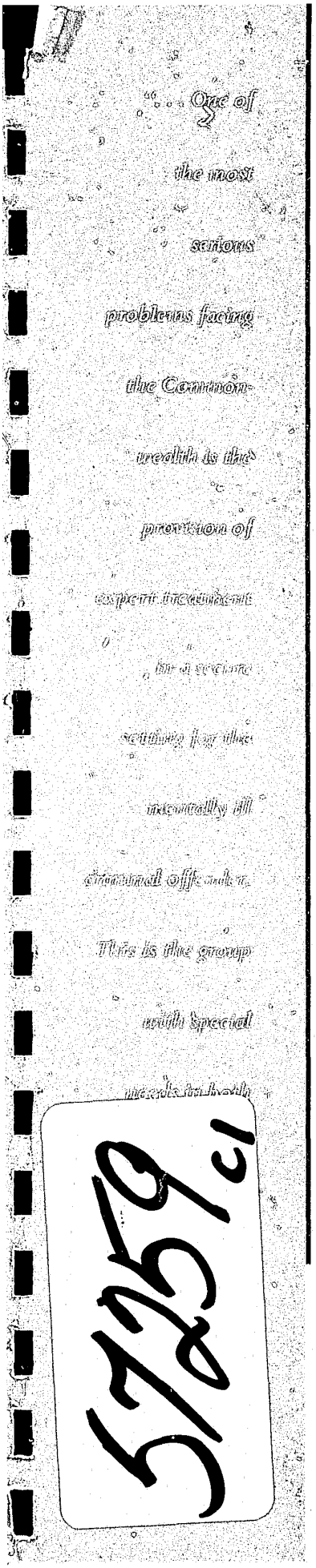

A PLAN FOR FORENSIC MENTAL HEALTH SERVICES IN PENNSYLVANIA

Report of the Governor's Task Force on Maximum Security Psychiatric Care

Robert M. Fishman, Esq.
Executive Director

COMMONWEALTH OF PENNSYLVANIA

GOVERNOR'S TASK FORCE ON MAXIMUM SECURITY
PSYCHIATRIC CARE

TELEPHONE
AREA CODE 717, 783-5132

December 1, 1977

The Honorable Milton J. Shapp
Governor
Commonwealth of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Shapp:

On behalf of the Task Force on Maximum Security Psychiatric Care, I submit to you our final Report.

Considerable effort has gone into the development of the proposed plan for a forensic mental health system in Pennsylvania. The Task Force has worked diligently and applied itself with unusual dedication in addressing the problems to which your Executive Order directed us.

Many individuals offered us support and help during these past eight months which have made our deliberations possible and fruitful. We believe this Task Force Report represents the best thinking the Commonwealth can produce in the area of providing forensic mental health services.

We look forward to your response and are hopeful that Pennsylvania will become a leader in forensic mental health.

Respectfully submitted,

Paul A. Dandridge

Judge Paul A. Dandridge
Chairman

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i. OVERVIEW OF THE TASK FORCE'S REPORT

This document contains the findings and recommendations of the Task Force established by Governor Shapp to review the current status of Maximum Security Psychiatric Care in Pennsylvania and to make recommendations concerning the steps the Commonwealth should take to ensure the provision of the best possible care for the mentally ill offender who requires treatment in a maximum security setting.

After reviewing the current status of maximum security psychiatric care in the Commonwealth and in other states, as well as the legislative, judicial and executive mandates under which such treatment must be provided, the Task Force's recommendations concerning the development of a forensic mental health care system are presented. These include:

1. Establishment of a comprehensive Forensic Mental Health System consisting of the following components:

   (a) Outpatient and diagnostic mental health services within State prisons.

   (b) Multi-level secure inpatient forensic units at selected State hospitals.

   (c) Crisis intervention, preventive, and aftercare services within the county jails.

   (d) County court diagnostic clinics.

2. The closing of Farview State Hospital by the end of 1980.

3. The establishment of interagency committees to plan and implement the proposed system.

4. The establishment of a forensic information system.

5. Creation of a central staff for forensic services within the Office of Mental Health.

6. The establishment of comprehensive forensic mental health services for women.

7. The establishment of a task force to address the psychiatric needs of juvenile offenders.

8. The establishment of a mechanism for voluntary commitment of mentally ill offenders.

9. Continued application of Act 143 in prisons.

10. The funding, by the Commonwealth, of forensic mental health services.

11. Consideration, by the state, of ways to offset the adverse economic effects to Wayne County of closing Farview State Hospital.

12. The involvement of the public, legislators, judges and other members of the legal system, and mental health administrators and groups in the planning and implementation of the Task Force's recommendations.

ii. ACKNOWLEDGEMENTS

Several people and administrative units provided special assistance to the Task Force. Polly Smith of the American Foundation, Institute of Corrections, researched the existing forensic psychaitric services within prisons and mental health facilities of twelve states. Andrea Jacobsen, Esquire and Jack Handler, Esquire of the Department of Justice, provided legal assistance and rendered opinions in several areas. Melvin Heller, M.D. of the Office of Mental Health, discussed many of the problems now existing in mental health care to prisoners and pointed out many complex issues that must be addressed in designing a forensic mental health system.

The participation of key persons from the Bureau of Correction and the Office of Mental Health greatly aided the Task Force's efforts. Both Commissioner Robinson and Ray Belford, Ph.D. provided helpful observations and data. Deputy Commissioner Robert Haigh and Ralph Phelleps provided information about the procedures and operations of the forensic components of mental health. Considerable administrative and clerical support was given by the Office of Mental Health. Special thanks go to Margaret Underkoffler for her handling of the organizing and clerical details.

In addition, the Task Force received helpful input from the many people who testified at the three public hearings. (Appendix I)

I. INTRODUCTION

A. The Governor's Executive Order

Governor Shapp in his Executive Order of March 29, 1977, established the Task Force on maximum security psychiatric care, and charged it to address the problems facing the Commonwealth in providing treatment in a secure setting for the mentally ill offender.

The specific responsibilities included in the Governor's charge to the Task Force were to:

a. review in depth the past and present history of Commonwealth programs to provide maximum security mental health treatment.

b. review the legislative, judicial, and executive direction which has been given to such treatment in the past.

c. survey innovative approaches which other states have used to meet this special need.

d. establish for the present, and project for the next ten years, the maximum security care service needs in Pennsylvania.

e. review the presently existing plans regarding Farview and the Forensic Mental Health System.

f. make specific recommendations regarding legislative and executive actions necessary to meet the need for maximum security mental health services in Pennsylvania.

g. make specific recommendations on where and how such services should be provided in Pennsylvania.

h. submit recommendations concerning a course of public education necessary to effectively implement the recommendations of the Task Force.

i. report its findings and recommendations to the Governor on or before October 1, 1977, and thereafter cease to function. (Governor Shapp acting on the request of Judge Dandridge extended the life of the Task Force to December 1, 1977, by amendment to the Executive Order on October 14, 1977.)

B. Task Force Membership

As defined in the establishing Executive Order, the Task Force was comprised of the following membership:

Mr. Louis Aytch
Superintendent, Philadelphia Prisons

The Honorable Albert Biele, M.D.
Member, Pennsylvania Board of Pardons

Mr. Harry Boyer
President, Pennsylvania AFL-CIO

The Honorable Paul A. Dandridge
Common Pleas Judge, Common Pleas Court of Philadelphia

The Honorable D. Donald Jamieson
Former President Judge, Common Pleas Court of Philadelphia

Mrs. Marilyn Kanenson
Vice Chairman, Pennsylvania Mental Health/Mental Retardation Advisory Committee

Mrs. Patricia McGrath
Director of Special Programs, The Easter Seal Society for Crippled Children and Adults of Pennsylvania

Mr. William Nagel [1]
Director, American Foundation of Corrections

The Honorable Michael A. O'Pake
Pennsylvania Senate, Berks County

The Honorable Laurel Rans
Member, Pennsylvania Board of Pardons

Donald Reihart, Esquire
York County District Attorney

Robert Sadoff, M.D.
Clinical Associate Professor of Psychiatry, University of Pennsylvania School of Medicine; Lecturer in Law, Villanova University School of Law

The Honorable Anthony J. Scirica
Pennsylvania House of Representatives, Montgomery County

[1] *Resigned subsequent to the naming of the Task Force due to previously made commitments.*

Herbert Thomas, M.D.
Adjunct Professor of Psychiatry & Law, University of Pittsburgh School of Law; Clinical Professor of Psychiatry, University of Pittsburgh School of Medicine; Editor of Bulletin of American Academy of Psychiatry & Law

The Honorable Edmund V. Ludwig [2]
Common Pleas Court of Bucks County, Judge
Chairman, Mental Health Committee, Pennsylvania State Conference of State Trial Judges.

Ex-Officio members of the Task Force were:

The Honorable Robert P. Kane
Attorney General

The Honorable Frank S. Beal
Secretary of the Department of Public Welfare

Robert M. Daly, M.D.
Commissioner of Mental Health

Governor Shapp asked Judge Dandridge to serve as chairman.

Mr. Robert Fishman was named Executive Director. In this capacity he aided the Task Force in its varied activities and researched issues identified as important.

The Task Force held its first meeting with the Governor on March 29, 1977. Its charge was interpreted as going significantly beyond the problem of providing mental health treatment to prisoners, and touched upon a myriad of legal, constitutional and social issues not readily resolvable. The problem of providing mental health services to offenders and detentioners is multifaceted and to be effective, such services require coordination and cooperation between the Departments of Public Welfare and of Justice, the Bureau of Corrections and often the judiciary.[3] Present services provided through State and local governments are limited; nonetheless it was felt that the design of an effective workable system is possible, and this became the principal goal of the Task Force. Early in the discussions, it became apparent to members that the Executive Order required addressing not only the need for maximum security psychiatric care, but consideration of the entire forensic psychiatric system. The demand, location and delivery of maximum security psychiatric treatment is directly affected, for example, by the existence of prison mental health services, and other secure psychiatric facilities, (e.g., medium secure forensic units). A forensic mental health system was defined by this Task Force as encompassing all units providing mental health services to detained or convicted individuals within the criminal justice system.

The Task Force took a series of actions prior to developing this report; it held a number of full day sessions; reviewed documents prepared by various members and staff; visited Farview State Hospital; conducted a demographic survey of the Department of Public Welfare's forensic units; analyzed the availability of prison mental health services in State correctional institutions; conducted public hearings in Philadelphia, Harrisburg and Scranton; reviewed submitted written testimony from a wide spectrum of individuals, including psychiatrists, psychologists, judges, social workers, patients, and the public; obtained and reviewed a variety of statistical data; and reviewed summaries of forensic systems in other states. (See Figure 1 on the following page for a diagrammatic representation of the Task Force.)

The issue of mental health services for juvenile offenders was raised. The Task Force decided to defer considering this question because of its complexity and the relatively short life of the Task Force. Presently, the Pennsylvania juvenile justice system, which is operated in part by the Department of Public Welfare and in part by the counties, offers minimal mental health services.

The Task Force deferred the issue of addressing the problems of providing maximum security settings for civil patients.

II. THE EXISTING SYSTEM

A. History, Past Practices and Forensic Services

As in other states, the delivery of public-sector forensic psychiatric services in Pennsylvania has been undergoing change reflective of increasing legislative, judicial, professional and public attention to patients' rights, due process considerations, involuntary treatment, and the needs of mentally ill persons involved with the criminal justice system.

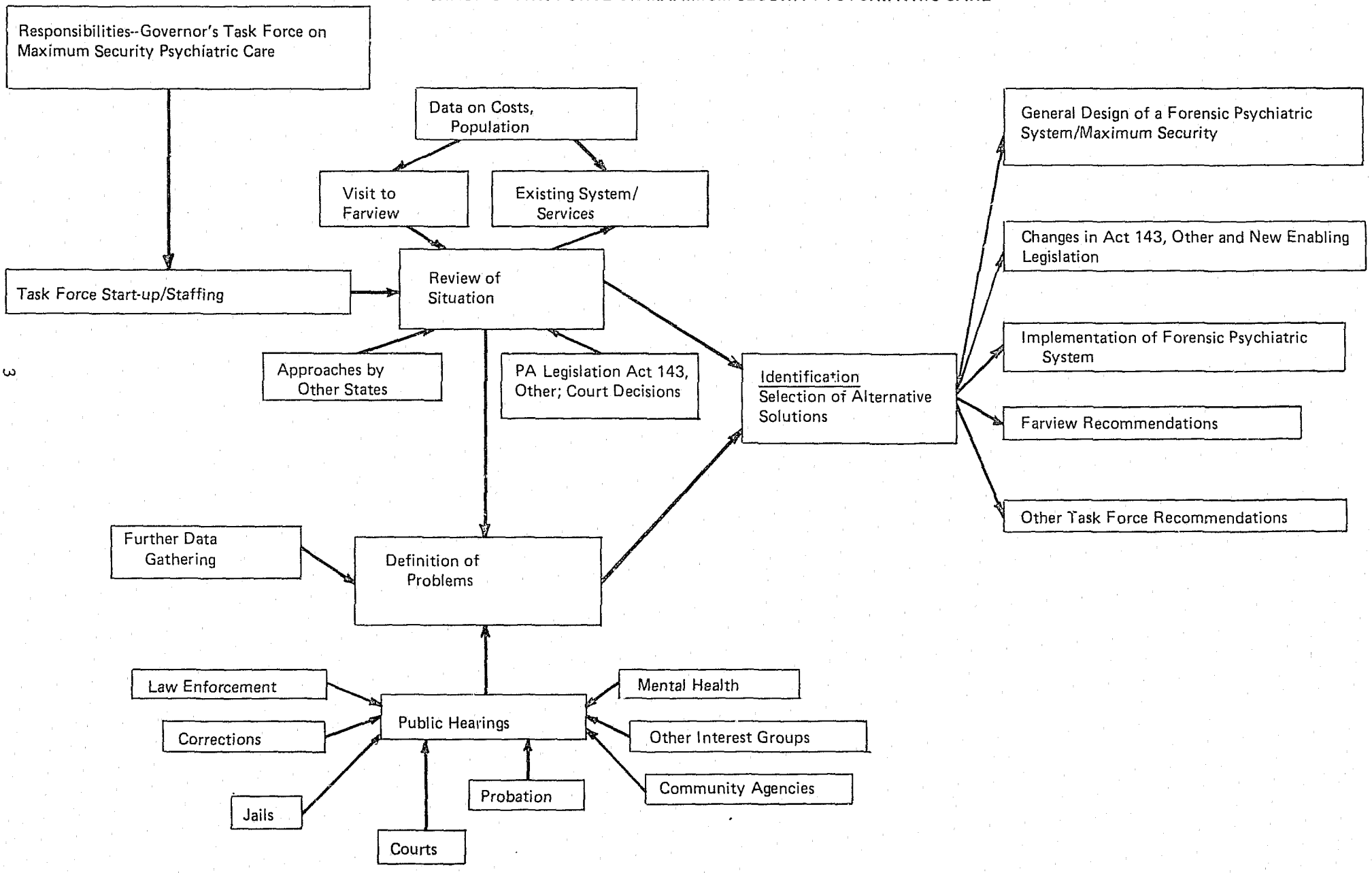
In the past twenty years Pennsylvania has come a long way. Up to the 1950's the Commonwealth had a lunacy commission whose function was to examine patients, determine if they had criminal tendencies and transfer them to Farview indefinitely. Under the Barr-Walker Act (later held unconstitutional), a sexual offender could be committed indefinitely to Farview or other State hospitals.

[2] *Appointed subsequent to the Executive Order.*

[3] *Although two agencies, the Department of Public Welfare and Department of Justice, Bureau of Correction, have primary roles, a variety of other groups are involved in this process: police, mental health units, judges, The Board of Probation and Parole, the community and mental health professionals.*

Figure I

DIAGRAMMATIC REPRESENTATION OF THE ACTIVITIES OF THE GOVERNOR'S TASK FORCE ON MAXIMUM SECURITY PSYCHIATRIC CARE



The history of the disposition of mentally ill offenders and defendants indicates a number of practices pertaining to both civil and criminal commitments, which now seem questionable. These include the mixing of civilly and criminally committed persons in State mental hospitals, and the retention of persons at the expiration of their sentence without adequate review on the assertion that they were mentally ill or dangerous. Wide use of these and similar procedures across the country led to such cases as Baxstrom v. Herold,[4] Jackson v. Indiana,[5] and Dixon v. the Attorney General of the Commonwealth of Pennsylvania.[6] It is telling testimony as to conditions in Pennsylvania that one of the Dixon findings was: "At the time the complaint was filed the medical staff at Farview consisted of the superintendent who is a psychiatrist, and five physicians, none of whom has had psychiatric experience before joining the Farview staff and none of whom had attained professional recognition as a psychiatrist."

In the mid 1960's the Legislature reviewed correctional system needs and authorized construction bonds to construct a maximum security medical and psychiatric center for mentally ill prisoners as part of that system, in or near Philadelphia. There was much resistence on the part of the communities in Southeastern Pennsylvania and no action was taken to construct a new facility there.

"Court-Units", which provide diagnostic workups and brief psychiatric treatment, were in limited operation at State hospitals such as Philadelphia, Norristown and Warren. Because of the special needs and the volume of service in Philadelphia, the Department of Public Welfare entered into a contract in 1966 with the City and Temple University to provide psychiatric services at Holmesburg Prison. Originally envisioned as a temporary measure, the contract was renewed each year for ten years. The Department of Public Welfare is moving toward a January 1, 1978 allocation to the city of Philadelphia which plans to contract with the Department of Mental Health Sciences of the Hahnemann Medical College to provide for the mental health needs of persons in Philadelphia prisons.

Short-term treatment of sixty-day court-committed cases, and mentally ill prisoners referred from the general prison population, have resulted in many hundreds of persons improving sufficiently after a four to six week stay on C Block[8] to be able to return to the general prison population, and proceed with their charges. The best estimates[9] are that, if this service had not been available, it would have been necessary to transfer to Farview State Hospital each year an additional 600-800 individuals requiring psychiatric hospital treatment and maximum security.

The crowded and marginal conditions in the Philadelphia County Prisons have resulted in a number of court-ordered changes following the judicial mandate in Jackson v. Hendricks.[10] In the past six months the City of Philadelphia has moved toward complying with Court mandates under the supervision of a Court-appointed Master. Furthermore, in the pending case of Green v. Soffer, an action was brought against the County Mental Health Commissioner to provide essential psychiatric services for untried mentally ill defendants held in the Philadelphia County Prison System.

Problems in providing emergency and short-term psychiatric treatment to mentally disabled offenders and defendants awaiting trial in county jails exist throughout the Commonwealth. In the past years Farview State Hospital stood ready to receive and hold any and all defendants, and to function as the primary statewide security facility for courts throughout the Commonwealth. Although Philadelphia, Bucks and Allegheny Counties have had psychiatric "Court Clinics" funded by and associated with the criminal courts, the less populated counties often require special arrangements in order to provide adequate diagnosis and treatment for mentally ill offenders and defendants. Urban areas often have greater need to establish court clinics and are better equipped to do so than rural areas. It is suggested that, where needed, counties join together to establish joint endeavors to provide adequate diagnosis and treatment for mentally ill offenders and detentioners.

In 1973 and 1974 separate wards were designated for the development of regional forensic units at the State hospitals at Mayview, near Pittsburgh; Warren, near Erie; and Norristown, near Philadelphia. Philadelphia State Hospital's Court Ward continued to function as a forensic ward, but was not specifically designated a regional forensic hospital facility. Additional attempts to establish forensic units at Clarks Summit and Danville State Hospitals met with overwhelming community and political resistance. The Department continued to review the question of the use of Farview and in 1975 Dr. Melvin Heller submitted a proposal which was widely circulated but not implemented at the time as other considerations emerged.

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[4] *383 U.S. 107 (1966).*

[5] *406 U.S. 715 (1972).*

[6] *323 F. Supp. 966 (1971).*

[7] *Currently, construction of a new 100-bed medical facility (50 psychiatric beds) at Holmesburg is in progress. This unit will replace the cell block presently being utilized and is expected to open in October of 1978.*

[8] *C Block is the State maximum security diagnostic facility at Holmesburg Prison.*

[9] *Office of the Superintendent, and Chief of Psychiatric Services, Philadelphia County Prison System - personal communication.*

[10] *457 Pa. 405 321 A2d 603 (1974).*

Presently constituted regional forensic units have not been able to develop sufficient clinical facilities or security safeguards to cope with mentally ill offenders and detentioners. Moreover, some individuals are currently held under unsatisfactory conditions in behavioral adjustment units in State penitentiaries, awaiting transfer to facilities for the treatment of mentally ill sentenced offenders. Many overtly psychotic, but not necessarily "severely mentally disabled" offenders as defined by Act 143 do not constitute candidates for involuntary commitment to State hospital facilities. Others, for whom "clear and present danger" is distinctly met as a criterion for involuntary commitment remain in behavioral adjustment units as an alternative to Farview. (See Appendix II, "Forensic Units–Current Staffing and Census," for the bed capacity, security rating, recent census and staffing patterns at the regional forensic units at Norristown, Warren and Mayview and the Court Ward (N-8) at Philadelphia State Hospital.)

Norristown State Hospital has a medium security capacity of 75 beds, and in addition, operates another 10-12 forensic beds for persons who require less secure management. Because of its proximity to universities and referral centers, the forensic unit at Norristown benefits from the consultative services of academically affiliated psychiatrists.

Mayview State Hospital's forensic unit has a current capacity of 56 beds for mentally ill offenders and defendants, and also benefits from its relative proximity to the Pittsburgh area, as well as from the special interest of Mayview's superintendent in forensic psychiatric issues. The communities surrounding Mayview continue however to have concerns about the location of a forensic unit at the facility.

Warren State Hospital has a regional forensic unit of 30 beds. While the professional staff at Warren State Hospital is a considerable asset to the forensic unit, additional professional staffing is needed. This problem is, however, not unique to this institution. None of the Commonwealth's forensic units has been successful in recruiting a full complement of qualified psychaitrists.

Philadelphia State Hospital's Ward N-8 has 44 forensic beds. This unit has remained a physically limited facility which has provided services for a relatively small fraction of the diagnostic and treatment needs of Philadelphia's mentally ill offenders and defendants.

In addition to its previously described functions, the forensic unit at Holmesburg Prison provides emergency psychiatric services and treatment for several thousand Philadelphia prisoners each year, many of whom would require commitment to State hospitals were these services not available within the county prison system.

The Office of Mental Health presently has a forensic staff of two, which has provided liaison consultative services with prosecutors, members of the defense bar, the Defender Association, individual courts, and a variety of academic colleagues and community agencies concerned with the criminal justice and mental health systems. Liaison services have also been provided to the Bureau of Correction for a number of mentally ill prisoners recently returned from Farview.

The present mental health services delivery system in Pennsylvania is composed of three major subsystems which are interrelated, though not fully integrated; that is, the County, State and Private Mental Health Systems. The primary legal base for the public program is the Mental Health and Mental Retardation Act of 1966, which charges the Department of Public Welfare (DPW) with the duty "to assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence, or economic or social status."

Under the Act, DPW is responsible for the operation of 19 State Mental Hospitals and one research and training institute, while the 41 community-based administrative units located in the Commonwealth's 67 counties are responsible for community Mental Health/Mental Retardation services. Mandated mental health services include short-term inpatient, outpatient, partial hospitalization, emergency services, consultation and education, aftercare, rehabilitative and training services, and information and referral services. These services must be available to the residents of each of the 86 catchment areas of the County Mental Health/Mental Retardation Program Units.

The county and institutional subsystems are organizationally encompassed under the Department of Public Welfare's Office of Mental Health, the unit responsible for Statewide development of mental health policy. Its responsibilities include program and budget analysis, planning, program evaluation, and the identification of mental health system needs; program policies and recommendations for regulatory and legislative changes; recommendations for approval by the Secretary of DPW of program plans and the allocation of State funds; and development of State plans. Four regional offices have also been developed in order to decentralize operational responsibilities.

Each catchment includes a Base Service Unit which serves as the unified intake agent for the program, which provides for the development of a comprehensive treatment plan and which is responsible for continuity of care, the maintenance of records, and appropriate monitoring of collaborative planning with State facilities. The County Mental Health/Mental Retardation Program is responsible for providing direct services as well as consultation and educational assistance, including preventive services, to its community.

Each of Pennsylvania's 67 counties contains one county prison or jail, with the exception of the city/county of Philadelphia, which has three major institutions. The administration and control of the jails vary widely according to the county classification, and numerous special legislative acts.

Thirty-six (36) counties are designated as 6th, 7th and 8th class; twenty-seven (27) are 3rd, 4th and 5th; two are 2A; one (1) is 2nd class and Philadelphia is the only first class county. The jails in 6th, 7th and 8th class counties are administered by a Sheriff whose governing board consists of the county commissioners. Two of these jails are used only as detention facilities, by agreement with the Bureau of Correction, with a 72-hour time limit. Their prisoners are then boarded out to adjoining counties. Few of the jails in these counties have the capability of providing anything but minimal treatment services for inmates. Generally, psychiatric services are obtained from local community mental health centers on an "as needed" basis. However, because of the current practices and interpretations of Act 143 and the reluctance of base service units to accept offenders, county jails are forced to deal directly with mental illness.

Counties of the 2A, 3rd, 4th and 5th classes are administered by an appointed warden and governed by a County prison board, the structure of which is set by statutes and special acts. Although many of these county jail facilities have professional staff who can identify patients with mental illness and deal with them to some degree, none of them can provide treatment in a hospital setting within the prison. They incur enormous costs for providing hospitalization and for guarding prisoners who are hospitalized.

Allegheny County Prison has a full-time psychiatrist and a psychologist through the auspices of the Allegheny County Behavior Clinic. They also have the services of volunteers in the mental health area.

B. Security Definitions

The Task Force's responsibility to "project...the maximum secure care service needs for Pennsylvania" presumes a clear definition of the phrase "maximum security". Similarly, the requirement of Act 143 that treatment of a prisoner in the mental health system "not affect the conditions of security required by his criminal detention or incarceration" presumes that both Mental Health and Corrections share concepts of security classifications. Unfortunately, no such uniformity exists. The Task Force has drawn upon the definitions and criteria used by both systems to formulate a working concept of what is maximum, medium and minimum security as it relates to psychiatric treatment, who requires or needs secure placement, and who is to determine the extent of such security in specific instances.

1. Mental Health Security Ratings

The Secretary of the Department of Public Welfare is responsible for designating the security rating of each mental health facility.[11] No official, written criteria for establishing such ratings exist. According to a spokesman for the Office of Mental Health, the following operational descriptions are currently in use:

a. A maximum security mental health facility is a self-sustaining, free standing unit so designed as to minimize escapes. Movement within a ward is monitored but unregulated whereas all other movement within the facility is by escort only. Staff for such a facility must be of sufficient size and have sufficient training to control and treat patients. The ratio of staff to patients should be greater than that in a medium security facility and should approach one-and-a-half to two to one. In addition to virtually eliminating the possibility of escape, a maximum security facility must insure the safety of patients from their own or others' violent behavior.

b. A medium security mental health facility is a unit with locked wards and sufficient security to permit outside recreation. Movement between wards is monitored. Ground privileges and home visits are granted with court approval. Staffing is at a ratio approaching one to one-and-a-half to one patient. Areas within the facility vary as to amount of supervision and usage of physical restraints.

c. There is no minimum security classification for mental health facilities. Cases not committed to medium or maximum security facilities are committed to the general population of State hospitals.

2. Correctional Security Ratings

Traditionally, security in a correctional setting has been based on the security level assigned to an institution in which an inmate was housed. This security designation was usually determined by the security of the perimeter of the institution (that is, a walled institution was considered a maximum security institution; a fenced institution was considered a medium security institution and an institution with minimal or no fencing was considered a minimum security facility). However, each correctional institution may have several different levels of security within its boundaries and thus correctional institutions tend to carry multiple security designations (such as, maximum/medium, or medium/minimum.) More recently the trend has been to assign individual security ratings to each inmate on a case by case basis. This individual rating also tends to carry treatment implications in terms of the amount of security

[11] *MH/MR Act of 1966, Section 202.*

and control a particular individual needs. Because each correctional institution usually has several institutional levels of security within its boundaries and because each institution, regardless of its institutional security rating, usually has inmates with all security ratings in its population, the individual security rating is of more significance than the rating of the institution in which an inmate is housed.

The Commissioner of the Bureau of Correction has published guidelines for security designations in "OM-2, Classification Manual" (September, 1976) and "OM-1, Diagnostic Center Manual" (January, 1977). These individual security ratings are based on the individual's offense, past history, stability and behavior. These classifications are subject to change based on an individual's adjustment in his program and his demonstrated behavior.

The following is a description of the individual security classifications assigned to each individual received in the Bureau of Correction. The four major classifications of individual security and several subcategories (see Table II) are as follows:

a. Persons with a *maximum security* rating are housed in single housing units and are constantly monitored by employees. Most programming for these individuals occurs in the maximum custody unit. All movement within the institution is escorted and transfers between institutions are conducted under physical restraint and close supervision. This custody level is for persons who present a threat of harm to themselves or others or who pose a threat to the security of the institution (for example, escape or riotous behavior).

b. Persons given a *close custody* rating are also placed in constantly monitored, single housing units. Movement within the institution requires constant visual control by an employee and may require an employee escort. Programs and work are available within the institution in areas where constant, direct supervision can be assured. Transfers from the institution are made under physical restraint and close supervision. This custody status is for inmates who require a high degree of supervision but less than maximum custody. Four subcategories[12] further define the reasons for close custody.

c. Persons with a *medium custody* rating are allowed "reasonable freedom of movement and programmings within the unrestricted confines of the institution".[13]

Four subcategories under this custody level specify movement or work opportunities as follows:

1) Inside program status allows work or program assignments without direct or constant supervision but within the institution.

2) Limited Outside Status permits work or program participation outside institutional walls but still on the property, and not without direct and constant supervision.

3) Escorted Leave or Privilege Status allows a person to attend special activities or programs, have special privileges (such as outside visiting) or do required institutional work off correctional property but under the direct and constant supervision of correctional staff.

4) Outside Honor Status permits an inmate to work on assignments outside of the institutional enclosure with indirect or intermittent staff supervision.

d. Persons on *pre-release* status are allowed participation in community based programs. Subcategory headings indicate the specific programming privileges allowed: furlough, educational/vocational release, work release, and/or community services center placement.

Table I depicts the Bureau of Correction's individual classification system; Table II shows the security ratings of existing mental health and correctional institutions.

The placement of individuals in specific mental health and correctional facilities is determined by different sources. Commitment to a forensic unit is made by a judge or mental health review officer who considers the security designation of the facility in relation to the individual's behavior, criminal charge or conviction and projected length of stay. Assignment to specific correctional facilities is determined after commitment by the court to one of three diagnostic centers[14] after considering a person's "security needs", based on sentence length, prior record, age, escape and violence history, and "treatment needs". Prisoners transferred to the mental health system on an emergency basis (section 302) are placed in a security status determined after consultation between mental health and correctional officials.

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[12] *Disciplinary custody, administrative custody, limited population, diagnostic center or reception unit.*

[13] *"OM-2, Classification Manual", September 1976, William Robinsion, p. VII-2.*

[14] *Eastern at Graterford, Central at Camp Hill, and Western at Pittsburgh.*

TABLE I

CLASSIFICATION SYSTEMS*
of the
Bureau of Corrections

BUREAU PROGRAM LEVEL	NAME OF STATUS	DESCRIPTION OF POSSIBLE PLACEMENT
I	**Maximum**	Single housing, employee escort needed
I-M	Disciplinary Custody – Maximum	
I-R	Administrative Custody – Maximum	
II	**Close**	Single housing, constant visual control by employee
II-E	Disciplinary Custody – Close	
II-K	Administrative Custody – Close	
II-H	Diagnostic – Assessment	Reception Unit of Diagnostic Center
II-T	Limited Population	Close Custody Cases permitted some general population programming.
III	**Medium**	General freedom for Institutional programming.
III-A	Inside Program	Inmate cannot leave the enclosure
III-B	Limited Outside	Closely supervised outside work assignments
III-C	Supervised Leave	Employee supervised off-the-grounds programs
III-D	Outside Honor	Indirect employee supervision outside enclosure
IV	**Minimum (Pre-Release)**	Inmate allowed off grounds without supervision
IV-F	Furlough	Inmate is permitted furloughs
IV-S	School	Educational/Vocational training release permitted
IV-W	Work Release	Work Release placement
IV-P	Pre-Release	All pre-release programs permitted
IV-G	Community Services	Placement in community center, etc.

*"OM-2 Classification Manual" – Sent 1976

TABLE II

Security Ratings for Mental Health and Correctional Institutions

FACILITY	DESIGNATED CLASSIFICATION(S)
Mental Health	
Farview	Maximum
Norristown (Psychiatric Forensic Unit)	Medium
Mayview (Psychiatric Forensic Unit)	Medium
Philadelphia (Psychiatric Forensic Unit)	Medium
Warren (Psychiatric Forensic Unit)	Medium
Other State hospitals	Open institutions
Corrections	
Camp Hill	Medium/minimum
Dallas	Maximum (limited)/medium/minimum
Graterford	Maximum/medium/minimum
Huntingdon	Maximum/medium/minimum
Muncy	Minimum
Pittsburgh	Maximum/medium
Rockview	Medium/minimum
Greensburg	Minimum

When sentenced incarcerated prisoners become severely mentally disabled, the treatment "facility is required to maintain custody and control over the person."[15] The transfer of prisoners to the mental health system for mental examination and treatment (Section 401) "shall not affect the conditions of security required by his criminal detention or incarceration". As the security description for institutions within the mental health and correctional systems is not identical, fulfillment of the Section 401 security requirement must be achieved on the basis of equivalent rather than identical security provisions.[16] Here lies the dilemma--what is equivalent rather than excessive or insufficient security?

The Task Force agrees with the Office of Mental Health and Bureau of Correction that security can be provided by various means, such as physical restraints built into the institution (the traditional cell, high wall, and gun tower) and/or in combination with programming, staffing and operational routines. Mental Health is presently more able than Correction to provide staff and environmental forms of security through smaller client populations, higher staff to client ratios, treatment programs and a therapeutic atmosphere. While internal programming and atmosphere may generate distractions from boredom or relieve a sense of purposelessness, ingredients of disruptions and escapes, these security elements cannot be complete substitutes for tight perimeter security. Movement within a maximum security facility must be by escort, and program or work opportunities must be conducted under close surveillance within the areas of the institution deemed maximum security.

As maximum security custody tends to be counterproductive to an effective milieu for mental health therapy, Correction should be encouraged whenever possible to reclassify maximum security cases to a lesser security rating. Also, prisoners who have been held in close or maximum security only on an emergency basis should be transferred to an institution with a security rating commensurate with the person's security needs.

The Task Force recognizes the urgent need for the creation of a common language or set of standards to be used jointly by Correction and Mental Health. As guidelines, these should set forth not only equivalencies or parallel conditions of security, but also establish when and by whom a specific case will be classified and, if necessary, reclassified. As has been pointed out, a confusion exists in terminology and in the purposes to be served; there is also a disparity in the range of security levels or conditions that are available. These uncertainties and deficiencies will have to be rectified in order to promote an effective interchange between the mental health and correctional systems.

C. Mental Health Services for Women

The way the criminal justice system deals with women frequently results in proportionately more female prisoners (detained and sentenced) having mental health needs than their male counterparts. Women are more often diverted from incarceration (their crimes tend to be less serious) yet there are very few community-based forensic mental health services available for them. Also, as a result of small female jail populations, jailed women face a paucity of social services, vocational opportunities, and interpersonal interactions, all which exacerbate latent and clinically recognized mental illness. Thus, the emotional problems of incarcerated women are compounded by lack of care in addition to the isolating conditions of confinement.[17]

Mental health services at the Correctional Institute at Muncy, the only State correctional facility for women, are curtailed because of the prison's primary minimum security status. Presently, because of the lack of sufficient resources, seriously mentally disturbed women are confined in maximum security cells and are held on a short-term basis in the hospital unit. When overflow occurs, they are housed with disciplinary cases in the "behavior adjustment unit". These women are isolated, sometimes for long period of time. Muncy does not have sufficient staff for treatment, nor does it have any medium secure housing. The State hospitals contain no forensic units for women. Furthermore, a regularized system of transferring women between the Correction and Mental Health systems does not now exist. All these inadequacies characterize the severely inappropriately handling of mentally ill female prisoners.

D. System Linkages

The Appendix contains an article describing the treatment and other options which have been available under the Mental Health/Mental Retardation Act of 1966 for mentally ill offenders and defendants.[18] For future planning purposes, Figure 2 and the description which follow present the flow of persons between the Mental

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[15] *Act 143, Section 401.*

[16] *House Bill No. 1486, introduced on July 12, 1977 seeks to amend Section 401(b) in requiring that if an individual detained on criminal charges or incarcerated is made subject to inpatient examination or treatment, he shall be transferred to a mental health facility with security identical to the institution to which incarcerated.*

[17] *From more than twenty-five years of research, it is clear that even the most normal, healthy people demonstrate psychotic reactions to sensory and perceptual deprivation. Isolation and seclusion in county jails can accentuate the illness of people who are mentally ill or marginally ill. (cf American Handbook of Psychiatry, 2nd Edition Vol. 1, p. 1102).*

[18] *See Appendix III for Guy, E. B., Heller, M. S. Polsky, S., "The Disposition of Mentally Ill Offender", Prison Journal, 49, 1: 24-33, 1969 (reproduced with permission of the authors).*

Health and Correctional system under Act 143.[19] As this Report goes to press, it is important to be aware that at least nine amendments have been introduced to Act 143, all of which will be debated in the months ahead. They represent a range of viewpoints.

DESCRIPTION OF FLOW CHART*

1. Mentally Disabled Detentioner

(a) Authority for commitment and transfer to a mental health facility for this individual emanates from Sections 401(a) and 401(b). Commitment is instituted under the provisions of Act 143, and is usually made to one of the Commonwealth's designated forensic units if space is available. If the detentioner remains mentally disabled and is incompetent to proceed, he is retained for the original commitment period, and for additional periods of either 90 or 365 day duration (depending on charges–see 304(7)(g)), if a hearing determines that severe mental disability persists. If competency is restored, however, the detentioner is returned to court. The determination of incompetency effects a stay of the prosecution as long as the incapacity continues, 403(b). A stay, however, shall not be in excess of five years or the maximum of the sentence for the crime(s) charged, whichever is less, 403(f).[20] As to the individual's criminal detention, he is to be detained in jail on the criminal charge no longer than it takes to determine whether a substantial probability exists that capacity will return in the foreseeable future (403(d)). If no probability exists, the individual is to no longer be detained, although the criminal charge remains in existence. If the probability does exist, the criminal detention cannot be in excess of that permitted by Section 403(f) (above).

(b) A court may order treatment not to exceed thirty days for an individual found incompetent, but not suffering from severe mental disability, if the court is reasonably certain that such treatment will restore competency (402(b)). If competency is not regained, then criminal proceedings continue to be stayed, and criminal detention continues unless there is not a substantial probability of the person's regaining competency in the foreseeable future (403(d)). If competency is regained, the detentioner is returned to court.

(c) Procedurally a court may order a competency evaluation (402(d)) upon application of counsel, the accused, the official in charge of the institution where the accused is detained, or sua sponte. Based on the report the court may then order involuntary treatment if the person is deemed incompetent but not severely mentally disabled (402(b)), proceed with the prosecution if he/she is competent, or proceed with the civil commitment process if the person is found incompetent and severely mentally disabled. If competent but severely mentally disabled, prosecution continues despite placement and commitment to a mental health facility.

2. Mentally Disabled Offender

The convicted and incarcerated offender suffering from severe mental disability, upon hearing and commitment, is transferred to a forensic unit on condition that the level of security required by his incarceration not be affected. Commitment and recommitment to such facility continues so long as severe mental disability persists. When said condition is alleviated, the individual is discharged and returned to the authority entitled to have him in custody (401(b)).

3. Not Guilty by Insanity

An individual found not guilty by reason of insanity may be released to the community, or at the discretion of the attorney of the Commonwealth a petition for involuntary commitment under Section 304 may be filed. If he/she is suffering from severe mental disability, commitment to a mental health facility is ordered.[21] The original period of commitment is dependent on the type of crime committed. Murder, voluntary manslaughter, aggravated assault, kidnapping, rape, or involuntary deviate sexual intercourse may result in a one year commitment. Discharge from the facility is mandated if at anytime the director of the facility concludes that the person is not severely mentally disabled and not in need of treatment.[22]

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[19] *Please note some individuals are placed on bail with the condition that they get "voluntary services".*

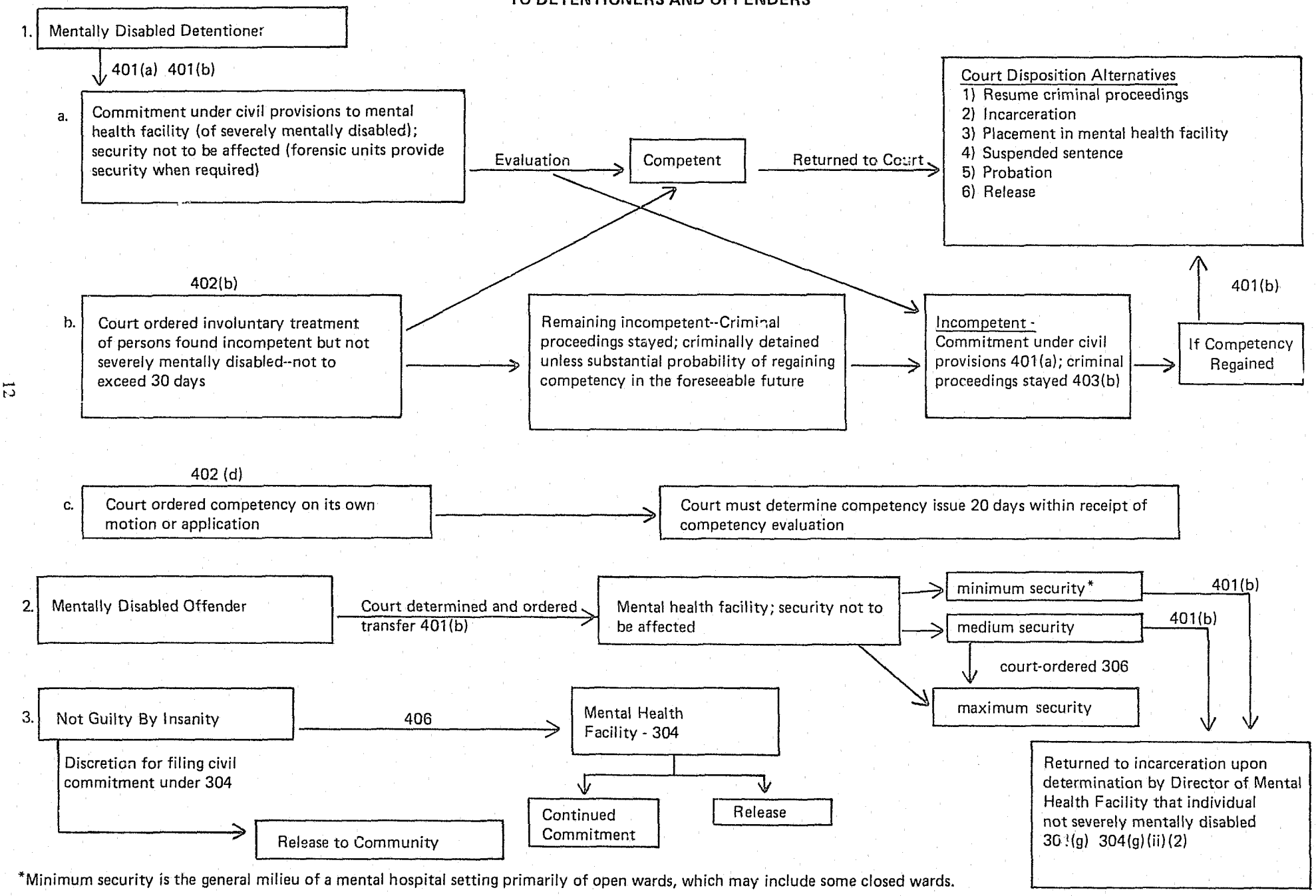
* *Numbers and letters correspond to Flow Chart, Figure 2.*

[20] *An amendment to Act 143, Senate Bill 1105, introduced on September 27, 1977 suggests changing the maximum of five years to ten years. This idea is a result of the concern that individuals may be feigning mental illness long enough to avoid prosecution. There is now a premium on being incompetent, whereas previous to Act 143 an incompetent was committed indefinitely or until competency had been restored. This Task Force is divided on this issue.*

[21] *Commitment sometimes occurs to a forensic unit, despite the fact that such individual is a civil patient and technically has no further criminal attachments because of the need for security. Such an individual should be committed to a regular civil hospital and if necessary housed with other civilly committed individuals who require greater security.*

[22] *House Bill 1486 in part seeks to amend Section 304 (g) (2) of the Mental Health Procedures Act of 1976 by requiring, that for individuals committed for one year (i.e., those found not guilty by reason of insanity for certain offenses), and by whom the maximum sentence for the offense has not been served through commitment to a mental health facility, the discharge must be approved by the committing court. The discharge by the committing court would have to be based upon a finding that such an individual would not be dangerous to self or others in the reasonable future. Present Pennsylvania law requires no such approval from the committing court and authorizes discharge when in the opinion of the director of the facility no further mental health treatment is necessary, or when the period of commitment has expired and no petition for recommitment has been granted. Senate Bill 1105 also seeks to amend this section by requiring the director to petition the Court ordering treatment for the unconditional or conditional release of the individual, whenever the facility determines the individual is no longer suffering from severe mental disability. A hearing would follow within 15 days after filing of the petition to determine whether the individual continues to be severely mentally disabled and in need of treatment. The Task Force endorses the concept of reviewing the release decision for individuals found not guilty by reason of insanity, but makes no judgment as to the legalities of such a mechanism. Mr. Reihart of the Task Force supports abolishing the not guilty by reason of insanity defense. Attached as Appendix IV is his suggested legislation to effectuate such abolition.*

Figure 2
MENTAL HEALTH SERVICES
TO DETENTIONERS AND OFFENDERS



*Minimum security is the general milieu of a mental hospital setting primarily of open wards, which may include some closed wards.

Existing Planning

As part of the 1977-78 budget the Department of Public Welfare and the Governor requested a program expansion at a cost of nearly five million dollars for forensic services. It contained the following elements:[23]

(1)	Affiliation contract with medical schools to upgrade clinical services at Farview	$400,000
(2)	Upgrade staffing at existing medium secure units	$702,600
(3)	Provide mental health services in State correctional facilities	$800,000
(4)	Provide program supervision through expanded Division of Forensic Psychiatry and Regional Staff	$ 65,100
(5)	Establish 130 additional medium secure beds	
	Renovation costs	$1,020,000
	Staff costs	485,000
(6)	Provide mental health services in city prisons; this would subsume and modify the existing Holmesburg contract as well as providing limited funds for other city prisons	$1,500,000
	Total Forensic PRR	$4,972,700

None of these items were directly funded in the final appropriation bill although inclusion of forensic services within the 1977-78 Philadelphia County Mental Health/Mental Retardation allocation will probably be possible within existing State resources. The Task Force understands that these were first year figures.

The Future of Farview

The Task Force received and considered many viewpoints regarding the usefulness and viability of Farview. *Among the arguments for continued support are:*

- Treatment at Farview has significantly improved within the last two years.
- The physical plant is in good shape and includes modern facilities for therapy, recreation, and development of vocational skills.
- The cost of recreating physical facilities equal to that of Farview would be too expensive.
- There is a corps of good personnel assembled at Farview who would be unable to relocate to new or other facilities.
- There is a strong spirit of support for the institution among residents of the Wayne County area as well as economic dependency on it.

Positions in support of closing Farview as a maximum security psychiatric facility are:

- The cost of treatment, approximately $63,000 per patient per year is inordinately excessive.
- The remote geographic location has prohibited recruiting fully qualified professionals.
- The remote location makes it impossible for families of patients to have regular contact and for patients to have sufficient access to legal counsel and to the committing courts.
- A continued racial imbalance between staff and patients cannot be rectified because of Farview's location.[24]
- Allegations of abuse of some Farview patients by some staff members is a matter of public record.
- Location and cost deter commitments to the facility.
- The enormous physical size of Farview makes it economically inefficient.

In balancing these pros and cons, the Task Force concludes that Farview should close as a psychiatric facility, when the proposed comprehensive forensic system is in place. Farview's continuation beyond that point in time cannot be justified. A significant element of our proposed plan is the availability of maximum secure mental health services at a regional level. Forensic services are more effective at smaller regional and urban located institutions, as staff at an isolated maximum security unit has the tendency to become institutionalized and hence pessimistic about the resident's prognosis and their own effectiveness in bringing about changes. Furthermore, regionalization combats the tendency of communities, agencies and other institutions to indulge in preventive detention and to incarcerate people at a far distance for their alleged dangerousness. Farview's geographic location in conjunction with present state salary rates prevents attraction of qualified professional personnel. The greater possibility of attracting competent professionals at regional urban units, in addition to more families being more proximate to facilitate visiting, will significantly add to treatment possibilities and success. It will also give patients greater access to legal counsel and the courts.

[23] *Analysis of these figures is available from the Office of Mental Health.*

[24] *As of January 30, 1976 Farview's population was 38% Black, with 5% Black staff.*

Regionalized forensic programming consisting of multi-level secure units encourages continuous evaluation as to the need for freedom and restriction of the individual patient. It also enhances the patient's ability to adjust to a less restrictive environment as the program and facilities are more visible and hence less threatening. This is not possible at Farview.

III. PUBLIC HEARING FINDINGS

A. Public Testimony

The Task Force held public hearings in Philadelphia, Harrisburg, and Scranton and reviewed written testimony submitted by other interested persons. The key themes running throughout the testimony are:

1. There is a clear and continuing need for maximum security psychiatric facilities, but such facilities should be used on a short-term basis for those mentally ill individuals chronically displaying dangerousness to themselves and others, and for those few individuals requiring long-term maximum security treatment. It was indicated that the optimal size of a maximum security unit is 50-75 beds.

2. As to the location of the secure units, there was consensus that accessibility to the resources of a metropolitan area is important. Testimony documented a need for the development of a coordinated system of regional secure units.

3. The current linkages between the Mental Health and Prison systems was questioned. This included the need for more mental health services in prisons. For those people requiring transfer to mental health treatment, the process must be streamlined. Linkages between Mental Health, Corrections, and the courts need clarification and strengthening. The due process considerations of Act 143 vis-a-vis the mentally ill offender are somewhat contradictory. The aegis of mental health treatment (either in prison or hospital) was debated.

4. Testimony revealed a critical need for forensic services for women and that presently no appropriate facilities exist.

5. The need for mental health services to juvenile offenders was also highlighted. This included services for those juveniles who are not treatable in the present system and those convicted of adult crimes. There was testimony as to the unique treatment needs of juveniles.

6. Testimony relating to Farview State Hospital indicated that:

a) because of its location sufficient professional staff could not be attracted there for employment;

b) family visits were inhibited; and

c) its size and staffing resulted in excessive cost and were not conducive to effective treatment. Others testified that abuses of the past continued in the present.

B. Future Needs for Secure Facilities

One of the purposes of the public hearings was to determine the types and extent of demands on the forensic psychiatric system in the next ten years, as set out in the Governor's Executive Order. As previously indicated, the maximum security care service needs in Pennsylvania are significantly affected by the full range of service provision. Although testimony at the public hearings gave some overview as to what the needs may be, the input is not sufficient on its own. Further, the Task Force did not have adequate data or the time and capability to undertake a reliable effort at population projection.

However, a variety of methods have been employed by states to determine the future size and composition of offender populations, or designated subpopulations such as offenders requiring mental health services. Such projection techniques have included: 1) simple linear (straight line) extrapolation; 2) input/output analysis of influencing factors; 3) multiple regression (multi-variables linear extrapolation); and 4) curve fitting.

The input/output multivariate technique seems to be the best in that it allows some advance warning of the turning point in a population cycle.[25] The ability to predict when rises or declines in a population will occur is essential in the planning and management of institutional capacity requirements, budget forecasting, delivery of the specified services, staffing requirements and other organizational considerations. Below are some of the factors which are frequently used in input/output analyses for correctional population projections (and would also have applicability to the problem of projecting forensic and maximum security populations):

[25] *Flanagan, John, "Projection of Prison Populations", American Journal of Correction, May-June, 1977, p. 12: "Recent experience suggests that it is more valuable to develop methods that give early warning of major cyclic changes than to develop methods that attempt to improve accuracy of short-term predictions within a given phase of a cycle."*

FACTORS INFLUENCING INPUT/OUTPUT

INPUT

unemployment rate
intake from courts
diversion to community programs
changes in legislation/policy
rate of parole revocation
incarceration rate for "at risk" population (ages 18-29)

OUTPUT

length of sentence
average length of stay for a particular crime
parole and discharge rates

Projections must include historical data, and some estimate of how each of these factors will operate during a future period of time. Unemployment (especially among young females and males between the ages of 16 and 25) seems to be a critical input variable in increases in both prison and mental health hospital admissions (see Appendix V). The Task Force does recognize the need for data gathering and analysis of variables such as those above as part of any future effort to estimate the psychiatric needs of maximum security offenders in Pennsylvania. [26]

Although we know that forty-seven involuntary commitment petitions were filed by the Bureau of Correction from September, 1976, to May, 1977, the reliability and use of this figure for projection purposes is to be questioned. The reasons for this doubt are:

1. As a result of the recent implementation of Act 143, the Bureau of Correction has admittedly taken a conservative approach in filing involuntary commitment petitions. The adjustment to the 1976 Mental Health Act is still in progress. This figure also does not take into account the practices of the county jails.

2. The Bureau of Correction indicates there are many inmates in need of mental health treatment who are unable to meet the criteria for involuntary commitment under Act 143. There is debate as to whether voluntary admissions are allowed under the Act.[27] Some indicate this may be done with court approval, although the Act specifies only involuntary commitment as credit toward time served. Credit should be given as well to time spent as a voluntary patient in a mental hospital. There is considerable hesitancy by judges to approve such transfers based on security considerations and costs. Presently, the county of conviction is required to pay the cost of treatment when a mental health commitment is made from a correctional setting. However, legislation to amend Section 507 of the Mental Health/Mental Retardation Act of 1976 is again pending.

Many inmates in need of treatment are going without mental health services. From a legal perspective it is important to recognize that lack of mental health treatment within correctional settings in conjunction with limited access to the mental health system may, in some instances, be in violation of an individual's Eighth Amendment right to be free from cruel and unusual punishment. See Bowring v. Godwin[28] and Jackson V. Hendricks, supra.

Most of the statistics contained in this section are either derived from testimony or from analysis of population reports. These at best represent estimates of requirements based on past experience and on existing system responsiveness. Efforts should be made by the Office of Mental Health during the next six months to develop the data base procedures and information system capability to establish an ongoing population analysis for appropriate correctional populations in need of acute and/or maximum security psychiatric care and projections of future trends for this population.[29]

SURVEY OF OTHER STATE FORENSIC MENTAL HEALTH SYSTEMS

To fulfill the task of surveying innovative approaches which other states use to meet forensic mental health needs, the Task Force's volunteer staff contacted the departments of Corrections and Mental Health of twelve states, selected on the basis of their reputation as innovators in the forensic psychiatric field. Each department was asked to describe mental health services available to male and female prisoners, requirements and procedures for transfer between the Correctional and Mental Health systems, recent changes in Mental Health's delivery of forensic psychiatric care, provisions for pre-trial competency evaluations, treatment of not-guilty-due-to-insanity cases, and use of or restrictions on involuntary treatment. Only the highlights are summarized here.

To circumvent the traditional inability of departments of correction to attract adequate numbers of professionally qualified, psychiatric staff, Tennessee and Ohio assigned the responsibility of hiring psychiatrists to the Department of Mental Health. Tennessee's department contracts with regional mental health centers to provide services and staff to prisons within their catchment areas.

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[26] *See Brenner, Harvey, Estimating the Social Costs of National Economic Policy: Implications for Mental and Physical Health and Criminal Aggression, Vol. 1 Employment, Paper No. 5, U.S. Congress Joint Committee on Economics, U.S. Government Printing Office, October 26, 1976.*

[27] *S. B. 1105 now seeks to amend Act 143 to allow for voluntary admissions subject to court approval. The Task Force supports this concept.*

[28] *551 F. 2nd 44 (4th Circuit 1977).*

[29] *See also Harvey Brenner's book, Mental Health and the Economy and Richard Light's 1973 Article in the Harvard Education Review.*

Mental health care for female prisoners is scant almost everywhere because there are not enough incarcerated women to justify fiscally a full service component. Thus, proportionately more women than men are transferred to state hospitals or inappropriately held in prison segregation units.

Courts and legislatures are stipulating stricter criteria for transfers from prison to a State hospital. Ohio, with the strictest criteria of the surveyed states, requires a person to have recently committed an overt, harmful act and be judged mentally ill. To care for prisoners not meeting the threshold for transfer and to design a mental health program appropriate for prisoners (usually described as occurring in a setting structured for behavioral change rather than a medical setting oriented toward facilitating swift return to the community), four states have developed or are developing secure medical facilities under the domain of their respective Departments of Corrections. The most adequately staffed one (Iowa) is located near, and draws from, a university hospital. Two other states are developing, for acutely ill prisoners, forensic units in State hospitals, either throughout the State or near major population areas. These states contend that, as much as possible, forensic mental health services should be provided by regular state mental health staff.

Two states are leading the field in providing courts with swift, inexpensive, sound pre-trial competency evaluations through the use of court evaluation teams or "court clinics". These teams complete pre-trial evaluations on an outpatient or in-jail basis. In Tennessee, Master's level mental health professionals who have attended a specific course are qualified to do the evaluations. Tennessee claims it completes eighty percent of its evaluations on an outpatient basis; Massachusetts claims its court clinics have significantly reduced the use of hospitalization for evaluations and subsequent dispositions.

The prevailing procedure for cases involving pleas of not guilty due to insanity included (a) a court finding of the charge (N.G.I.); (b) when requested, a sixty to ninety days' hospitalization for evaluation; a commitment hearing, and subsequent civil commitment or release.

Four states interpret a court order for hospitalization to mean a responsibility to administer treatment regardless of consent. Among these, California has adopted the most detailed set of regulations varying with the type of forced treatment; only tranquilizers can be involuntarily administered without a court order and then for only ten days.

Of all states surveyed, Tennessee, with its decentralized hospital forensic units and prison services provided by regional mental health centers, is most often described as the most forward looking state in the field of forensic psychiatry.

THE DEVELOPMENT OF A FORENSIC SYSTEM

A. Design of the System

The Task Force has considered various ways of providing forensic mental health care,[30] and recommends developing a comprehensive forensic psychiatric system. This system must include: 1) the provision of mental health services within the State prisons (in essence outpatient and diagnostic services); 2) multi-level secure inpatient forensic units at selected State hospitals; 3) crisis intervention, preventive and aftercare services within the county jails; and 4) county court diagnostic clinics.

Such an extensive system would be able to address the needs of prisoners who presently are not committable to an inpatient mental health facility. Currently, there is a paucity of prison mental health services (see Appendix VI) resulting in the transfer of individuals to the mental health system. The availability of diversified services would also serve to limit the numbers of persons needing maximum security psychiatric treatment.[31] A fuller description of the components of this forensic psychiatric system follows.

1. Services in Correctional Institutions [32]

In accordance with the philosophy and stipulations of the 1966 Mental Health/Mental Retardation Act, a prison shall be considered as part of the general "community" with a concomitant need for mental health services. Thus, prisoners should be afforded, within the correctional setting, all the mandated services which are available to the non-prison mentally ill population in Pennsylvania. These services would include emergency and crisis intervention, diagnosis and evaluation, and consultation and education. However, the inpatient mental health treatment should be provided to prisoners in the mental health hospital system, rather than in prisons.

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[30] *The Task Force reviewed the following approaches among others:*

(1) The mental health system supplying treatment at mental health facilities (presently Pennsylvania's system).
(2) Development of a joint mental health-correctional facility to provide treatment for those incompetent to stand trial and prisoners with specialized needs.
(3) The Bureau of Correction developing the capacity to provide mental health treatment for its population in its prisons.
(4) Expansion of the community mental health system to serve persons in county jails and persons leaving State prisons.
(5) Development of mental health services in State correctional institutions and expansion of county court diagnostic units.

[31] *The phrase "maximum security psychiatric confinement" is used since under the law, security considerations take precedence over treatment issues. Corrections' responsibility for preventing escapes gives rise to a setting which severely limits mental health's ability to establish an effective treatment milieu. Thus the use of such facilities should be limited to short-term treatment or for those few mentally ill individuals who have demonstrated repeated assaultive behavior.*

[32] *See Appendix VII "Manual of Standards for Adult Correctional Institutions", particularly sections 4275 and 4279.*

The Bureau of Correction will need to establish the distinct services cited above for the care of mentally ill offenders. The extent of these services will depend on the number of inmates in need.

The Office of Mental Health should develop professional guidelines, policies, and standards for the provision of these services. Funds for these services should be budgeted through the Office of Mental Health. Also, this Office should continually monitor the flow of individuals between mental health and correctional systems.

The Bureau of Correction and the Office of Mental Health should share the responsibility of recruiting and selecting mental health staff qualified to render services in prison.

Mental health professionals working within correctional facilities will, of necessity, be faced with a dual role. They will need to be responsible to the administrative and security demands of prisons and hence administratively responsible to the superintendent. At the same time, these professionals will need to be responsible for following the treatment policies and professional standards established by the Office of Mental Health. Thus, representatives of the Bureau of Correction and the Office of Mental Health must meet regularly to insure that priorities, policies, and guidelines of both departments are coordinated and observed. This coordination should begin with the implementation of this report. (A method for accomplishing this and particular topics to be addressed are set forth on pages 20 and 21 under the "Implementation" section of this report.)

Recruitment of the best possible staff is an issue of concern to the Task Force. Salaries must be increased to reflect the difficult work setting and potential hazards. Also, medical and graduate schools should be encouraged to develop appropriate training in order to interest professionals in forensic mental health care early in their professional careers. It is erroneous to conclude that board certified psychiatrists and people trained in related disciplines must receive, and will be willing to receive, additional post-graduate training to work in a forensic setting. Instead, medical school residency programs and university graduate programs should institute, within their regular programs, specific training to increase and enrich the reservoir of professional personnel interested in forensic mental health work. Appropriate funding should be legislated to support the development and effecting of these training programs. Once appropriate funding is in place for this training, other state funding should be conditioned upon the implementation of these training programs. The Task Force recommends that this development be a condition of their funding from the State. Appropriate funding should be provided commensurate with these mandated services.

The provision of mental health services in prisons raises two issues:

a. when transfer to the mental health system is appropriate; and

b. what constitutes legally acceptable involuntary treatment. With regard to these issues, the Task Force recommends all possible treatment short of inpatient care, should take place in prison with expeditious transfer only when clinical judgment indicates. The Task Force anticipates that mental health interventions will take place in the following sequence.

An inmate within the general population begins to exhibit behavior of concern to other inmates or staff. If mental illness is suspected, the inmate's behavior is monitored and frequently he/she is referred to medical services. Where violent, aggressive or bizarre behavior is displayed, the inmate is usually transferred to a more secure environment within the institution. At this point, medical and mental health personnel become more directly involved in the evaluation of the person's behavior and provision of intensive or emergency treatment.[33] If at any stage in this process, it is determined that the situation is acute (either because the inmate presently being monitored in the hospital or general population progressively deteriorates or because an inmate suddenly becomes identified by the commission of some serious act against another person or him/herself), a transfer to a forensic unit at a State hospital would be effected by the prison.[34] (Note that Section 302 of Act 143, "Involuntary Emergency Examination and Treatment

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[33] *The Task Force considered the legal aspects of providing treatment in prison with or without the inmate's consent.*

As to treatment for physical illness, it is clear that informed consent is necessary except in cases of extreme emergency, where consent is implied. See for example, Gray vs. Grunnagle 423 Pa. 144,223 A 2d 663 (1966). Many of the same considerations would appear to apply to treatment of the mentally ill. The scope of Act 143, however, purports to cover "all involuntary treatment of mentally ill persons whether inpatient or outpatient and. . . all voluntary inpatient treatment. . . . ." Section 103. There is also a provision that when someone in prison". . .is made subject to inpatient treatment, he shall be transferred to a mental health facility"; and "inpatient treatment" is defined as that which requires "full or part-time residence." Section 103 and 401(b). The Task Force concluded that most instances of treatment in prison fall into the category of outpatient and that the procedural requirements of Act 143 must be met whenever such treatment is not voluntary or rendered under highly exigent circumstances.

Where inpatient treatment becomes necessary, Act 143 provides that an inpatient facility must satisfy hospital accreditation standards unless exempted annually by the Department of Public Welfare. Section 105. However, as it relates to those in prison, the distinction between inpatient and outpatient treatment appeared to the Task Force to be unrealistic and often unhelpful. According to Task Force members and other mental health professionals experienced in prison work, many inmates treated in a prison setting do well even though they might be thought of as "residential" or inpatient cases. The better rule or classification would seem to depend on whether the inmate, following crisis intervention or other initial treatment, continues to make progress toward recovery. The period of treatment involved could last several weeks. The Task Force therefore urges the Department of Public Welfare to take steps to grant appropriate exemption for this purpose or, in the alternatives, would support legislation clearly authorizing short-term inpatient treatment, voluntary and involuntary, to take place in prison.

[34] *The Bureau of Correction visualizes a number of possible examples of persons requiring transfer for treatment. See Appendix III.*

Authorized by a Physician–Not to Exceed 72 Hours" indicates that involuntary treatment at a treatment facility can be administered when a physician upon examination determines severe mental disability and need of emergency treatment for 72 hours.)[35]

In some cases, immediate emergency psychiatric treatment can be of very short duration and the inmate can be returned to his correctional institution to follow-up outpatient care. However, if the mental health hospital staff feels that the inmate requires additional inpatient treatment, an extension hearing must be initiated. Evaluation of the status and treatment needs of the inmate would be ongoing as stipulated under Act 143. In the greater number of instances, it is anticipated that the offender will be returned to his/her correctional institution, terminating the inpatient status. It is anticipated that as the provision of psychiatric services within the prison progresses, many of these returned offenders will receive short-term follow-up, outpatient psychiatric services within their respective correctional institution.

2. Forensic Units in State Hospitals

The presently existing forensic units at Norristown, Mayview, Philadelphia and Warren should continue to be developed. The Task Force recommends that a similar unit be developed in the Central Region of the State. Use of these units should be limited to (a) prisoners who become acutely mentally ill while incarcerated; (b) mentally ill, detained incompetents who are likely to regain competency; and (c) county prisoners who require treatment beyond that supplied in the jails through the development of liaisons with County MH/MR units. The forensic units should also be available for individuals pleading not guilty by reason of insanity while they await trial. The Task Force recommends that forensic units not be used for civil involuntary patients who may need a more secure setting.

The design should include several levels of security in one facility. Three of the potential five units need to have maximum security capability. The establishment of multi-level security forensic settings will resolve the problems and costs of establishing one or two units solely as maximum security facilities. The development of these units will also allow confined individuals to be closer to families and legal counsel, as well as providing greater access to the accompanying full staff complement.

Security needs and due process rights of the patients are integral elements in transfers from the correctional system to these units. Section 401(a) stipulates that the sentencing judge must authorize that the transfer of a prisoner to a mental health unit shall not affect the conditions of security required by his criminal detention or incarceration.

Under the present structure, the cost of commitment to mental health facilities is billed to the county where such individual was tried, even though the individual may be committed from a State correctional institution located in another county. The Task Force agrees that counties should not have to incur this cost, but that it should be borne by the Commonwealth.[36] Under this suggested structure, corrections personnel should be less hesitant to petition for involuntary commitment and judges more willing to order involuntary commitment since their counties would not be fiscally encumbered with the cost.

3. Mental Health Services at County Jails

Historically, the county jail has become the repository of individuals in need of mental health treatment. This appears to be particularly so under the new provisions of Act 143 and its current interpretations. However, essentially little or no mental health services are available in these jails.[37]

The Task Force recommends that the county MH/MR units provide mental health services in jails located within their catchment areas. The method of providing such service should be by contract with community mental health centers or direct staff. Involuntary treatment provisos need to be considered and standards defined as to the extent of services. The provision of mental health services in jails falls under the duties of the Department of Public Welfare as stated in the 1966 Mental Health/Mental Retardation Act, Section 201: "to assure within the State the availability and equitable provision of mental health...services for all persons who need them regardless of...residence...or social status."

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[35] *With the expansion of a central office for forensic development and coordination, and the delivery of mental health services by mental health personnel, the mechanism for effective monitoring and administration is supplied to protect against potential abuses. Furthermore, personnel should attempt to notify the inmate's attorney and/or nearest of kin in addition to the central forensic office of all involuntary emergency treatment. Records must be kept of all medications.*

[36] *S.B. 599 seeks to accomplish this. The Task Force supports such legislation not including the retroactivity on this bill.*

[37] *A recent survey of county correctional facilities indicated that the number of commitments to mental health facilities from county correctional institutions under Act 143 (845 commitments versus 471 commitments). Belford, R. "Survey of Mental Health Resources in County Correctional Facilities", October, 1977, pp. 4.*

The Task Force underscores the concept of the Mental Health/Mental Retardation Act of 1966 that services be on a 90% State 10% county basis, unless specifically identified in that Act as being 100% State.[38] The counties should have funds available for this purpose if S.B. 599 is passed as the Task Force recommends and counties no longer have fiscal responsibility for prisoners in State mental hospitals. As the Department must approve the annual county plan for the county to receive the annual grant for services (Section 509 of the 1966 Mental Health/Mental Retardation Act) the Department can potentially reject any plan not calling for the provision of mental health services to the jail population. If after approval of a county plan, including forensic services, the Department determines that a county or combination of participating counties is not complying with required services, the Department shall provide such services. Under Section 512(d) when the Department shall provide the services, the county must pay its share computed in accordance with Section 509 (90%) plus an additional fifteen percent of the net cost to the Commonwealth for the county program. Section 509(5) indicates, however, that the counties are required to provide only those services for which sufficient funds are available. Therefore, it is necessary in order to insure adequate delivery of forensic services, that sufficient monies be appropriated.

Steps must be taken to develop a mechanism whereby the counties will have the monetary resources and personnel to provide these much needed services. The Task Force acknowledges that counties continually struggle to provide needed services within the restraints of limited financial resources available. More resources simply must be made available.

4. **Local Court Diagnostic System**

Court diagnostic clinics are usually established for the following purposes:

a. To eliminate unnecessary commitment of adults to State hospitals for observation;

b. To examine and evaluate persons immediately rather than unnecessarily committing them to county jails and State prisons;

c. To be immediately available to the court for consultation on problems involving legal-psychiatric issues; and

d. To support and enhance the investigative and rehabilitation functions of probation with consultation and inservice training.

Court clinics should become involved in cases as a result of referrals made only by a judge or his designee. Referrals should be conditioned upon the court's need to have information of a clinical nature about a defendant's competency, sanity, criminal responsibility, commitment, dangerousness, probation risk and pre-sentence and treatment needs. Cases should be seen on demand, examinations done, and reports returned in accordance with the court's trial schedule.

In the past, two main approaches have been used in developing local court diagnostic clinics. One approach, such as exists in Philadelphia, uses the clinic only for diagnostic and pre-sentence consultation purposes, the clinic being located within City Hall where many of the courts are also located. Treatment in Philadelphia occurs within the Holmesburg Prison. No outpatient services are available to individuals within prison settings through the court system. A second approach, such as exists in Bucks County, uses the clinic for diagnostic, pre-sentence diagnostic consultation, and treatment purposes. Diagnosis and treatment functions are provided through the prison with outpatient services being available to those individuals coming through the court system.

Although the Task Force recommends that diagnosis and treatment services be available in the county jail system, these need not be established as distinct and apart from one another. Either of the above approaches is satisfactory as long as both diagnosis and treatment are provided. If, however, a county (or group of counties) decides to provide diagnosis and treatment jointly, then there should not be a separate component for treatment within the county jails established through the county MH/MR system. Counties must be given the flexibility to opt for the method of providing diagnosis and treatment which best suits their needs.

The Task Force recommends that funding for these clinics be through the county MH/MR system on a 90% State/10% county basis. Where counties are already operating such units their level of fiscal participation should be continued. The design and operation of the clinics will be a county responsibility and will be subject to annual review by the Department of Public Welfare.

Establishing Forensic Services for Women

The Task Force agrees that forensic mental health treatment for women should follow the same pattern as that for men, and include emergency and non-acute treatment available through mental health personnel in jails and prison, decentralized, multi-level secure forensic units in State hospitals for women offenders.

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[38] *Those services which the State funds at a 100% level are inpatient, partial hospitalization and interim care services (this latter for the mentally retarded).*

The following recommendations are made for establishing adequate services for women:

1. A total of forty beds should be created within the State mental hospital forensic units to serve women who do not respond to treatment provided in jail or prison, need inpatient psychiatric care and meet the criteria of the Mental Health Procedures Act of 1976. Women in the Western Region would be best served by a fifteen bed unit near Pittsburgh. Women in the Eastern and Northeastern part of the State should receive care in a fifteen bed unit being established at Norristown. Women in the Central Region of the State could be served by a ten bed unit established at a hospital in that Region, to be designated as maximum security. This unit could then serve the needs of Muncy and would be equally accessible to both the Western and Eastern areas of the State. The final location of this unit would have to be determined on the basis of resources and need.

Only one unit need have maximum security capability as the great majority of women do not exhibit the type of assaultive behavior requiring maximum security. Intensive staffing in a medium security unit can be an adequate alternative in most situations.

2. A full component of mental health staff and services should be available at Muncy. Staff should be attuned to the particular mental and physical health service needs of women. The staff should include male and female professionals, paraprofessionals, and peer counselors.

3. With the cooperation of county MH/MR units, development of mental health services and staff in the county jails should begin. These services should be identical to those offered to men, except that staff should be sensitive to the particular needs and perspectives of women.

A staff position within the new forensic staff of the Office of Mental Health should be designated as responsible for developing and monitoring forensic mental health services for women. The same functions which are assigned to the forensic unit for men would also be carried out for women.

Finally, the provision of forensic units for women within the State hospitals should be given a top priority due to the present complete lack of services. Staffing of the unit being developed at Norristown State Hospital could be an immediate beginning.

B. Implementation

Successful implementation of the Task Force's recommendations depends on the coordinated efforts of county government, the State legislature, the Office of Mental Health, the Bureau of Correction, and the sub-divisions of these organizations. The State legislature and county governments must authorize finances and pay for the recommended mental health services, staffing and facilities. The State legislature must also pass the enabling legislation described in this report (See page 21). The Office of Mental Health and Bureau of Correction share the administrative responsibilities of implementation.

The Task Force would anticipate that the Commissioner of Mental Health, Commissioner of Correction , Superintendents of Philadelphia and Pittsburgh County jails, head of the Office of Mental Health, Department of Forensic Psychiatry, a designee of the Attorney General, and appropriate staff members will meet on a monthly basis to plan for, develop and review the requisite forensic mental health services.

Critical tasks to be accomplished in these intra-departmental meetings include the need to:

1. Develop a dual information and reporting system (See Recommendation 4) so that service needs can be readily projected.

2. Establish shared or equivalent definitions of individual and institutional security ratings and establish when and by whom specific cases are to be classified.

3. Plan for, design and oversee the establishment of forensic units in appropriate State hospitals.

4. Assure the provision of mental health services in the prisons and county jails.

5. Assist interested counties in starting court diagnostic units.

6. Oversee the establishment of accounting and billing procedures.

7. Review the ongoing operations of forensic mental health services; in particular, intra-system transfers, staffing, recognition of procedural safeguards, costs, and new intra-system problems and data collection.

8. Develop a timetable for the implementation of the recommendations of this report.

To insure that this implementation process continues in the spirit of the Task Force's recommendations, the Governor should appoint a monitoring body consisting of a limited number of active and informed citizens and professionals involved in corrections and mental health fields. This body would see that the Bureau of Correction , Office of Mental Health, State legislature, county governments, correctional institutions and State mental hospitals fulfill their responsibilities as outlined in this report. The monitoring body should regularly make their findings publicly available.

C. Organizational Framework

In order for the Commonwealth to develop a comprehensive forensic mental health system, the Office of Mental Health needs to expand its staffing for forensic services directly attached to the Deputy Secretary for Mental Health. Duties of the central office as recommended by the Task Force have been previously defined.

The Office of Mental Health should develop a clear and effective organizational framework for establishing and monitoring forensic services.

D. Legislative Recommendations[39]

The Task Force concludes that its recommended plan for comprehensive forensic services can only be implemented with a clear legislative base.[40] This will require several steps:

1. Amending the 1966 Mental Health/Mental Retardation Act so that it specifically defines community to include persons in prisons and jails who are thus entitled to mental health services.

2. Amending Act 143 so that individuals incompetent to stand trial or found not guilty by reason of insanity, and thereafter involuntarily committed to a State hospital, are not released to the community without prior court action. Presently these persons are released when the director of the treatment facility determines that they are not longer severely disabled or in need of inpatient services.

3. Amending Act 143 to clearly permit emergency involuntary treatment in a prison setting without involuntary commitment even though the prison will not necessarily be designed as a treatment facility. Safeguards of Act 143 should apply.[41]

4. Passage of legislation to allow voluntary commitments from correctional settings to mental health settings.

5. Passage of legislation that provides for the Commonwealth to bear the cost of treatment for convicted individuals transferred from correctional settings to mental health settings (presently charged to the county of conviction).

6. Legislation providing sufficient appropriations to clearly demonstrate the commitment of the General Assembly to the recommendations of this Task Force.

7. The General Assembly must provide enabling legislation to establish new multi-level security forensic units.

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[39] *Appendix IX sets forth the position of the Attorney General in regard to these legislative recommendations.*

[40] *Several of these recommendations have already been introduced as legislation.*

[41] *The Bureau of Correction takes the position that the safeguards of Act 143 are designed for use in the free community and the environment of the correctional institutions is vastly different from the free community. Therefore, certain modifications in Act 143 may be necessary to facilitate treatment in a correctional institution (e.g., should the 302 requirement of an examination within two hours be modified in light of the fact that correctional institutions do not have doctors on duty 24 hours a day and in light of the fact that the inmate is not being restrained in a sense that a prison in the community would be restrained; is notification of family necessary in that there has been no change in the inmate's residence, etc.).*

E. Estimated Costs for Developing Comprehensive Forensic Services

The Task Force has not overlooked the cost factor of its recommendations but is certain that a Commonwealth investment in this area will have long range benefits for all citizens. As a point of departure a preliminary estimate of the cost of the major elements of this proposal was developed. Additional refinement will be needed. These figures were provided by the OMH.

Cost Estimate: Task Force Proposal: Institutional Construction

1. **Construction – Maximum Security**

a)	50 bed Western unit (1200[42] x $90[43] x 50[44]) =	$ 5,400,000
b)	75 bed Eastern unit (1200 x $90 x 75) =	8,100,000
c)	25 bed Central unit (1200 x $90 x 25) =	2,700,000
d)	10 bed Women's unit (1200 x $90 x 10) =	1,080,000

2. **Construction – Medium Security**

a)	25 bed Central unit (1200 x $90 x 25) =	$ .2,700,000
b)	25 bed Eastern unit (Renovation) =	320,000
c)	30 bed women's unit (1200 x $90 x 30) =	$ 3,240,000
	TOTAL CAPITAL COST	$23,540,000[45]

Cost Estimate: Task Force Proposal: Non-institutional

1. **Services to State prisons**

8000 prisoners x 15% = 1200 clients
$25/session x 52 sessions x 1200 = $1,560,000
100% funding new appropriation — $ 1,560,000

2. **Services to county jails**

Philadelphia	$1,000,000
Allegheny	750,000
39 Other Units	1,950,000
	3,700,000
	x .90 (percentage of State Funding)
	$3,330,000

3. **Services to county courts**

Philadelphia	$ 250,000
Allegheny	200,000
Bucks	100,000
38 Other Units	1,520,000
	2,070,000
	x .90 (percentage of State Funding)
	$1,863,000

TOTAL ANNUAL COST — $6,753,000

42: Represents the total space required per patient. This includes patient living space, recreation areas, program space as well as necessary office facilities for staff. Thus, the figure represents the space required for a fully self-contained unit providing for the security & program needs of the patient.

43: Represents the construction costs per square foot

44: Represents number of beds

45: New construction design should provide for limited expansion of these facilities if necessary

Cost Estimate: Task Force Proposal: General Government

1. **Central Office**

2 Psychologist II	$44,400	
1 System Analyst III	19,400	
1 Clerk Steno II	10,300	
½ Programmer II	8,500	
Salaries	82,600	
Benefits	24,800	
Computer time	5,000	
		$ 112,400

2. **Regional Offices**

4 Social Workers III	$74,400	
Salaries	74,400	
Benefits	22,300	
		$ 96,700
TOTAL ANNUAL COST		$ 209,100

Cost Estimate: Task Force Proposal: Annual Operating Costs of maximum security units at State Hospitals

1.	Program staff additional medium security units (staffing ratio of 1.5: 1 = 120 staff @ $17,000)		$2,040,000
2.	Program Staff new maximum security units (staffing ratio at 2:1 = 320 staff @ $17,000)		5,440,000
3.	Incremental operating cost new bed (240 beds x $20.61 x 365)		1,805,000
4.	Total new cost 81-82 fiscal year		9,285,000
	a) less: Farview operating cost	$14,900,000	
	Net: (represents difference between operating Farview & operating new multi-level secure Forensic units)	5,615,000	

Cost Estimate: Task Force Proposal: Relieve County Liability

1.	Relieve county of liability for commitment cost	$10,000,000

Note: Until such time as the new multi-level secure forensic units are established certain additional costs will necessarily be incurred at Farview.

These are

1.	Life Safety Code Renovation at Farview	$ 600,000
2.	Upgrade treatment staff at Farview (8 professional positions)	296,000
		$ 896,000

VI. RECOMMENDATIONS

1. Establish a Comprehensive Forensic Mental Health System

Essential elements of the Task Force proposal are: multi-level secure forensic units, mental health services at State correctional institutions, mental health services at county jails through the County MH/MR System, county court diagnostic clinics and a strong forensic unit within the Office of Mental Health. To assure action upon this proposal the Office of Mental Health should develop a detailed implementation plan within six months after the Governor approves this report.

2. The Future of Farview

The Task Force acknowledges that Pennsylvania must provide maximally secure forensic psychiatric care for the protection of all people and treatment of acutely ill, dangerous offenders. Farview as it exists, however, has no place in an efficient and effective forensic mental health system. Costs in excess of $63,000 per patient per year are prohibitive.

The Task Force consensus is that Farview must be closed by the end of 1980; to close Farview by the recommended date will require that the proposed comprehensive forensic system be fully operative. This is necessary to assure that security and treatment facilities are continuously available.

3. Mental Health and Corrections Should Establish Interagency Committees to Plan and Implement a Forensic Psychiatric Maximum Security System

The provision of mental health services to detentioners and offenders requires extensive coordination and cooperation between the Bureau of Correction and the Office of Mental Health. In order to address the design and implementation issues inherent in establishing a forensic mental health system, the Office of Mental Health and Bureau of Correction share administrative responsibilities for implementation. In addition, it is recommended that the Governor appoint a monitoring committee to oversee the movement towards implementation of this report. See pages 20-21.

4. Establish a Forensic Information System

The Office of Mental Health, in cooperation with the Bureau of Correction , should establish an information system that is able to:

Aid in identifying the types and categories of psychiatric treatment required by offenders and related services needed by correctional agencies.

Collect specific data that will be useful in projecting numbers of offenders who require maximum security psychiatric care.

Provide rates, flows and costs to decision-makers for future planning of facility space requirement, personnel and service needs, and budget requests.

Monitor patients transferred from State prisons and provide information on length of stay, services required, and case management/review for special commitment categories.

5. Creation of a Central Staff for Forensic Services Within the Office of Mental Health

This staff would be responsible for: developing policy, initiating the design and improvement of forensic units, working with County Mental Health/Mental Retardation System to develop services for county jails, monitoring and expediting the flow of individuals within the system, and participating in the development of a county court diagnostic system.

6. Establish Comprehensive Forensic Services for Women

To serve the mental health needs of women offenders, the Commonwealth should develop forensic services for women. These include, mental health services at Muncy Prison, mental health services in county jails, and a specific staff position at the Office of Mental Health Central Office to be primarily responsible for forensic services to women. Distinct forensic women's units in three of the State hospitals must be established. This is a top priority.

7. Address the Psychiatric Needs of Juvenile Offenders

Further study is needed to determine the forensic needs of persons in the juvenile justice system. It is recommended that a Task Force be established to investigate the problem and propose a solution.

8. Set Up a Voluntary Mental Health Commitment Procedure for State Prisoners

A mechanism for voluntary commitment of mentally ill offenders to mental health settings with appropriate safeguards, subject to court approval, be established. Credit should be given to time spent as a voluntary patient in a mental hospital.

9. Implementation of Act 143 in Correctional Institutions

It is recommended that the safeguards of Act 143 be appropriately applied within correctional facilities.

10. Funding of Forensic Mental Health Services

The Commonwealth should incur the expenses of providing mental health services for persons in prison who are transferred to mental health facilities, increase the level of funding to counties for the purpose of forensic services in

county jails, increase salaries to attract qualified personnel at State hospitals and to grant appropriate state funding to mandate the involvement of medical and graduate schools in forensic services.

11. **Aiding Wayne County Area**

To offset any adverse effect on the economy of the Wayne County area caused by the closing of Farview, the Governor should exert every effort to help Wayne County develop a sound economic base. Strong consideration should be given to exploring what, if any, alternative uses could be made of Farview.

12. **Involvement of the Public in the Implementation and Monitoring Processes**

The recommendations of the Task Force will only be achieved if there is full community understanding, participation and acceptance in the planning and implementation stages. A careful public strategy must be planned to include legislators, hospital superintendents and Boards of Trustees, judges, district attorneys and mental health groups.

Groups of interested citizens should be encouraged to form monitoring bodies for mental health and prison forensic psychiatric units within their geographic areas.

Finally, the Task Force recommends that a limited number of active citizens and professionals be appointed by the Governor to monitor the continued progress of the Bureau of Corrections and the Office of Mental Health in the implementation of this Task Force's recommendations.

ADDITIONAL COMMENTS

Dr. Daly dissents in part:

Until an alternative forensic system which replaces the services of Farview is developed, the establishment of an arbitrary closing date is unrealistic.

I also agree with Dr. Biele's comments.

Mr. Boyer dissents in part:

I non-concur with the consensus that Farview must be closed by 1980. The psychological effect of such a recommendation now, upon both the employes there and the citizens in the community (since it is almost totally dependent upon said employment) would understandably be devastating. The decision to close Farview should only be considered after the proposed comprehensive, forensic system in the Commonwealth is in actual operation.

Consideration should be given, as early as possible, to review the practicability of utilizing as much of the Farview properties, as deemed possible, for other purposes; so as to lessen the economic impact upon the workers and the community if and when Farview's present operations may be finally closed.

To prevent said community from possibly becoming a "Ghost Town" this should be done.

Mr. Reihart dissents in part:

Farview presently is an essential part of the forensic mental health system in Pennsylvania. It must not be closed until other facilities are available which can provide for the care and protection of those persons who need maximum security psychiatric care. I agree with Dr. Daly that an arbitrary closing date is unrealistic. I would also add that closing Farview without the alternative forensic system in place and functioning would constitute an irresponsible, inhumane, and dangerous act of government.

Senator O'Pake dissents in part:

In addition to agreeing with the dissents of Representative Scirica, Dr. Daly and Mr. Boyer, as a member of the Pennsylvania Senate I feel constrained to add an additional caution. In these times of fiscal difficulti ., every expenditure of the public's tax dollars must be judiciously guarded. There is too strong a tendency at present to scrap existing programs and facilities that are fully functional. Decisions to so change present systems cannot be based solely on idealistic and emotional resolutions of the problem. I do not feel comfortable with either the costs projected by the Task Force, or the manner in which they were determined.

It is critical, in order to evaluate a proposal for any major program change, to have a responsible, detailed fiscal analysis. Without such research and planning, it is simply not possible to adequately compare existing with projected costs, much less recommend abolishing existing programs. As a member of the Legislature which will eventually be called upon to fund whatever new direction is taken, I have practical problems with a plan so unrelated to fiscal reality.

Representative Scirica dissents in part:

I do not concur with Legislative Recommendation No. 7.

The General Assembly will oversee the development of the forensic mental health system through its control of the appropriation of public money.

Multi-level security forensic units will be created only if the Legislature agrees to fund them. It is not necessary to pass enabling legislation for the specific purpose of establishing these units.

Dr. Biele comments:

I submit the following comment which should not be construed as changing the intent, tone or conclusions of the Task Force.

The staffing of the maximum security unit (as in Section 2(a) under the section entitled, "Security Definitions") should consist of two separate disciplines both of which will function at a high level of mutual collaboration. The matter of physical security should be handled exclusively by correctional officers from the Bureau of Corrections. All psychiatric matters will be administered exclusively by mental health personnel assigned by the Office of Mental Health. Thus, those personnel engaging in the therapeutic process will not be identified with those who are responsible for issues relating to punishment and safety. Nevertheless, physical security will always take precedence over any other issue among those who have been deemed to require maximum security. On the other hand, matters relative to psychiatric evaluation, treatment and change of status predicated either on psychiatric improvement or intensified psychiatric disability should be the exclusive responsibility of those professionals functioning under the aegis of the Office of Mental Health.

SEPARATE REPORT OF JUDGE EDMUND V. LUDWIG ON THE NEED FOR MAXIMUM SECURITY PSYCHIATRIC FACILITIES IN PENNSYLVANIA

I agree, in substance, with the findings and recommendations of the majority of the Task Force, and I have joined in its Report. One vital aspect of the Report, however, in regard to the future of Farview State Hospital, requires specific comment and a markedly different emphasis.

The Task Force was unanimous in concluding that there are extremely dangerous mentally ill offenders who must be kept, involuntarily, in maximum security facilities. Historically, the sole institution ever to be designated for such persons in Pennsylvania is Farview State Hospital, which was opened in 1912 as a hospital for the criminally insane. As reflected in the Task Force Report, despite many recent improvements, it is arguable whether Farview should be continued as a maximum security mental health facility, particularly in view of the escalating considerations that now approach 65,000 per resident per year. The Task Force Report recommends, after much consideration, that Farview be closed by 1980 and that alternative maximum security units be established and made available for use in the meantime.

This recommendation, as worded, is not acceptable to the Pennsylvania Conference of State Trial Judges, the membership of which includes nearly every Common Pleas Court Judge and Municipal Court Judge in the Commonwealth. The reason, in large part, is that it puts the institutional cart before the executive or legislative horse. At this moment, the Commonwealth cannot afford, whether by executive order or act of assembly, to take the risk of deciding on any specific closing date for Farview State Hospital. Instead, an appropriate timetable should call for the immediate development of alternative institutions. Once these have been built, opened, staffed, and found to be serviceable, then, if the circumstances so dictated, maximum security commitments to Farview could be discontinued.

In January of this year, exactly the same question was presented to the Pennsylvania Conference of State Trial Judges by its Mental Health Procedures and Administration Committee. The Conference membership, by a vote of 224 to five, endorsed a statement of position, which read as follows:

> "As Judges, we are keenly aware that a hardcore of extremely disturbed and dangerous offenders is inherent in the criminal system. For them, the only alternative to incarceration is a maximum security mental health facility."

In regard to Farview State Hospital, the statement said:

> "We have been given no reason to believe that any substitute facilities will be made available. We cannot accept expressions of hope or promises. We cannot utilize facilities that are less than maximum security if we are to continue to discharge our obligation to the public."

By resolution, the Conference strongly opposed "the closing the Farview State Hospital in the absence of the establishment of other maximum security facilities suitable for the care and treatment of the mentally ill." This position was reaffirmed at a meeting of the officers and executive committee of the Conference on October 8, 1977.

Trial judges occupy a unique vantage point from which to observe the correctional system and the mental health system. They also are charged with the special responsibility of applying the law so as to protect both the individual and the community. In their work, they are required to deal with the many-sided and often difficult issues and the competing interests and needs affecting the mentally ill offenders - whose criminal record may include repeated acts of serious violence or who may be disabled and virtually helpless.

Given this background, a trial judge's first order of business, however, is to decide what must be done in a particular case, sometimes under emergency conditions, and always in the light of what is most just and practical. The safety and welfare of the citizens of the State cannot be ignored or depreciated in the name of trying to compel the Commonwealth to provide better care and treatment service in the future. Where the need is great and the choices are few, a judge must choose the best alternative available. The choice, at present, is therefore an easy one. So long as Farview State Hospital remains the only reliably secure mental health facility in Pennsylvania, trial judges are overwhelmingly in favor of keeping it in operation. To this extent, I join with other members of the Task Force in their expressions of similar views.

APPENDIX I*

The Alliance of the Liberation of Mental Patients

Michael Basista, Esquire
Columbia and Montour County Court of Common Pleas

Richard Bazelon, Esquire

Dr. Vincent Berger, Director
Regional Psychiatric Forensic Unit, Mayview State Hospital

Lloyd Brackwell
Former Farview Patient

Judge Beryl Caesar
Philadelphia Court of Common Pleas

Dr. Joaquin Carals
Norristown State Hospital

Walter Cohen, Esquire

Gerald Cooke, Ph.D., Chief Psychologist
Norristown State Hospital

Rendell Davis, Executive Director
Pennsylvania Prison Society

William Davison
Northampton County Probation Officer

Allen Deibler, Administrator
Lehigh County MH/MR Program

Judge John C. Dowling
Dauphin County Court of Common Pleas

The Honorable D. Michael Fischer
House of Representatives

Mahmood Ghahramani, M.D.
Philadelphia State Hospital

Ronald Gibson
Former Farview Patient

Ray Hamill, Esquire
Representative Farview Patient Body Government

Elsie Heard
Philadelphia District Attorney's Office

Dr. Robert Hickey
ACLU, Pittsburgh

Glenn Jeffes, Superintendent
CHASE Correctional Institution, Dallas

Terry Johnson
Pennsylvania Prison Society

Ned Levine, Esquire
Philadelphia Public Defender's Office

Dr. Richard Mays, Medical Director, Divine Providence Community Mental Health Center, Williamsport

James Moore, Vice President
Western Wayne Landowners and Taxpayers Association, Inc.

Judge Jay Myers
Columbia and Montour County Court of Common Pleas

Robert Nappi
Mental Health Association of Lackawanna County

Joseph Radley
Lycoming/Clinton County MH/MR Center

Ronald Refice, Ph.D.
Director of Social Rehabilitative Services
Farview State Hospital

William B. Robinson, Commissioner
Bureau of Correction

Dr. Jack Roop, Superintendent
Allentown State Hospital

Frank Schubert
Council Director for District Council 87 of AFSCME

Andrew Schneider, Esquire
ABA Monitoring and Advocacy Project

Richard Sheehan
Mental Health Review Officer (Norristown)

Hilda Silverman
Pennsylvania Program for Women and Girl Offenders

William Sipes
Former Farview Patient

Maxine Stotland, Esquire
Philadelphia District Attorney's Office

Robert Switzer, M.D. Superintendent
Eastern State School and Hospital

Ronald Thomas
Former Farview Patient

Margery Velimesis
Pennsylvania Program for Women and Girl Offenders

Mr. Jonathan Vipond
Mental Health Association of Pennsylvania

*This list represents those individuals formally presenting oral testimony to the Task Force.

APPENDIX II

FORENSIC UNITS–CURRENT STAFFING AND CENSUS

	Northeast Region	Southeast Region		Western Region	
	Farview	PSH N-8	Norristown	Mayview	Warren
Bed Capacity	475	44	75 closed + 10-12 forensic pts. open ward	56	30
Census as of 9/8/77	176	40	70	42	22
Security Rating	Maximum	Medium	Medium	Medium	Medium
Staff:					
Psychiatrists	1f/t 2p/t	1	1	20hr	1
RNs	29	3	5	10	5
P.S.A.s	254	26	63	30	19
Social Workers	6	1	2½	3	1
Psychologists Psychology Interns	8	60hr	98hr	80hr	20hr
Ministers	4	1p/t	30%	0	10%
Occupational Therapists Therapeutic Activities Workers Recreational Therapists	12f/t	28½hr	45hr	120hr	80hr
Custodial Workers	0*	2	3	2	0
Clerk-Secretary	20	0	0	0	0

*For this classification at Farview, 44 CETA employees principally perform this function. Also as Farview is an institution to itself, it has many other job classifications of employees, with total staff complement being 493 as of 9/13/77.

APPENDIX III

Disposition of Mentally Ill Offender

EDWARD B. GUY
MELVIN S. HELLER
SAMUEL POLSKY

THE MENTALLY ILL OFFENDER deserves the best possible psychiatric care and treatment, particularly when involved in criminal litigation; and society deserves the very careful appraisal and management of his potential for dangerousness.

For pragmatic as well as humanitarian reasons, it is imperative that the mentally ill offender be handled skillfully and expeditiously at all levels of the legal process. A number of definitive consequences flow from this requirement.

To begin with, it is necessary that the law, as set forth in the appropriate Mental Health and Retardation Acts or other statutes, be clear and concise. It is equally important that the necessary diagnostic and treatment facilities be available: a law that cannot be implemented is worse than useless—it is a deception. Furthermore, any program, however well conceived and supported, must fail if its administrative machinery does not provide for swift and easy transfer from one facility or operational level to another. Finally, the purposes and implications of diagnosis and treatment at each stage of legal inquisition or disposition must be clearly understood by the judiciary as well as the attorneys, if the statutory procedures are to be used effectively and well.

Mental illness has a pervasive influence, sometimes unrecognized and often neglected in the criminal law, including: determination of competency in each phase of proceedings, from the pre-trial stage to the execution of sentence; problems of exculpatory insanity; reduction in grade of offense; diminished responsibility; mitigation of punishment; and alternatives to a prison sentence. These varied considerations, in turn, must often take into account the individual's need for special external controls, psychiatric treatment, and special rehabilitative considerations. Perhaps most neglected are the dispositional judgments that are made outside the formal courtroom setting but are essential interstitial parts of the administration of justice.

Attempts to improve the management of mentally ill offenders raise two basic considerations. The first involves the more efficient utilization of existing personnel and facilities, and the second lies in expansion in critically needed areas. Until the most efficient use is made of what we already have, we are hardly justified in asking society for more.

From a realistic and pragmatic point of view it is not likely that our society will reorder its priorities in the immediate future and devote a significantly larger portion of its resources to the care and treatment of the mentally ill, and especially not to the mentally ill offender. Neither the professionals currently working in the field, nor the offenders or their families, have any great influence on our legislators, and certainly no lobbies are working on a federal or state level to increase spending in this area. We must, then, within the field itself, devote our first efforts to the more efficient utilization of existing staff and facilities.

The basic psychiatric needs fall roughly into two broad areas—diagnostic and treatment, each requiring a specialized staff and physical facility.

The average psychiatric professional is not equipped through training or experience to deal effectively with the mentally ill offender whose socio-cultural background, values, behavior, thoughts, and feelings are so different from those of the average patient encountered in psychiatric practice. The forensic psychiatric questions which arise in these cases also require a special understanding of the legal aspects of the case and the various dispositional possibilities which are open.

Similarly, the average psychiatric hospital facility is not staffed or physically equipped to deal with the special considerations of maximum security and special handling which these criminally inclined and mentally ill persons require.

Legislation in most states provides a reasonably comprehensive mental health and mental retardation act, which serves as the framework for all the activities concerning the disposition of the mentally ill offender. These acts in the United States tend to follow a common pattern. In consequence they share characteristics that lead to common problems.

First, the acts are designed primarily for civil commitment, and criminal commitment becomes a peripheral, rather than a central part of the act's design.

Second, the distinction between civil and criminal commitment represents a normative and administrative convenience rather than an operative reality. The line between civil and criminal conduct leading to commitment is often blurred for a variety of reasons. In addition the distinction between criminal and non-criminal behavior turns upon the determination of a state of mind more or less recently antecedent to the behavior that leads to the commitment. There is an obvious circularity here that is difficult to escape.

Third, protection of the individual's civil rights, including due process and the determination of his state of mind, is very uneven. Where a mental health act spells out such protections, it is apt to do so in greater detail with respect to criminal commitment than for civil commitment. Furthermore, some of the basic protections are not spelled out in mental health acts, but are part of the greater complex of constitutional law. Mental health acts assume that the best interests of society and the best interests of the individual coincide. This is often far from the fact, and an adversary procedure may not be the best way to determine an optimum balance between the two conflicting interests.

Fourth, commitment in lieu of sentence poses special problems of its own. It is an admirable enlargement of judicial discretion to permit an individual to be treated as sick after he has been found guilty. It is also a double valued system that, to some extent, contradicts itself in operation. The indefinite commitment appropriate to civil cases cannot be utilized. The offender has the right to be freed or to have his criminal commitment converted into a civil commitment after he has served an appropriate sentence. This tends to result in commitment for a specific number of years, rather than for the period of therapeutic necessity, which cannot be determined in advance.

The director of the mental health facility faces several handicaps in dealing with criminal commitments for a fixed period of years. Security requirements frustrate his ability to mix such individuals with general hospital population and interfere with their integration into the general therapeutic program of the hospital. When the individual is well enough to be released completely or when it would be therapeutically effective to release him for home visits, this cannot be done readily without the complexities of judicial approval, since the individual is still a court case.

A reasonably comprehensive mental health act, in providing for commitment to mental facilities under a variety of specific situations and conditions, must address itself to the broad considerations of voluntary and involuntary civil commitment, emergency examinations, emergency and indefinite involuntary commitments, and criminal commitments under such circumstances as pre-trial cases on bail and in detentioner status, pre-sentence cases requiring psychiatric examination and/or care and treatment, and sentenced individuals in correctional institutions or committed to mental health facilities in lieu of sentence. The act must provide for the expeditious transfer of the individual case to the most appropriate facility; be it a correctional or psychiatric one, and must provide for the re-transfer of the individual when the appropriateness of the commitment changes.

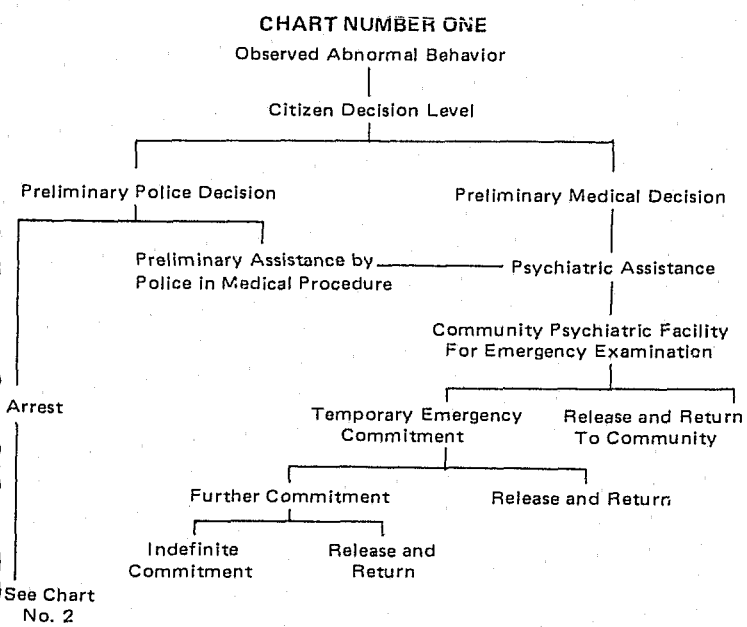
In dealing with mentally ill offenders, the responsible persons in the legal process range from the arresting police officers through the courts and correctional institutions, to the post release Probation or Parole departments. Despite the differences in training and experience, all must address themselves to both the legal and psychiatric components of each case.

The four appended charts represent diagramatically the integration of the legal and medical-psychiatric components of a case as it proceeds

from the initial citizen decision level through the various court and correctional institutional proceedings.*

Chart Number One: When a citizen observes an act of abnormal behavior he is faced with the first of what may become a long series of "clinical" decisions. The particular act of observed behavior may or may not represent a criminal act, and he must decide where to turn for help. This decision involves two basic choices; one, police and arrest proceedings, and two, medical assistance.

If the citizen decides to call the police, the investigating officers make a second clinical decision—whether to proceed with the legal arrest or whether to render assistance in securing psychiatric help in the case.



Where the citizen has elected to proceed along lines of medical assistance, he may involve the family doctor, minister, social agency, or lawyer. If a psychiatric examination is deemed necessary, the mental health act must make provision for such an emergency examination: it is best carried out at a community psychiatric facility.

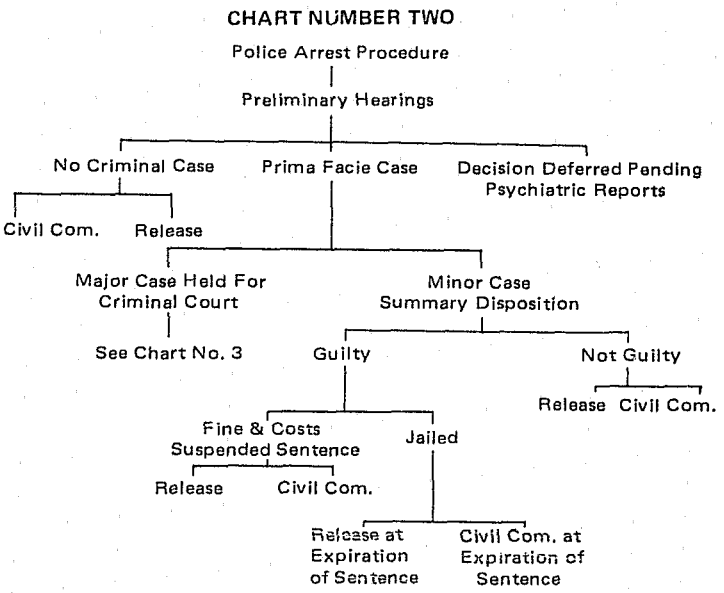
The examining psychiatrist makes one of two essential decisions. He may decide that an emergency or temporary commitment to a mental health facility is necessary and may institute the necessary commitment proceedings. On the other hand, he may decide that there are no indications for psychiatric hospitalization, in which case the individual is released and returned to the community.

If emergency commitment has been instituted, a further decision regarding its continuance must be made at the end of this temporary period. Here the two choices are indefinite commitment to a mental health facility, or release and return to the community.

Chart Number Two: This outlines the various steps in the disposition of major and minor cases when the police are called and arrest proceedings are instituted. After the formal arrest procedures, a series of preliminary hearings may result in one of three conclusions.

First, it may be determined that there is no significant criminal case and the individual is discharged from the criminal process. If, however, there seems to be significant evidence of mental illness, the case may be referred to an appropriate psychiatric facility as indicated on Chart One.

Second, legal decision may be deferred at this stage, pending emergency psychiatric evaluation and commitment if necessary. In



such case, there will continue to be a criminal detainer against the individual.

Third, a prima facie case may be established. Major cases which will be held for criminal court are outlined under Chart Three.

In minor cases, there may be a summary disposition at the municipal court level. Two basic outcomes are possible. One, a not guilty finding, in which case the criminal proceedings are ended, and the individual could be released to the community. If, however, there is significant evidence of mental illness, it may be referred into the general psychiatric dispositional channel for possible civil commitment. In the event of a guilty finding, two possibilities are open. Fine and costs or suspended sentence may be assigned and the individual could be returned to the community. Again the psychiatric aspects of the case may be handled through civil procedures if necessary. If the individual is jailed, his psychiatric care becomes the responsibility of the institutional psychiatrist. At the conclusion of his jail sentence he would either be released to the community or, if further institutional care is needed, he could be re-introduced into the civil psychiatric commitment proceedings.

Chart Number Three: Major cases held for criminal court present two immediate possibilities for disposition. One a guilty plea, and the other a not guilty plea. In the event of a guilty plea, three possibilities are open. The first would be a fine and cost or suspended sentence disposition, which would then open the way for the handling of the psychiatric components of the case under civil proceedings by either commitment to a facility for care and treatment or out-patient treatment as a condition of probation. The second possibility would be a commitment to a mental health facility for care and treatment in lieu of a criminal sentence. This commitment, under these criminal proceedings, could not be for a period of time longer than the maximum sentence for the crime involved. If during this commitment period the director of the mental health facility determines that the individual no longer requires his institutional care, he can petition the court for a transfer of the patient to a correctional facility. At the expiration of the commitment period the director of the facility may, in appropriate cases, institute indefinite civil commitment proceedings and retain the individual in his institution. The third possibility is imprisonment in a correctional institution. The Pennsylvania Mental Health Act makes provision for the transfer of individuals from correctional institutions to mental health facilities in appropriate cases. While imprisoned, the psychiatric aspects of the case are handled by the prison medical staff. At the expiration of the sentence period, the individual may be released to the community. In rare cases requiring further psychiatric care, civil proceedings can be instituted.

**These charts are keyed to Pennsylvania law. For a more detailed description, see Temple University Unit in Law and Psychiatry, Standard Legal Procedures in the Disposition of Mentally ill Offenders, 1969, 30pp.*

In the event of a not guilty plea, two possibilities are open for the disposition of the criminal components of the case. The charges may be nolle prossed at this level and, in appropriate cases, civil commitment procedures instituted, either for in-patient or out-patient care. The other dispositional channel, through grand jury indictment and arraignment, can result in four resolutions. *One*, the indictment may be quashed, again opening the way for civil psychiatric proceedings. *Two*, the individual may enter a guilty plea which then re-introduces the possibilities as already described under guilty plea. *Three*, a not guilty plea resulting in trial, in which case findings will be either not guilty or guilty. In the event of a not guilty finding, the individual may be released to the community or, in the presence of evidence of serious mental illness, civil psychiatric commitment proceedings can be instituted. If the individual is found guilty and is sentenced, the possible psychiatric implications of the case would be the same as under a guilty plea above. The fourth possibility is that the proceedings will be nolle prossed, in which case the individual may be released to the community or, as above, civil commitment proceedings can be instituted.

CHART NUMBER THREE (a)

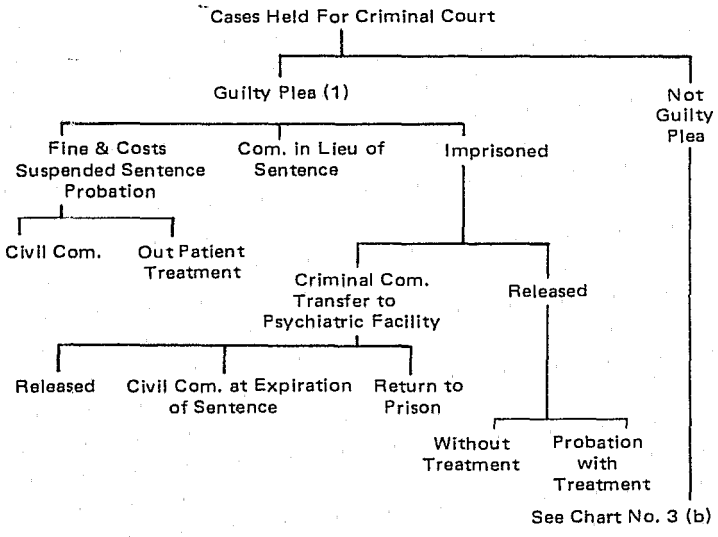


CHART NUMBER THREE (b)
(Cases Held For Criminal Court)

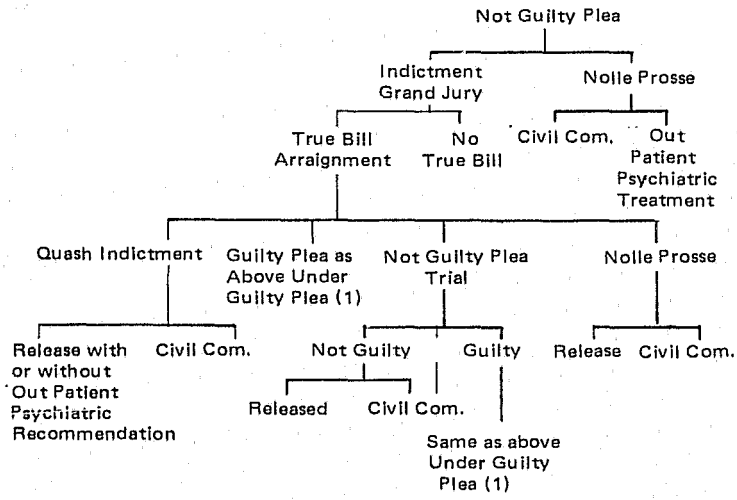
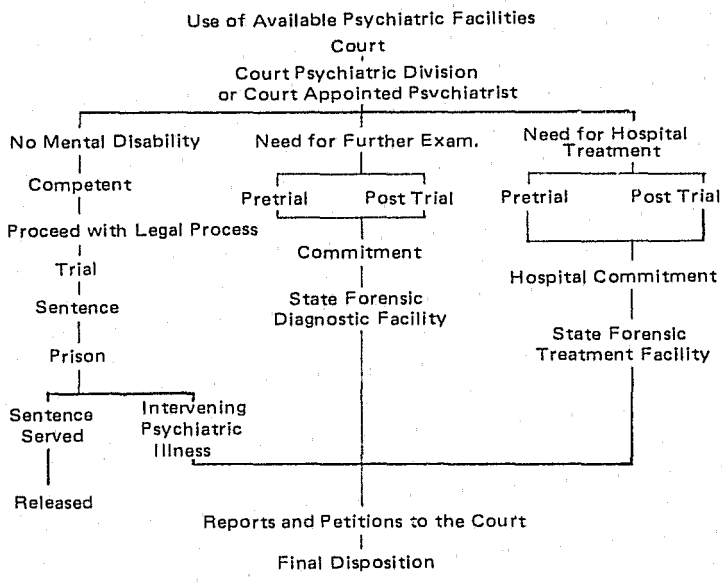


Chart Number Four: This chart outlines the utilization of available psychiatric facilities, both diagnostic and therapeutic. In the adversarial situation, either side may at any time ask for and secure their own private psychiatric evaluations. Based on these determinations, recommendations can be made to the court for disposition of the case. The court itself, however, should have available a psychiatric division within the general court structure, or at the very least there should be court appointed psychiatrists to act as consultants to the court and make recommendations for appropriate disposition of mentally ill persons.

Any interested and responsible person may petition the court for the psychiatric examination of the defendant by the court psychiatrist. The court may order such an examination and the reports should be addressed to the ordering judge. It should be his discretion to distribute the reports to the involved persons or agencies.

If the psychiatric division, or the appointed psychiatrist, is ordered by the court to examine a defendant, there are three basic possibilities which may present themselves. *One*, there will be a finding of no significant mental disability, in which case the individual will probably

CHART NUMBER FOUR



be found competent to proceed with trial, sentencing, and imprisonment if found guilty. Unless there is some intervening psychiatric situation during the process, the individual would be released back to the community at the conclusion of the sentence. If during the course of the sentence, a significant psychiatric situation intervenes, then the court should be petitioned for further psychiatric examination. Based on the recommendations of the examining psychiatrists, certain requests for transfer and re-transfers into and out of mental health facilities may be instituted. *Two*, the examining psychiatrist will be of the opinion that further psychiatric observation in a mental health facility is indicated before a definitive psychiatric opinion can be expressed. The Mental

Health Act should provide for the handling of both pre-trial and post-trial cases requiring further examination and commitment proceedings. These cases requiring extensive forensic psychiatric appraisal are best handled in institutions which are both staffed and physically equipped to deal with the special problems involved. These commitments are usually for limited periods of time—for example in Pennsylvania, for not more than sixty days. At the conclusion of this period of time the definitive psychiatric report is submitted to the court for its consideration in the further disposition of the case. *Third*, the examining psychiatrist will determine that hospital treatment is necessary, in which case the mental health act must make provision for the handling of pre-trial and post-trial cases requiring prolonged hospital treatment. The director of the hospital facility should inform the court of any change in the condition and requirements of the individual. As in the case of specialized diagnostic facilities, it is necessary that these treatment facilities be staffed and physically equipped to handle the special requirements for maximum security as well as treatment. In some cases it is possible that these individuals can be handled in the usual state hospital facility, but special institutions are often necessary. It should be the responsibility of the mental health officials to recommend to the court the most appropriate institution. These hospital authorities will make reports to the court, request transfers and re-transfers, and assist the court in arriving at a final disposition in the case.

Summary: There are serious defects in legal and psychiatric understanding of mental illness and its influence on criminal behavior. Increasing research, experience, and effort is slowly expanding our knowledge.

Present knowledge in the field is often not effectively utilized in the treatment and disposition of mentally ill offenders because of the poor integration of existing legal and psychiatric facilities. We have attempted to outline the basic legal and psychiatric requirements, both professional and structural, of a meaningful system, and have established flow charts, which trace the progression of cases through the legal process and show the integration of psychiatric diagnostic and treatment facilities into this legal process.

APPENDIX IV

PREAMBLE

The Legislature of the Commonwealth of Pennsylvania does hereby acknowledge that the mentally ill criminal offender presents a sufficient threat to the citizens of the Commonwealth of Pennsylvania to require special treatment and procedures where crimes involving the killing of human beings are involved.

This law acknowledges not only the right that a person who is mentally ill is entitled to receive humane treatment to aid him in recovering from his mental illness, but also the right of a free society to protect itself from the dangers of those persons who kill other citizens while insane or suffering from mental disease or defect.

It is likewise acknowledged that the prospect of using mental illness as an excuse for killing is unwise and may lead to feigned abuses. The Commonwealth of Pennsylvania does hereby demand that all persons shall be responsible for the consequences of taking the life of a human being.

BILL No.

KILLING WHILE INSANE:

It shall be unlawful for any person to kill or cause the death of another human being under any of the following circumstances:

a. While legally insane, or

b. While suffering from any unsafe mental condition, disease or defect that prevents the offender from fully apprehending, knowing and intending the consequences of his behavior or acts.

This offense shall be known as killing while insane and shall specifically be declared to be a "malum prohibitum" offense.

PROCEDURE:

Upon a finding of guilty of this offense, the defendant shall be sentenced to be confined in a state correctional institution or such other state institution as deemed appropriate by the Commissioner of Mental Health for a period of five (5) years to life.

The sentence shall be imposed by the trial court following a trial which shall be limited to the question as to whether or not the defendant in fact killed another human being. This crime may be charged in the same proceeding as the charge of criminal homicide and must be proven beyond a reasonable doubt in the same manner and same form as such other criminal charges.

At the end of five (5) years, the Commissioner of Mental Health shall act as Chairman of a Board comprised of two other psychiatrists, one elected district attorney, a defense lawyer and a member of the Board of Probation and Parole; all of whom shall be appointed by the Governor. This board shall evaluate the prospect of the defendant's propensity to commit future acts of violence, and if:

a. The Board unanimously agrees that it is extremely unlikely for the defendant to repeat his past acts; and if he is not required to take medication in order to maintain a normal mental condition, he shall be released on parole and be subject to such probationary conditions as may be established by the Parole Board.

b. If the Board unanimously agrees that it is likely that the defendant will commit future acts of violence, he shall be recommitted for one (1) year; and his case shall be reviewed every year to determine when he may be released to society in accordance with the standards set forth herein.

c. If the Board agrees that the defendant may be released to society and be an unlikely candidate for repeated future acts of violence through the compulsive taking of medication, the said defendant may be released on the strict condition (in addition to any other probation requirement) that he be required to appear and accept medication at such reasonable times as is deemed medically proper and necessary. A refusal of the defendant to comply with this procedure shall cause the immediate recommitment for one (1) year, after which time his case may be reviewed to determine when he should be released.

d. If the majority of the Board agrees that the defendant poses some prospect of harm to others, he may nonetheless be released upon such conditions as the Board deems reasonable to assure that the defendant's release from confinement presents a minimal threat to society. A person who is released under this fashion who, in fact, kills or severely injures another person shall be immediately recommitted upon a finding that he has committed such harm by a Court of competent jurisdiction and thereafter shall not be eligible for release until the conditions of subsection a may be complied with.

APPENDIX V[1]

A recent study by the Joint Economic Committee of the United States Congress[2] determined that by the end of the decade it is estimated that current employment will result in deaths and institutional admissions nearly three times larger than shown below in this table.

CUMMULATIVE IMPACT OF THE 1.4 PERCENT RISE IN UNEMPLOYMENT DURING 1970

Social Stress Indicator	Stress Incidence 1975	Change in stress Indicator for a 1.4 Percent Rise in Unemployment	Increase in Stress Incidence Due to the Rise in Unemployment
Suicide:	26,960	5.7%	1,540
State Mental Hospital Admission:	117,480[3]	4.7	5,520
State Prison Admission:	136,875[4]	5.6	7,660
Homicide:	21,730	8.0	1,740
Cirrhosis of the Liver Mortality:	32,080	2.7	870
Cardiovascular-Renal Disease Mortality:	979,180	2.7	26,440
Total Mortality:	1,910,000	2.7	51,570

Between 1926 and 1962 admissions to State prisons for the entire United States were positively correlated with the unemployment rate. Two points require attention in our consideration of unemployment and population projections:

1. The unemployment rate has a fluctuating pattern over time which tends to be cyclic in nature. The distribution of economic trauma would be wave-like rather than linear, e.g., overtime pathological reactions to economic trauma build up, reach a high point and then decline. Also, "height of the wave", e.g., higher levels of unemployment seem to have considerably more deleterious effect on percent changes in the stress indicators.

2. The effects of economic recession upon social stress indicators varies for different subgroups of the population. The effects of structured unemployment and cyclic unemployment seem to be particularly damaging to minorities and youth. The economic growth of the last two decades has not affected greatly the economic condition of a substantial proportion of inner city residents. Unemployment and subemployment have been especially severe for youths and minorities. (August, 1977, U.S. Department of Labor Statistics show 40.4% of black teenagers are unemployed [compared to 14.7% white] and 34% of the 18-24 black males.)[5]

Clearly, fluctuations, levels and duration of unemployment, particularly for youths and minorities, all affect prison admission rates. Further, the full social consequences of adverse economic conditions may have a time lag of two years or more. It seems realistic to conclude that employment affects, besides the homocide rate, other personnel violent crime rates. But little information is available on increases in the numbers of violent crime commissions or the resulting numbers of persons requiring maximum security psychiatric care due to changes in unemployment rates.

[1] *Brenner, Harvey,* "Estimating the Social Costs of National Ecomonic Policy: Implications for Mental and Physical Health and Criminal Aggression", *Vol. 1 — Employment, Paper No. 5, U.S. Government Printing Office, October 26, 1976. Pg. vii.*

[2] *Ibid.*

[3] *1972 date, age 65 and under.*

[4] *1974 data.*

[5] *Flanagan, p. 36: "Zimring (1975) concludes that the number of urban non-white males, ages 18-20, will increase until 1980, will decline about 6% between 1980 and 1985 and will return to the 1980 level by 1990. In terms of the peak prison ages of 23-25, this means an increase until 1985, a 6% decrease between 1985 and 1990, and a return to the 1985 level by 1995.*

APPENDIX VI

PSYCHIATRIC SERVICES AVAILABLE
IN BUREAU OF CORRECTION

Institution	No. of Inmates Physically Present as of March, 1977	No. of Psychiatrists	Hours Per Week
SCI Camp Hill	1,102	1	12
SCI Dallas	844	1	6
SCI Graterford	1,848	2	21
SCI Huntingdon	1,026	1	16
SCI Muncy	224	1	4
SCI Rockview	884	1	20
SCI Pittsburgh	1,042	2	16
RCF Greensburg	214	0	0
		9	95

Bureau of Correction population 7,763 inmates.

It should be noted that because of commutation evaluations, other program evaluations (pre-parole, pre-release, furloughs, etc.) and if medication reviews are excluded, it is estimated that our psychiatrists average only 13 to 15 treatment contacts per month.

NUMBER OF PETITIONS SUBMITTED TO THE COURT, NUMBER OF INMATES COMMITTED TO MENTAL HOSPITALS, NUMBER OF INMATES RETURNED BY THE COURT FOLLOWING COMMITMENT HEARINGS

SEPTEMBER 1976 – MAY 1977

Number of Petitions Submitted		Number Committed	Number Returned Non-Committed
SCI Camp Hill	0	0	0
SCI Dallas	7	6	1
SCI Graterford	16	13	3
RCF Greensburg	3	3	0
SCI Huntingdon	8	7	1 *committed later date
SCI Muncy	0	0	0
SCI Pittsburgh	13	7 4 pending	2
SCI Rockview	0	0	0
TOTAL	47	36	7

NUMBER OF PSYCHOLOGISTS ON STAFF IN THE STATE CORRECTIONA'. INSTITUTIONS AS OF MAY 1977

		Psychologist	Psychological Services Associate
SCI Camp Hill	Institution	1	1
	*DCC		2
SCI Dallas		1 (½ time)	1
SCI Graterford	Institution	1	
	DCC	1	3
SCI Huntingdon		1	1
SCI Muncy			1
SCI Pittsburgh	Institution	1	1
	DCC		2
SCI Rockview			1
RCF Greensburg			1
TOTALS		6	14

**DCC — Diagnostic and Classification Center*

The primary function of DCC psychological staff is the diagnosis and classification of all new admissions to the Bureau and therefore, they have very little or no time for treatment activities. Thus we have a total of 12 psychological personnel (5 Psychologists and 7 Psychological Services Associates) available for treatment services. Out of these 12, the PSA's at SCI Muncy (1) and RCF — Greensburg (1) carry a dual function of initial assessment of commitments received at their respective institutions as well as treatment responsibilities. The nine remaining institutional psychological personnel are responsible for commutation evaluations pre-parole evaluations, pre-release and furlough evaluations, as well as routine program requests for evaluations. Thus the time they have available for treatment activities (i.e. individual therapy, group therapy, working with emotionally or behaviorally disturbed inmates, crisis intervention, etc.) is very limited. It is estimated that over the system as a whole our psychological personnel have approximately 15% of their time available for direct treatment activities.

NUMBER OF INMATES CONFINED IN BEHAVIOR ADJUSTMENT UNIT*

Number in BAU 3/77**

	Maximum Security	Administrative Segregation
SCI Camp Hill	31	59
SCI Dallas	11	17
SCI Graterford	35	41
SCI Huntingdon	24	36
SCI Pittsburgh	30	36
SCI Rockview	14	11
RCF Greensburg	2	3
SCI Muncy	—	12
TOTAL	147	215

**Figures represent the number of individuals confined in BAU as of March 31, 1977.*

***BAU — as used here refers to placement in a secure unit within the institution with restricted movement from general population providing closer supervision and protection.*

CRIMINAL STATUS CLASSIFICATIONS FOR FORENSIC UNITS

As of May, 1977

Farview

Total number of patients — 186

Criminal Status:

7	— Not guilty — insanity
62	— Incompetent for trial
46	— Observation
51	— Undergoing sentence
9	— Unable to determine
0	— Not available

Philadelphia

Total number of patients — 33

Criminal Status:

0	— Not guilty — insanity
22	— Incompetent for trial
5	— Observation
10	— Undergoing sentence
1	— Unable to determine
0	— Not available

Mayview

Total number of patients — 56

Criminal Status:

1	— Not guilty — insanity
8	— Incompetent for trial
3	— Observation
11	— Undergoing sentence
29	— Unable to determine
0	— Not available

Warren

Total number of patients — 26

Criminal Status:

1	— Not guilty — insanity
3	— Incompetent for trial
13	— Observation
3	— Undergoing sentence
0	— Unable to determine
6	— Not available

Norristown

Total number of patients — 82

Criminal Status:

4	— Not guilty — insanity
6	— Incompetent for trial
5	— Observation
46	— Undergoing sentence
21	— Unable to determine
0	— Not available

TOTALS

13	— Not guilty — insanity
101	— Incompetent for trial
72	— Observation
121	— Undergoing sentence
60	— Unable to determine
6	— Not available

APPENDIX VII

Manual of STANDARDS for Adult Correctional Institutions

COMMISSION ON ACCREDITATION
FOR CORRECTIONS

Sponsored by the
AMERICAN CORRECTIONAL ASSOCIATION

Funded by the Rehabilitation Division, Office of Regional Operations, Law Enforcement Assistance Administration, United States Department of Justice

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United States Steel Foundation, Inc., Pittsburgh, Pennsylvania
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Through the American Correctional Association, the Commission on Accreditation for Corrections has been supported by LEAA Grants, Nos. 74-DF-0005 and 76-ED-99-0016, and by financial contributions from the additional organizations listed above. The fact that these organizations provided financial support for the activities leading to this publication does not necessarily indicate their concurrence in the statements and conclusions contained herein.

MEDICAL AND HEALTH CARE

In the event of suicide, homicide, accidental death or death under suspicious circumstances, the chief executive officer also should notify the coroner and appropriate law enforcement officials.

4271 Personnel who have received training in emergency first-aid procedures are available on each shift. (Essential)

DISCUSSION: Emergency first-aid may be required at any time by an inmate or an employee. Personnel who have received training in emergency first-aid should therefore be available on each shift. Also, first-aid supplies should be available at key points in the facility.

4272 There are written plans for providing emergency medical care at any location of the institution; these plans also specify the method and route of transporting patients to the hospital. (Essential)

DISCUSSION: Along with the various emergency plans the institution maintains, e.g., for fire, riots, etc., emergency plans should be developed to provide inmates and personnel prompt medical care and transportation to the hospital from any location in the institution.

4273 In institutions for women, there are medical services to meet the special health care needs of women. (Essential)

DISCUSSION: Obstetrical, gynecological, abortion, family planning, health education and child placement services should be available as needed.

4274 Administrative policy provides for housing and programs for disabled and infirm inmates in facilities appropriate to their needs. (Essential)

DISCUSSION: Disabled and infirm inmates require separate housing in facilities that are conducive to their program needs.

4275 Written policy and procedure govern the treatment of inmates with severe emotional disturbances. (Essential)

DISCUSSION: Many emotionally disturbed inmates are prone to violent and destructive behavior and are oriented toward escape. While severely psychotic inmates should be transferred to state hospitals, less disturbed inmates should be retained in the general inmate population, where possible, and provided treatment programs that are supervised by competent mental health professionals and that utilize the least coercion necessary.

4276 Where there are separate living units for inmates with severe emotional disturbances, an interdisciplinary team is assigned to these living units. (Essential)

DISCUSSION: All staff members responsible for providing services in a living unit for emotionally disturbed inmates should be integrated into a multidisciplinary team and should be under the direction and supervision of a professionally trained staff member. Consistency in approach and treatment is essential for the

emotionally disturbed inmate, and a team approach that includes regular meetings ensures that the treatment given these inmates is intensive, coordinated and direct.

4277 Written policy specifies that appropriate facilities are available for inmates who are diagnosed by qualified psychiatrists or psychologists as severely psychotic. (Essential)

DISCUSSION: Psychotic inmates should be transferred to mental health institutions. However, many state mental hospitals are becoming more open and are resisting the admission of disturbed inmates for whom secure housing is required. Partly in response to this, state correctional systems have begun to develop their own psychiatric facilities. Whatever system prevails, psychotic inmates should be transferred to a facility that can treat them effectively and assure public safety. These facilities must be under the supervision of mental health personnel and operated according to the standards and procedures of the psychiatric field.

4278 Written policy and procedure specify that qualified psychological and psychiatric personnel provide services for inmates diagnosed as severely mentally retarded. (Essential)

DISCUSSION: Severely mentally retarded inmates should be placed in facilities specially designed for their treatment. If they cannot be placed in such facilities outside the correctional institution, the institution should provide adequate services for their health, development and protection of their dignity. Where possible, programs should provide for their continued physical, intellectual, social and emotional growth and should encourage the development of skills, habits, and attitudes that are essential to adaptation to society.

4279 Psychiatric consultation is available for the management and treatment of inmates with special needs. (Essential)

DISCUSSION: A qualified psychiatrist should always be available to assist the trained mental health personnel who are responsible for the day-to-day management of inmates with special needs. Depending upon the size of the institution and the number and type of inmates classified as special needs inmates, the psychiatric services may range from one or more full-time staff psychiatrists to one part-time consulting psychiatrist. Whatever the arrangement, this service should be available 24 hours a day.

Inmate Rights

4280 Written policy and procedure ensure the right of inmates to have access to courts. (Essential)

DISCUSSION: Inmates should have the right to present any issue, including challenging the legality of their conviction or confinement; seeking redress for illegal conditions or treatment while under correctional control; pursuing remedies in connection with civil legal problems; and, asserting against correctional or other government authority any other rights protected by constitutional or statutory provision or common law.

APPENDIX VIII

The Bureau of Correction has suggested the following kinds of cases needed to be transferred from the correctional system to the mental health system:

1. The severely mentally ill who are a danger to themselves or others (e.g., the actively suicidal, the person who is assaultive on the basis of a delusional system, etc.).

2. Those individuals who are so severely mentally ill they cannot adequately care for themselves (e.g., chronic or acute psychotics).

3. The severely depressed individual who, although he has not made an overt suicidal gesture, is a high suicidal risk (particularly those cases that do not respond rapidly to medication).

4. Those individuals who are clearly psychotic but are not dangerous to themselves or others (i.e., they have not committed any acts of violence and are able, in the structured setting of an institution, to care for themselves), but who may be paranoid, delusional or have a very tenuous hold on reality.

5. Persons suffering severe brain damage that is accompanied by psychosis.

6. Persons suffering from senile psychosis.

APPENDIX IX

OA-501 12-67 COMMONWEALTH OF PENNSYLVANIA

SUBJECT: Legislative Recommendations of the Task Force

TO: Members of the Governor's Task Force on Maximum Security Psychiatric Care

FROM: Robert P. Kane
Attorney General

I have reviewed the Legislative Recommendations of the Governor's Task Force on Maximum Security Psychiatric Care as set forth in the attached draft Report. These proposals, as I understand them, represent policy responses to the mandates of the Governor's Executive Order and, in this regard, my views as a member of the Task Force have previously been received and considered.

My present remarks concern certain purely legal and constitutional ramifications of the Legislative Recommendations and are submitted to you in my official capacity as Attorney General. I am submitting my observations to you in this form and at this time for the reason that I may be called upon at some later time to render an official opinion or opinions concerning the legal and/or constitutional aspects of such proposals and, accordingly, I feel it is appropriate to bring to your attention the following comments regarding certain of the recommendations. I must emphasize, however, that the within observations are just that -- that is, observations only -- and in no way represent binding legal conclusions or advice. Such conclusions and advice are specifically reserved for inquiries, appropriately made, in a non-abstract context which permits of an adequate opportunity to achieve the definitive conclusions to which these proposals -- some of which raise extremely complex questions -- are entitled.

Recommendation 1. "Amending the 1966 Mental Health/Mental Retardation Act so that it specifically defines community to include persons in prisons and jails who are thus entitled to mental health services."

The MH/MR Act of 1966, 50 P.S. §4201 et seq. authorizes and mandates the Department of Public Welfare, through the county mental health and mental retardation program:

> "To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence or economic or social status." (Emphasis added.)

The proposed legislation would presumably expressly prohibit any denial of services on the basis of an individual's detention or incarceration under the criminal justice system by adding prisoner status to the list of conditions that must be disregarded under the mandate of delivery of MH/MR services. The proposed legislation would clearly emphasize the right of prisoners to obtain services, but I bring to your attention the fact that there has been, to my knowledge, no official interpretation of the Act which excludes prisons or jails from the meaning of "residence or economic or social status" under the language quoted above. In the absence of specific inquiry and further study, I am not at this time rendering an opinion as to the extent of the present service mandate, and I do reserve judgment as to the necessity of the legislative change for any purpose other than to underscore an already existing right and duty.

Recommendation 2. "Amending Act 143 so that individuals incompetent to stand trial or found not guilty by reason of insanity, and thereafter involuntarily committed to a State hospital, are not released to the community without prior court action. Presently they are released when the director of the treatment facility determines they are no longer severely disabled nor in need of inpatient services."

Under Section 304 (g) (2) of Act 143, the Mental Health Procedures Act of 1976, 50 P.S. §7301 et seq. any individual who has been involuntarily committed is to be released whenever the director of a facility concludes that the person is no longer severely mentally disabled or in need of treatment. At the end of the court-ordered involuntary treatment, the court may, upon petition of the director of a facility or county administrator, order additional treatment. There must, however, be a finding of a need for continuing involuntary treatment. The Task Force recommendation would amend these release procedures so that those individuals acquitted of a criminal charge by reason of insanity, a small subset of the classification of individuals involuntarily committed, would be returned to court prior to their release. The larger class of those committed involuntarily without criminal charges would be released without court approval.

The proposed amendment may face constitutional attack insofar as it provides for release procedure and release standards for those individuals found not guilty by reason of insanity which differ from the standards and procedures applicable to other civilly committed patients. See Jackson v. Indiana, 406 U.S. 715 (1971). Baxstrom v. Herold, 383 U.S. 107 (1966). Furthermore, by predicating discharge upon a judicial finding of non-dangerousness to self or others in the reasonable future, the amendment directly conflicts with Act 143's general purpose and intent that involuntary commitment must be premised on a finding of severe mental disability and the medical necessity of further involuntary treatment.

I do not here predict the result of a constitutional attack on the proposed amendment. In U.S. v. Ecker, 543 F. 2d 178 (D.C. Cir., 1976), cert. denied, 429 U.S. 1063 (1977) differences in release procedures for those committed following acquital because of insanity and release of civil committees was held constitutionally permissable. However, the statutory scheme of civil commitment under the D.C. Code is not identical to the scheme in Pennsylvania and, therefore, the analysis of Ecker may not be applicable to the proposed amendment.

Recommendation 3. "Amending Act 143 to clearly permit emergency involuntary treatment in a prison setting without involuntary commitment even though the prison will not necessarily be designated a treatment facility."

The legislation contemplated by this recommendation would establish treatment standards and commitment procedures for individuals incarcerated or detained in correctional facilities which differ from the standards and procedures applicable to other mental health patients. It would presumably permit involuntary mental health treatment of prisoners under circumstances not meeting the requirements of Section 302 of Act 143 and under treatment conditions not approved by the County MH/MR Administrator or the Department of Public Welfare as required by Section 105 of Act 143.

To the extent that such legislation would authorize involuntary mental health treatment of prisoners in situations where similar treatment of other individuals would be prohibited, it may be vulnerable to constitutional challenge. See Jackson v. Indiana, 406 U.S. 751 (1971); Baxstrom v. Herold, 383 U.S. 107 (1966). I do not at this time predict the result of such a challenge.

Recommendation 4. "Passage of legislation to allow voluntary commitments from correctional settings to mental health settings."

It is my opinion that this legislative recommendation presupposes a negative response to the unanswered question of whether Act 143 permits voluntary admission to mental health facilities of persons confined in county jails or state correctional institutions. This question is raised by the language of Section 401 (a) of the Act which provides:

> "Whenever a person who is charged with a crime, or who is undergoing sentence, is or becomes severely mentally disabled, proceedings may be instituted. . . under the civil provisions of this act. . . ."
> (Emphasis supplied.)

"Severely mentally disabled" is defined in Section 301 and is the criterion for involuntary commitments under Sections 302-305. The standards for voluntary treatment are quite different; all that is necessary is that treatment be "medically indicated", (Section 206(c)), and that informed consent be obtained, (Section 201). Article IV of Act 143 makes no reference to voluntary treatment and it has been argued that this omission is significant and precludes mental health treatment of prisoners not meeting the involuntary treatment standards.

However, it is also true there are numerous cases which have held that prisoners are guaranteed life's basic necessities, including reasonable medical care as needed. See Estelle v. Gamble, 429 U.S. 97 (1976); Fritzke v. Shappell, 468 F. 2d 1072 (6th Cir. 1972). In addition, the Fourth Circuit has found, in Bowring v. Godwin, 551 F. 2d 44 (4th Cir. 1977), that there is no underlying distinction between the right to medical care for physical ills and their psychiatric or psychological counterparts. How far this right extends is uncertain since even Bowring limited this right to treatment to those cases which are "medically necessary." If Section 401 is read to limit mental health treatment of prisoners or detainees to those individuals who meet the "severely mentally disabled" standard, it would exclude psychiatric treatment of prisoners if such treatment was medically necessary, but yet not severe enough or not of such a nature to qualify within the §401 (a) standard. This would be contrary to Bowring which mandated psychiatric treatment where it was medically necessary. To arbitrarily exclude prisoners from voluntarily seeking medically necessary psychiatric treatment may violate the Eighth Amendment's prohibition of cruel and unusual punishment.

If the "severely mentally disabled" standard cannot constitutionally be applied so as to exclude voluntary prisoner transfers to mental health facilities, it is possible that § 401 (a) can be read to establish procedures for transfers only where psychiatric treatment was necessitated by a severe mental disability, rather than where treatment was medically necessary and available on a voluntary basis. In ascertaining the legislative intent of a statute, it is presumed that the General Assembly does not intend to violate either the State or Federal Constitutions. 1 Pa. C.S.A. § 1922(3). If § 401 (a) would be unconstitutional if it were read to preclude the voluntary transfer of those cases which are medically necessary, § 401 (a) must be read only to establish the procedures relating to involuntary placement, and the omission of "voluntary transfers" in Article IV could not be read to exclude a prisoner's constitutional right to voluntary treatment-- a right which is available to all persons under Article II of Act 143.

In the absence of specific inquiry and further study, I am not at this time rendering an opinion as to whether Act 143 precludes voluntary mental health treatment of prisoners. Until called upon to do so in my official capacity, I will reserve judgment on the question.

Recommendation 5. "Passage of legislation that provides for the Commonwealth to bear the cost of treatment for convicted individuals transferred from correctional settings to mental health facilities (presently charged to the county of conviction)."

This Legislative Recommendation represents a policy decision of the Task Force and in the abstract raises no legal or constitutional problems.

Recommendation 6. "Legislation clearly demonstrating the commitment of the General Assembly to the recommendations of this Task Force regarding Farview's future. This includes: a) timetable for closing Farview and developing multi-level units; b) providing the fiscal base; c) determining clear legislative intent as to location and size of the multi-level facilities."

This Legislative Recommendation represents a policy decision of the Task Force and in the abstract raises no legal or constitutional problems.

Recommendation 7. "The General Assembly must provide enabling legislation to establish multi-level security forensic units."

This Legislative Recommendation represents a policy decision of the Task Force and in the abstract raises no legal or constitutional problems.

END