is represented by the number of months the patient was held in the hospital.

FINDINGS

(1) *Socio-biographical factor*

Age: The mental hospital staff appears to keep older patients longer than younger patients ($r = .162$). The beta coefficient (.207) indicates that when all other variables are held constant, age is the best single predictor of the length of commitment of all sociobiographical variables. Age is second in importance of all independent variables. The unstandardized partial regression coefficient indicates that where two patients are alike in all the characteristics represented by the independent variables, except that one is ten years older, the length of commitment of the older patient will be one and one-half months longer ($10 \times .151$). This increase due to the patient's age represents an eight per cent longer hospitalization in relation to the mean length of commitment in the sample ($\bar{X} = 17.94$). Apparently, the staff is more cautious in releasing older patients. Young patients are probably viewed as better prospects for reintegration into society through other programs (for example, probation or parole) which may follow the hospital commitment.

Race: Non-whites are held in the mental

four factors (due to their high loading coefficients); patients' performance in therapy (.77); physician contact with patient (-.99); downward mobility (.67); pressure from the world outside the hospital (-.93). The variables were then inserted with the other independent variables in the multiple regression equation.

hospital for a longer period than whites ($r = .045$), although the relationship is extremely weak and non-significant. However, when the severity of punishment, the type of crime, the prior criminal involvement and all other independent variables are held constant, whites are committed for slightly longer periods of time than non-whites, although the difference is again not statistically significant ($\beta = -.078$). The partial regression coefficient ($b = -1.39$) indicates that whites are committed for approximately one and one-half months longer than non-whites. These data indicate that race is not an important variable in the staff decisions to continue or terminate the indefinite commitment of a patient.

Marital status: Initial analysis of the data shows that married patients are released earlier than divorced or widowed patients ($r = -.083$). When all other independent variables are controlled, the sign of the relationship becomes positive ($\beta = .015$) indicating that married patients are in fact committed for a longer period than divorced or widowed patients. The difference is not statistically significant, but indicates that marriage may represent a factor which makes release from the mental hospital more difficult than does a familial status which does not involve responsibility to other persons.

Socio-economic status: Patients with higher socio-economic status are committed for a shorter period of time than those with lower socio-economic status ($r = .247$).¹³ While the mean socio-economic status of the sample indicates that the group of patients, according to the Hollingshead two-factor index, is on the borderline of the lower class ($\bar{X} = 59.95$), there are variations in socio-economic status (S.D. = 8.4) which exert an influence on the staff decision to release. The regression coefficient indicates that when all other independent variables are controlled, a lower socio-economic status of ten units on the Hollingshead scale accounts for one and one-half months' increase in the period of commitment ($10 \times .154$). The beta coefficient ($\beta = .161$) shows that socio-economic status is the third best predictor in relation to the length of hospitalization among all the socio-biographical dimensions.

Type of county: Patients committed from rural counties are released earlier than those committed from urban counties ($r = -.18$). The excess length of commitment is two and one-half months for patients referred to the mental hospital from urban counties ($b = -2.18$), and this reflects a twelve per cent increase in the mean commitment period ($\bar{X} = 17.94$). Two hypotheses may be advanced in explanation of this result. The first is that the findings may depend on the nature of the relationship between judges from rural counties and the hospital administration. Since the recommendation of release must be approved by the judge, it is possible that judges in rural counties rely more frequently on staff recommendations and consequently lower the number of recommendations which fail to receive the required jurisdictional approval. Hospital administrators, on the other hand, may recommend earlier release of patients committed from rural counties, thus anticipating the judge's reaction to their recommendations. This could be a situation where inter-organizational efficiency is maximized and possible organizational strains minimized. The second hypothesis is that administrators may consider the likelihood of future probation or parole of the released patient and may believe that social reintegration is simplified when the patient returns to a rural rather than an urban environment. Both hypotheses have some support. The first may be corroborated by the research findings of a study on the attitudes and beliefs of judges, which indicate that urban judges are more severe and punishment-oriented than rural judges.¹⁴ The second hypothesis rests on the social-disorganization theory in criminology.

(2) Legal Factor

Severity of punishment: When other factors are controlled, the positive strength of the association between the severity of punishment (as indicated by the maximum term of the sentence) and the length of hospitalization ($r = .127$) exerts little effect on the staff decision to recommend the termination of commitment ($\beta = .029$). Consequently, the fact of institutionalization for a shorter or longer period than the average maximum sentence ($\bar{X} =$

¹³ See C. BONJEAN, SOCIOLOGICAL MEASUREMENT 384-85 (1967).

¹⁴ See J. HOGARTH, SENTENCING AS A HUMAN PROCESS 221-24 (1971).

16.82 years) does not represent a factor which improves or exacerbates the chances for release of a patient when his case is considered by the staff. Simply, the maximum possible sentence is not a factor in the decision-making process of the staff.

Type of crime: Patients found guilty of committing violent crimes are hospitalized longer than those who committed non-violent crimes ($r = .166$). In particular, the commission of a violent crime increases the length of hospitalization two and one-half months, or fourteen per cent, in relation to the average period of commitment ($b = 2.66$). The independent effect of the type of crime on the dependent variable ranks fifth in the hierarchy of the independent variables' explanatory power. This finding is consistent with the results obtained when other crime classifications are used. In fact, when the crime variable is inserted in the regression equation, dichotomized according to the classification of non-probational versus probational and property versus personal/sex offenses, the effect produced on the dependent variable is similar ($\beta = -.122$ and $\beta = .093$, respectively).

Non-probational and personal/sex offenses overlap to a certain degree with violent offenses. This finding is particularly important in light of the fact that a history of violence contributes to professional predictions of dangerousness and instability—the tendencies which the psychopath statutes were intended to control.

Prior criminal involvement: Even if all other independent variables are controlled there is no relationship between prior criminal involvement and length of commitment ($r = -.001$) ($\beta = -.109$). Although this relationship is statistically insignificant, the fact that those patients with more extensive prior criminal involvement are hospitalized for shorter periods of time is of theoretical interest.¹⁵ Perhaps, patients who have been previously imprisoned are more aware of the dynamics, informal rules and culture of a total institution. In this sense, they may be able to win their

discharge more rapidly than patients who are institutionalized for the first time.

(3) Mental health factor

Diagnosis upon commitment: There is no relationship between diagnosis and length of hospitalization ($r = .040$). Sexual psychopaths are hospitalized longer than mentally ill patients, even when all independent variables are controlled ($\beta = -.071$).

Previous hospitalization: If there is a period of previous hospitalization, the commitment will be longer ($r = .172$). However, when other variables are controlled, this relationship becomes statistically insignificant ($\beta = -.093$).

(4) Institutional factor

Performance in therapy: A patient's performance in therapy is unrelated to length of commitment ($r = .014$). When all of the independent variables are controlled, the direct effect of this institutional dimension is rather low ($\beta = .085$) and statistically insignificant. It should be noted that if performance in therapy does not constitute an indicator for the decision to end or to continue commitment, then court commitment must serve purposes other than treatment.

Physician contact with patient: The frequency of contacts between physician and patient has an immense relationship to the length of commitment ($r = -.363$). Of all the independent variables, frequency of contact is the best predictor of length of commitment ($\beta = -.323$). This finding raises the question of the reason for the differences in the number of contacts between physicians and patients. A possible answer is that doctors are preoccupied with those patients who cause more trouble in the hospital. This theory is not supported, however, by the positive relationship existing between the variable of downward mobility and length of commitment ($r = .084$; $\beta = .154$). Unacceptable behavior apparently leads to longer commitment. If the rationale for the contact between the doctor and the patient is unacceptable behavior, the direction of the relationship between the two independent variables (physician contact and downward mobility) and length of commitment should be in the same direction. For the same reason, perform-

¹⁵ In studying parole board decision making, Scott discovered that prior criminal involvement is inversely related to severity of punishment. J. Scott & R. Vandiver, *The Use of Discretion in Punishing Committed Adult Offenders*, May, 1973 (unpublished manuscript, Department of Sociology, Ohio State University).

ance in therapy may be discounted as the reason for the frequency of contacts between physician and patients. In fact, performance in therapy does not exert any significant influence on length of hospitalization. Moreover, the positive relationship between performance in therapy and the dependent variable is inconsistent with the negative relationship between physician contact and length of commitment. A third alternative is pressure (in the form of letters inquiring about the condition of the patient, meetings with the staff, visits to the patient, etc.) exerted by the family, friends or lawyers of the patients. Physicians may feel that if someone supports the patient there may be potential conflict with the administration.

Downward mobility: For every time a patient is transferred to a more secure ward of the hospital, he remains in the hospital one and one-half months longer than the average commitment ($b = 1.49$). Downward mobility constitutes the fourth best predictor of length of commitment ($\beta = .154$). Transfers follow episodes of negative behaviors such as fighting with other patients, refusal to obey staff orders, and failure to conform to hospital discipline. In general, violent behavior is penalized by the staff and considered as a demotion in the patient's hospital career.

Pressure from outside the hospital: If there is strong outside pressure on the hospital concerning the patient, the length of commitment will be longer ($r = -.211$). The independent effect of this variable on length of commitment is, however, insignificant when other variables are controlled ($B = -.05$).

ANALYSIS OF VARIABLES AS SETS

With the effects of the other factors held constant, the independent variables have also been grouped in theoretically meaningful sets in order to analyze their separate effects on length of commitment. The best predictor of length of commitment is the institutional factor ($R = .396$; $R^2 = .157$). The socio-biographical factor ranks second in ability to explain variance of the dependent variable ($R = .321$; $R^2 = .103$). The institutional factor actually explains only five per cent greater variance in the dependent variable than does the socio-biographical factor. The socio-biographical and the institutional factors taken simultaneously are

able to explain as much variation in length of commitment as can be explained by using all four factors ($R = .509$; $R^2 = .260$). The legal and the mental health factors ($R = .189$; $R^2 = .036$ and $R = .196$; $R^2 = .038$) do not play any statistically significant role in the staff's decision to continue or to terminate commitment. Inasmuch as only twenty-six per cent of the variation in length of commitment can be explained, other variables not taken into account by this research must have some effect on the continued detention or release of the prisoner-patient population.

DISCUSSION

Two questions arise concerning the staff's decision to recommend the termination of indefinite commitment. First, what model of mental health administration does the data support? Second, why is one specific model implemented instead of another? Before discussing these questions, however, it is necessary to distinguish between the two possible alternative models.

The control model of mental health administration is analogous to the control model in the administration of criminal justice.¹⁶ It emphasizes organizational efficiency, values ascriptive personal characteristics and works with speed, finality and routine procedures. The treatment model, on the other hand, rejects absolute efficiency as a sufficient goal in itself and focuses on the welfare of the patient. It does not advocate placing a premium on ascriptive qualities, but instead promotes non-discriminatory action. It rejects speed and finality where they might impair medical understanding of the patient. It de-emphasizes routine because it is a model which focuses on the individuality of the patient. Advocates of this model regard man as a human being and not as an object.¹⁷ The control model in mental health administration reflects a presumption of illness,¹⁸ as opposed to the pre-

¹⁶ For an exposition of the theory of models in criminal justice administration, see H. PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 149-73 (1968). For an examination in the field of mental health, see S. HALLECK, *PSYCHIATRY AND THE DILEMMAS OF CRIME* 229-44 (1971).

¹⁷ See R. LAING, *THE DIVIDED SELF* 17-26 (1971).

¹⁸ See Scheff, *The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State*, 11 *SOCIAL PROBLEMS* 401 (1964).

sumption of the relativity of mental illness¹⁹ which characterizes the treatment model.

The data indicate that a control rather than a treatment model of mental health administration is operative in the institution examined. In reality, it has been indicated that the patient's improvement, as reflected in his performance in prescribed therapy, does not significantly influence the staff's decision to release him. This finding indicates that treatment is not the key factor in the administration of the sexual psychopath statute, although it cannot be denied that in theory it is considered to be an important element. Furthermore, the patient's continued commitment is apparently based on factors other than the patient's treatment performance. Some of these factors, such as age and socio-economic status, are ascriptive in nature, although they may be perceived by the staff as being important considerations in the patient's release. At this stage, however, there is insufficient evidence to support the staff's implicit assumption that lower-class adults cannot be returned to the criminal justice system as soon as other patients.

Other findings indicate that the hospital staff tends to operate in such a way as to avoid organizational strain. In fact, the staff seems to be very sensitive to the pressure exerted by family, friends and lawyers on behalf of the patients. These patients are seen more frequently by the staff and are released earlier from the hospital since a family angered by the commitment may cause serious problems for the hospital administration, both through legal action against the staff and through the sympathy which is expressed by civil libertarians and other groups. Inter-organizational strains are also avoided since the time of release appears to depend on the socio-geographical location of the court and on the judge who must react to the staff recommendation of release. In general, organizational requirements significantly influence staff decisions regarding the patient.²⁰

In addition, the staff apparently perceives the main function of the mental hospital to be the control of dangerous behavior. Those that are perceived as dangerous are penalized with

longer periods of commitment. It is not suggested that dangerous behavior should not be controlled, but it should be emphasized that dangerousness per se is a relative phenomenon and its diagnostic determination is at best ambiguous and arbitrary.²¹ It has been suggested that institutional psychiatrists tend to protect themselves against censure for the premature release of patients by over-estimating the dangerousness of their patients and retaining them until there appears to be a diminished risk of recidivism.²² The actuality of control, in lieu of treatment, has suggested that indefinite commitment in a mental hospital should actually be called "indeterminate therapeutic incarceration."²³

The second question resulting from analysis of the staff's decisions deals with the possible reasons for the control model as opposed to the treatment model. Theoretically, the antagonism between control and treatment may stem from the differential focus between state psychopath laws, which emphasize control, and the United States Supreme Court's orientation. Since the Supreme Court is charged with the responsibility of affirming and protecting the constitutional rights of an individual, it is predisposed to protect against abuses of their expression and to emphasize the principle which should govern the administration of law. This predisposition is different from giving priority to the application of bureaucratic discretion.²⁴ The mental hospital as an organization inherits this disjunction between state laws and the Supreme Court and responds to the law in a way which is unfavorable to the individual. Furthermore, the inherent contradiction which characterizes the role of the staff administering mental health laws may be considered as another factor responsible for the adoption of the control model. In particular, the psychiatrist must act simultaneously as the agent of the state by seeking the protection of society, and as the agent of the patient by seeking the welfare of the patient.²⁵ This role conflict is exact-

¹⁹ HALLECK, *supra* note 16, at 313.

²² SCHMIDBERG, *The Promise of Psychiatry*, 57 Nw. U.L. REV. 19 (1962).

²³ SCHREIBER, *Indeterminate Therapeutic Incarceration of Dangerous Criminals: Perspective and Problems*, 56 VA. L. REV. 602 (1970).

²⁴ CHAMBLISS & SIEDMAN, *supra* note 8, at 231-36.

²⁵ HALLECK, *supra* note 16.

¹⁹ See T. SZASZ, *LAW, LIBERTY & PSYCHIATRY* (1963).

²⁰ See T. SCHEFF, *MENTAL ILLNESS and SOCIAL PROCESSES* 313-18 (1967).

erbed by the legal rights which protect the individual in the criminal process. The rationale for this legal deprivation is that the patient is receiving treatment, not punishment, and therefore does not need legal protection. What the patients feels, on the other hand, has been graphically stated by Schreiber;

To be taken without consent from my home and friends; to lose my liberty; to undergo all these assaults on my personality which mod-

ern psychotherapy knows how to deliver: to know that this process will never end until either my captors have succeeded or I have grown enough to cheat them with apparent success—who cares whether this is called Punishment or not?²⁸

²⁸ Schreiber, *supra* note 23, at 612 (footnote omitted). See also F. ALLEN, THE BORDERLAND OF CRIMINAL JUSTICE 25-41 (1964); Lewis, *The Humanitarian Theory of Punishment*, 6 RES JUDICATAE 224-27 (1953).

APPENDIX

Regression for fourteen variables on length of commitment

INDEPENDENT VARIABLE	DEPENDENT VARIABLE			
	Pearson's r	Regression Coefficient b	Beta Coefficient β	N
<i>Socio-Biographical f^a</i>				
Age.....	.162**	.151*	.207*	103
Race.....	d.045	-1.39	-.078	103
Marital Status.....	t-.083	.186	.015	103
Socio-economic status.....	.247*	.154*	.161*	103
Type of county.....	d-.181**	-2.18**	-.120**	103
<i>Legal factor^l</i>				
Severity of punishment.....	.127	.016	.029	103
Type of crime.....	d.166**	2.66**	.129	103
Prior criminal involvement.....	-.001	-.056	-.109	103
<i>Mental health factor^h</i>				
Diagnosis upon commitment.....	t.040	-.825	-.071	103
Previous hospitalization.....	.172**	.003	.093	103
<i>Institutional factorⁱ</i>				
Performance in therapy.....	.014	.482	.085	103
Physician contact with patient.....	-.363*	-.161*	-.323*	103
Downward mobility.....	.084	1.49*	.154*	103
Pressure from out-hospital.....	-.211*	-.004	-.05	103

* Significant at-or beyond the .05 level of probability

** Significant at the .10 level of probability

d Dichotomously coded

t Trichotomously coded

g Multiple correlation coefficient

s Multiple correlation coefficient socio-biographical factor

l Multiple correlation coefficient legal factor

h Multiple correlation coefficient mental health factor

i Multiple correlation coefficient institutional factor

R	R ²
.509*	.260
.321*	.103
.189	.036
.196	.038
.396*	.157