# CASE LOAD, PROFESSIONALIZATION, AND ADMINISTRATION: CIVIL COMMITMENT AS A "STREET-LEVEL" BUREAUCRACY+

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FEBRUARY, 1978

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## I. Introduction

In recent years social scientists from a variety of disciplines interested in a number of policy areas have increasingly focused attention on questions of policy implementation.[1] For example, the traditional concern of political science with such areas as Congressional and judicial decision making has been supplemented by the awareness that decisions by Congress or the judiciary only become public policy when the citizen-consumer-subject actually has his values "authoritatively allocated" by the public actor. Furthermore, it has been found that the public actor--the social worker, teacher, policeman, probation officer, etc.--often acts at substantial variance with legal prescription.[2] Sociologists and organization theorists studying human services organizations have similarly observed in numerous and varied circumstances that "line actors" can become the principal determinants of agency policy and performance.[3]

These findings suggest that those concerned with comprehending and improving existing, as well as developing new, public services must consider closely the "lowest" level of administrative actors. The extent to which this approach differs from conventional public policy analysis was stated in a recent paper: "[T]he usual study of implementation [is thus turned] on its head, for we now regard the lowest levels of the policy 'chain' as the 'makers' of policy, and the 'higher' level of

decision-making as circumscribing (albeit in important ways) the lower level policy-making context."

Several factors are associated with such systems involving line implementor-actors or street-level bureaucrats: substantial discretion is available (often unavoidable) to the individual decision maker; decisions are initiated by direct actor-citizen contact and are often made in the presence of the subjects of those decisions; substantial ambiguity exists in the decision-making criteria; time or resource pressures tend to limit the decision-makers' ability to satisfy all potential "consumers" or explore all data pertinent to the decision; and "consumers" of the "services" or decisions tend to be socially, economically, and politically marginal and therefore lack resources to control or monitor decisions. Finally, the ambiguity of decision-making criteria and the discretion required in supplying the service renders intra-agency or bureau supervision problematic.[5]

Lipsky and Weatherly see these characteristics affecting street-level bureaucrats in predictable ways:

> To accomplish their required tasks, street-level bureaucarats must find ways to process their work, to accommodate the demands on them and confront the reality of personal and organizational limitations. They do this typically by routinizing, modifying goals, rationing the services they offer, redefining or limiting the clientele to be served, controlling clients, asserting priorities and generally developing practices which permit them to process the work they are required to do <u>in some way</u>. (Lipsky-Weatherly's emphasis)

When this pattern of job characteristics is combined with the professional or semi-professional status and norms that many of these roles have, these actors are "constrained but not directed in their work, and are thus relatively free . . . to develop mechanisms to cope with their jobs."[7]

This theory and related research find an almost syndrome-like relationship among these factors. However, much remains to be done to evaluate the possibly varying impacts of individual variables on performance. This article presents a study of five separate "street-level" bureaucracies concerned with administrative civil commitment in which variations in work-load pressure and levels of professionalization can be considered.

## II. Civil Commitment in Nebraska

The pre-1976 Nebraska statutes empowered local administrative boards of mental health, consisting of the clerk of the district court, a locally practicing attorney, and a locally practicing physician, to commit persons who were "mentally ill" and in need of hospitalization to state mental hospitals. Any person could initiate the process by filing an application for board action. If the board decided there were sufficient grounds to proceed, it was authorized to issue an arrest warrant and to appoint a physician to examine the proposed patient. In the vast majority of cases (93%), the board physician performed the examination.[8] The examining physician was then to report to the board the results of his examination, and "as soon as practicable" after the physician's report was filed, a final hearing was to be held.

The process of arrest or other entry, examination, and hearing took about three days in a typical case in 1974. In almost every case the board's finding agreed with the physician's certification, and of the patients examined in 1974, ninety percent were found to be mentally ill.[9] If the board concluded that the person was mentally ill and should be admitted to a hospital, the board authorized the hospital

superintendent to receive the proposed patient for an observation period not to exceed sixty days. The superintendent was then required to certify to the committing board prior to the end of this observation period whether the patient was mentally ill and in need of extended hospitalization. If he so certified, commitment for an indefinite was complete.[10]

It should be emphasized that the relevant state statutes authorized commitment of alcoholics, sexual sociopaths, the mentally retarded, drug abusers, and those simply "mentally ill." The statutes provided ambiguous or circular definitions of these terms and offered no direction as to whom, among those in the categories, were "ill" enough to warrant commitment. For example, section 83-306 is typical of this deficiency: "The term mentally ill, as used in this act, shall include persons suffering from any type of mental illness whatsoever, whether hereditary or acquired by internal and external conditions, diseases, narcotics, alcoholic beverages, accident or any other condition or happening."[11]

While an administrative approach to commitment was recently approved by a three-judge panel of the Federal District Court of Nebraska, the court held that the statutory scheme failed to provide constitutionally sufficient commitment standards and adequate procedural safeguards.[12] In response to this decision, the Nebraska legislature has since revised its civil commitment laws.

The county mental health board-administrative civil commitment system found in Nebraska before 1976 appears to fit many characterisitics of the street-level/human services organization model. Tasks and decisions were, to say the least, highly ambiguous. As noted, the statutes under

which the boards operated were unclear in "defining" the "populations" subject to board actions. Compounding the incomplete specification of the statutes was the perhaps inherent ambiguity of determining what constitutes "mental illness" and "mental health."[13] In these respects, civil commitment in Nebraska was an unusually ambiguous street-level bureaucracy. Moreover, in meeting, "examining," and interviewing patients, boards were engaged in substantial direct actor-citizen contact. Supervision by superior authorities was essentially non-existent. While the statutes provided for the appeal of board decisions to the state court system, virtually no such appeals had been made within the memory of any court or board role incumbants prior to 1976. In practice, there was no effective supervising agency nor were there any organized clientele groups to monitor or contest board actions.

It is within this environment of highly ambiguous decisions and tasks, potentially intense actor-subject contact, and no supervisory or external "challenge" groups that all five boards operated.[14] However, two possibly crucial elements of the street-level bureaucratic model varied substantially among the boards researched: case-load pressure and professionalization. While prior studies certainly suggest that high levels of task uncertainty and discretion, face-to-face contact, resource constraints, and case-load pressures create inherently unstable systems, it is not yet clear which, if any of these variables, is uniquely critical or necessary to stimilate or facilitate extensive street-level policy implementation-modification.[15]

The varying rural-urban patterns among the five boards studied provide an opportunity to consider the impact of two of these variables

on five otherwise similar street-level bureaucracies. With regard to case load, it is hypothesized that the need to reduce psychological threat, to control potential external criticism or internal uncertainty, and to ease work tasks will be intensified by higher case load. It is also hypothesized that high-load boards will develop working procedures, attitudes toward board subjects, and personal role definitions which rationalize the system, resolve or prevent role conflict, and diminish, depersonalize, and limit contact with board subjects. These tendencies,



it is expected, will be less pronounced among lower case-load boards. Table One shows the case load in 1974 for each of the five boards studied.

Table One

Population and Case Load by County

| | Douglas | Washington | Dodge | Sarpy | Cass |
|---|---|---|---|---|---|
| Population 1970 | 389,455 | 13,310 | 34,782 | 66,200 | 18,076 |
| Case Load 1974 | 755 | 17 | 55 | 15 | 9 |

The relationship one might expect between professionalization and "line" behavior is less clear. In theory, professionalization of services has long been held to be a means by which more skilled and effective practitioners of "scientific" disciplines may provide more personalized and effective delivery of services. More recently, however, research in several areas has suggested that professionalization carries with it norms which reduce legitimized client input and leads the professional to seek a more predictable and stable work environment. Professionalization thereby leads an agency more rapidly and securely to process larger numbers of cases, but with less attention to each case and on terms

defined by the professionalized staff.[17] In addition, it may be expected to affect board members' role definitions. Thus, one might hypothesize that professionals on the boards would tend to adopt role definitions which reduce contact with subjects and eliminate ambiguous situations and decisions.

Professionalization and access to professional resources among the boards in question follows the rural-urban division. The urban board (Douglas County) included a locally respected practicing psychiatrist; the rural boards (the other four counties besides Douglas) were staffed by general practictoners, three of whom were retired or semi-retired. The urban board had access to major psychiatric hospital services, specialized private agencies for treating numerous mental and physical disorders, two medical school hospitals, and several dozen local psychiatrists. The rural counties had no comparable facilities and, indeed, had limited access to the facilities of the urban county because of distance as well as legal and financial complications.

In an analysis of the effects of case load and professionalization on the performance of this bureaucracy, it is unlikely that these two variables can be controlled vis-a-vis each other. Nonetheless, conclusions regarding their varying impacts as seem defensible will be made. In presenting a complete survey of the impact of case load and professionalization on board operations, three aspects of the boards will be considered: (1) daily procedures and routines, particularly as they pertain to problems of system rationalization; (2) external relations of the boards, specifically board members' perceptions of board roles vis-a-vis society in general; and (3) internal relations of the boards, including both

members' definitions of their own roles and their attitudes toward board subjects. This three-part analysis should provide a complete description of board operations and a broad set of indicators to assess the impact of case load and professionalization on board operations. The analysis, it is hoped, will contribute to the continued development of the street-level bureaucracy model, to the understanding of the administrative civil commitment system, and to the development of effective ways of improving the performance of this and other bureaucracies.

## III. Board Procedures and System Rationalization

Rationalization of board procedures is used here in a manner consistent with the Weberian model of rational-legal bureaucracy. This model suggests that the most efficient and predictable administrative system is one based on general principles clearly articulated in law which can then be applied with minimum uncertainty and maximum predictability to each case coming to the bureau. Rationalization, or bridging the distance between general law and specific application in order to clarify and specify exactly what bureaucrats are to do, is, in the ideal-typical model, effected by logically and systematically deriving operating rules and procedures from the general principles established by statute. Obviously, the Nebraska statutes on civil commitment do not provide a sufficiently clear framework for such a logical and systematic process to occur. In this system, therefore, such rationalization as does occur will be done by "line" actors in performing their duties. This section of the paper will consider whether and how case load and professionalization have affected the rationalization of board operations.

Extensive analysis of interviews with all board personnel (reported elsewhere) indicates that board personnel lacked clear criteria with which mental health might be evaluated and that there were no explicit or specified procedures of inquiry and decision-making.[18] All five boards could be characterized as seeking consensus in an impressionistic, discussion-interview format. A typical description of the interview-examination process was as follows:

> We listen to witnesses and they tell about their [the proposed patient's] strange act or what they have done and if they do seem bizarre, then we will ask the patient about.them and it depends on the answers he gives and once-in-a-while you can have a patient, you know, that seems very good and you just keep digging at him with a few questions and pretty soon, they start answering in a wild fashion, and if they give good straight answers -- we feel that that maybe is not the normal behavior, but is still not abnormal enough to commit.

Another board member, when asked how they reached a decision, responded: .

> As you went along on the interview, you could kind of pick up what you wanted or were looking for I really can't put it down in medical terms or legal terms, but during the interview, you pretty much pick up what the problems were, whether or not you had an idea of whether the person at least in the layman's view, was mentally ill and I think by the time I reached the conclusion, most of these before we even got to the end, you know, we kind of nod one way or the other on this thing as we go along as we approach them, you can pick up a sense for the . . .

Commitment criteria included a usually implicit mix of such factors as dangerousness to others, need for care, and functionability in society. It is evident from their unsystematized, ad hoc procedures and decision-making criteria that none of the boards developed systematized, explicit, and specific internal principles and procedures to supplement the vague statutes and clarify their tasks. In this sense, boards had not rationalized their procedures. Nevertheless, the boards did in a limited sense rationalize the operating system by defining their own procedures,

tasks, and roles reduce the scope rather than clarify the substance of [19] their activities.

Rural board members focused on that portion of the statutes which reserves for the state hospital superintendent the final decision on civil commitment. Several of these board members took exception to referring to their function as making "commitments." Rather, they defined their function as providing a means by which people who might be mentally ill would receive a professional "evaluation" at the state hospital. This attitude was expressed by members of each rural board, and by a majority of members of three of the rural boards. One rural board member, for example, described the board's role as sending the subject "for a short rest." Several board members also mentioned that the professionals in the state hospitals would "catch" and correct "in a few days" any errors the boards had made.

Such a role redefinition, while not major, reduced tension caused by categorical and procedural ambiguity in several respects. First, the ambiguity and uncertainty apparent in decision criteria and procedures was made more tolerable to the board by reducing the significance of the decision for the subject. Furthermore, the tension between the reality of a process that commits ninety percent of the persons coming before the board and the protection of individual rights, a goal also emphasized by rural board members, also appeared to be circumvented by depreciating the impact of board action on individuals.

On only one of the rural boards studied was there any disharmony or conflict. There, the board attorney seriously doubted the competence of the board physician and explicitly refused to accept the limited definition

of board impact held by his co-members. Instead, he emphasized the impact commitment had on subjects' personal lives, its influence on any mental board or agency decisions in the future regarding the subject, and was unable to resolve the conflict among the competing goals of protecting society, protecting individual rights, and getting mental care to those who needed it. For this actor, board service appeared to have been an unpleasant task which led him to self-doubt, unsought conflict, and serious reservations regarding the system. He resigned from the board shortly after the period researched.

Among rural boards, the filing of an "information" alleging mental illness was nearly always a routine, semi-clerical act. Upon this filing, boards would automatically detain the proposed patient and hold an "exam" and hearing to evaluate if he were "mentally ill" and fit for commitment. Each of the rural boards, in practice, collapsed the exam and hearing into one hearing; the exam thus became essentially a group interview of the proposed patient. At the end of the interview, the subject of board action was either released or committed, usually the latter, and usually to the state hospital.

The urban board, however, modified the system substantially more than did rural boards. While it also failed to rationalize the statutory structure, the urban board rationalized what it actually did by reducing and specifying the scope of board activity and by placing most decisions concerning with questions of mental health on either board support personnel or professional mental health actors and facilities.

In the urban county potential information filers first came into contact with the board by talking with one of the clerk's secretaries.

The secretaries acted as important sources of information regarding board procedures, routines, and alternative actions filers might take. In doing so, they also screened the board from many potential informants. Once an individual had decided to file an information, the board secretary filled out the information form, including the potential subject's demographic data, medical history, and alleged symptoms. The filer then would be interviewed by the board at its daily meeting. At this hearing the board members' primary function was to evaluate the credibility of the filer's testimony. They considered inconsistencies in the filer's oral presentation and the statements taken by the secretary prior to the hearing. They also pursued matters which just did not "ring true" through follow-up questions of the informant. During the year under study, board records indicate that eight percent of those coming before the board had their informations refused.

For the remaining ninety-two percent, the board issued a warrant which ordered the sheriff to pick-up the proposed patient and deliver him to the custody of the county hospital. The board very rarely had any further contact with informant or the proposed patient. Upon delivery by the sheriff to the hospital, each subject was admitted to the psychiatric ward, examined, and included on the next general rounds (daily exams) by the regular hospital psychiatric-psychological staff. Within a period ranging from a few hours to several days the board physician, a psychiatrist, also examined the subject and "reported" his diagnosis to the board. His findings were apparently always "confirmed" without the required "final hearing." The subject was then either released or left in the custody of the hospital superintendent.

## Board Procedures and System Rationalization: Conclusions

Both the urban and the rural boards failed to develop a rationalized system of identifying and committing the allegedly mentally ill. Both did, however, modify their activities to reduce their task ambiguity. However, unlike the rural boards, the urban board went well beyond a simple redefinition of role to a substantial revision of structure and function.

In the urban county, the primary activity of the board was screening the potential filers of informations, with the exam of the proposed patient occurring at the county hospital and being carried out by only the board psychiatrist and hospital staff. The final "hearing" was supplanted by a clerical "act" performed by the psychiatrist, which was rarely, if ever, discussed or overturned by the board. The urban board thus had rationalized its proceedings in several ways. Its only real task was one of assessing the veracity-credibility of the informant's testimony. While it was hardly a simple and self-effecting administrative task, it is a task which was more familiar to the board attorney and district court clerk than diagnosing mental illness; it was also one which was much more limited and well defined. The ambiguity involved in "diagnosing" mental illness was eliminated, in part, by displacing this task to hospital staff. Furthermore, the urban board reduced by fifty percent its personal contact with potential informants by interviewing only actual filers and rarely interviewing the proposed patients.

Urban board members, interestingly enough, were like rural board members in emphasizing their concern for protecting individual rights.

Regardless of whatever objective differences in performance one may suggest to differentiate the two board-types from one another, both types emphasized their concern for this role. The urban board, however, clearly addressed fewer issues in deciding each of the many more cases it heard; it displaced such issues as dangerousness, level of illness, need for and benefit to be derived from hospitalization onto the psychiatrist and hospital staff.

In sum, the urban board functioned primarily as an initial judge of mental competence through an ex parte hearing of complaints brought by second parties. Regardless of how one might assess their effectiveness, rural boards did meet, interview, and "examine" the primary party concerned, the proposed patient. At the same time, however, rural board members doubted their ability to diagnose mental illness, were aware of their lack of psychiatric skills, and failed to rationalize an informal, impressionistic, undefined, and largely ad hoc decision-making process. That they, without apparent tension, could operate such a system modified only by subjectively redefining board activity, it might be suggested, is related to their low case load. Specifically, the vulnerability of such actors to cognitive dissonance caused by decision ambiguity and inconsistencies between their role perceptions and actual board activity may have been reduced by three of the boards handling an average of only one case monthly, and by the fourth board's informal disposition of nearly half its somewhat higher case load (fifty-five during the year under study) into local outpatient facilities. It might be suggested as well, that the infrequency of board hearings also inhibited rationalization of the vague statutory system, because of the difficulty of developing an extensive body of agency "case-law" with so few and infrequent cases.

Structurally, the urban board became far more integrated into the dispositional institution, the county hospital. The hospital and a portion of the urban board, the psychiatrist, certainly interacted regarding ultimate patient disposition, and most often shared the decision. Rural boards, on the other hand, were almost completely isolated from all treatment facilities and were essentially independent from all other mental health decision-making structures. It is suggestive, though by no means conclusive, to observe that the single rural board which upon occasion brought mental-health care personnel into their decision making was the rural board which had the highest case load.

Thus, the rural boards retained, with slight changes, a system which brought them into substantial contact with individuals who might be expected to be under great stress, and one which required them to make ambiguous decisions under vague guidelines. The urban board, with an immensely higher case load and far greater professional facilities, utilized a substantially different system of processing cases. In all respects the revisions of the urban board reduced their personal contact with board subjects, clarified and reduced the scope of the decisions they retained, and externalized (to other agencies) the most ambiguous decisions.

## IV. Board External Relations: Societal Roles

While the civil committment law in Nebraska provided the legal means of committing individuals who were determined to be mentally ill, the law failed to guide boards in setting priorities and choosing among competing goals. For example, were boards to commit all individuals

who might benefit from the care offered by mental facilities, only those individuals who clearly needed care, or only those who were likely to do great harm to themselves or to others? Were boards to concern themselves only with "mental-illness," or when more general social-adjustment problems came to their attention, were, they to attempt to refer the individual concerned to an appropriate social agency? Were boards to see themselves as general-crisis resolvers for individuals or other social agencies i.e. were they to interpret their roles strictly? In short, once the legislature had established civil-commitment boards, what operating roles and priorities did they set for themselves? In the previous section the impact of case-load and professionalization on the extent of procedural rationalization found within the board system was addressed. By comparing the urban and rural board member role definitions, this section will consider whether case load and professionalization have affected operating roles and priorities.

As was hypothesized previously, a higher case load could be expected to lead boards to develop role definitions consistent with rationalizing the system, resolving or preventing member role conflict, and diminishing, depersonalizing, and delimiting contact with board subjects. Professionalization, it was suggested, would carry with it norms which might be expected to increase the stability and predictibility of board operations, leading to diminished legitimate client input and limited contact with individuals and ambiguous cases. Unfortunately, case load and professionalization in the context of this study are confounding variables and must therefore be analyzed with caution.

The data for this (and the subsequent) analysis were gathered from interviews with all fifteen board members. Each subject was interviewed

according to the same open-ended interview schedule. The interviews were taped, transcribed, and all perceptions and attitudes pertaining to roles and attitudes were identified and isolated. Four coders were trained and coded the items in a staggered format such that each item was coded by three individuals. A coefficient of reliability (1 minus "errors" divided by total items coded) for the entire analysis and each sub-analysis was obtained. The coefficient for the entire content analysis was 0.88.

Table Two

Board Role Definitions

| | All Boards N=114 | |
|---|---|---|
| Protecting Society | 10% | (11) |
| Protecting Individual Liberties | 23% | (26) |
| Providing Access to Mental Health Facilities (Passive Delivery of Services) | 34% | (39) |
| Delivering Whatever Care Necessary to those with Mental or General Behavorial Problems (Aggressive Delivery of Services) | 11% | (13) |
| Responding to Public Disturbances | 1% | (1) |
| Resolve or Respond to Social-Welfare Agnecy Crisis | 4% | (5) |
| Resolve or Respond to Family Crisis | 14% | (16) |
| Provide a Definitive Medical Diagnosis | 1% | (1) |
| Ambiguous or Other | 2% | (2) |
| | 100% | (114) |

CR=0.86

(CR=[1-$\frac{E}{I}$] where E="errors" and I=total items coded)

## General Patterns

As Table Two illustrates, board role perceptions were multifaceted. Half the board roles defined dealt with providing access to mental care facilities for those needing such care. Where the board members perceived their role as providing a linkage by which possibly i l l individuals might be provided with expert evaluation and care, approximately three-fourths of these perceptions were essentially passive. Typical of these comments are the following:

> The board of mental health is basically established to help those people who for some reason do not want to help themselves or cannot help themselves.

> We look at it that we are trying to perform a service for people to get an unfortunate person into a situation where there is more expertise that can be exerted upon him to see if you could help him - We are trying to assist unfortunate people and that's the main thrust of our function.

Approximately one fourth of the "care delivery" perceptions, however, reflected an assertive and aggressive role, when board members defined the scope of their activity to include sanctioning more general disruptive behavior (family disorder, excessive drinking, etc.), pressuring subjects to "improve" behavior, or following-up on subjects after treatment was completed. For example:

> I think after a certain point of continuous drinking, the person gets to the place where they cannot, in and of themselves, without some outside help, get away from drinking. When they get to that stage they have to be confined for this outside help because i f we discharge them they will go right across the street and start drinking again. There are those who get drunk over the weekend and sober up Monday morning and go to work and don't take a drink for a week, if they want to, they can quit drinking without being confined. And those people who have jobs realize the seriousness of i t – we will frequently l e t go and with an admonition that you stay off of this and i f you don't and you come back in front of us, we'll know then that you can't quit it and w i l l help you quit i t .

> Sometimes we play God and try to put a little fear into them and tell them well, we are going to let you go, but we are not going to close this case, we may open it again, if we think there is good reason to do it.

After the passive and aggressive delivery of services role perceptions, the next most frequent board members role perception was of protecting individual liberties:

> That's one of the misconceptions, that people have. They think they can come down here and just sign a statement and its automatic. . It's not. Those people come in here and we interrogate the informant because we want to make sure we have enough basis to, number one, pick a person up and, number two, to make sure that there is someone mentally ill, either direct mental illness, or alcoholism, or drug incapacitation or something. We just sit here, we sit right here and talk it over. The informant will give us all the' information, we will question the informant. It's not like a court proceeding because it's not adversary, you know, but we just keep cross-examing that person.

Nearly equal in emphasis were the role perceptions of resolving family crises and protecting society from the potentially mentally ill. However, each of these two role definitions troubled board members. In the former, board members felt they were often drawn into essentially domestic disputes and hostilities, where husbands and wives, or sometimes parents and children, brought non-illness, family-related problems to the board:

> There seems to be a trend for -- for example, for a wife can't understand why her husband doesn't want to come home after work to the family but would rather go down to the bar and gulp down ten or eleven beers with the boys, so she concludes that he must be insane. In other words, we get a lot of cases which are really marital problems and not pure case of insanity; and the same thing seems to be with the people who have children and perhaps don't do what they think they should. The girl gets caught smoking pot behind a garage and their rationale is they must be crazy. That's my kid and they wouldn't do that otherwise.

The boards responded to these cases in a variety of ways. Sometimes, particularly when divorce proceedings were underway, boards simply refused to accept the information:

> [T]here are some instances where we have had one member of a family] committed or filed upon, not committed, but filed upon by another member of the family and after we have had them in the hospital and it looks like the other member is trying to return in those cases, we will question it a great deal before we actually accept the information from an irate informant.

At other times board members attempted to mediate and settle such family problems, but it appears they more often simply recommended that the parties take their dispute elsewhere:

> [W]e really find by having them both in the mental health board at the same time and sometimes they can iron out their differences and you can always kinda tell like one is trying to get even with the other one and its, the doctor can determine this and he thinks that if they can't get along, then they should get a divorce and not use the mental board for this -- their problems.

Sometimes, of course, a family crises and an apparent mental health problem coincided, and board proceedings followed:

> The family is just at their wits' end. They don't know what to do. The person just keeps on drinking and he threatens the family. He doesn't work. And there's much abuse in many cases. And the family says something has to be done -- we've got to help him or her.

More awkward, however, were circumstances where the source of a disturbance was unclear, and other family problems or mental disorder may have been involved:

> For example, the last case that we had was definitely a marital problem, however, the man did get a shotgun and had it loaded and had it headed for his head and -- in my opinion this is more than a marital problem. We asked him whether he was serious about destroying himself. He said yes, he was so depressed he would have if they hadn't of grabbed the shotgun and taken it away from him. I would say that it is a marital problem and its also a mental problem. Suicidal tendencies there. But, this man was referred to, of course. Very definitely, I think, in that particular case. But if the gun hadn't entered in and they were just standing here bickering back and forth, I think, probably in this case we would have dropped the mental court proceedings and let them get into civil court, if that's what they -- because he started out saying . . .we're separating and

> I'm filing and so forth, he was threatening her, that this is what he's going to do -- then if there weren't any suicidal attempts, I think, then probably we would have dropped this case.

The role of protecting society was mentioned nearly as often as responding to family disturbances. This, role was also a difficult one for board members, since it often appeared to conflict with protecting individual liberties and required decision-making in ambiguous circumstances:

> I can conceive of a place where a guy is shrewd enough to fool the board [garbled], and then the other thing is well, I either turn this guy loose and like the guy down in Texas who went to a psychiatrist and he says there is nothing wrong, then here you got a guy that maybe is running loose and is going out and shoot down fifteen people and then you of course have got a problem because you let him go, and the easy way is maybe to send them down to the state [hospital].

Another board member observed:

> . . . the cases that trouble me and I guess would trouble the doctor and the young clerk couldn't [help but] notice it, you have cases where the relatives come in and tell wild, wild stories about the behavior of this person and who went you bring them in to see this person, about ready to wack you over the head, you know, and he comes in very docile, very neat, very polite, you talk to for one-half hour and you see nothing and you get the Sheriff that says if this guy is crazy, I'm nutty too and actually, however, in some cases he was. He was somewhat clever enough to cover it up. Those are the ones that we agonize over. You know, what should we do about them. And frankly do you sell them an axe and send them. One memorable case - the wife wanted to commit the husband and we ended up committing the wife because all this was her imagination and she was getting kind of wild.

Still another board member reflected:

> If we have no information in that the person is ever been dangerous, if you think he is just peculiar or something, we don't send to Norfolk if we have any doubts. If he has made threats, such as a fellow did the other day, he's still making threats - he is going to cut himself and his family, we think we would probably commit him. Just in case something goes wrong. If we are wrong, we have taken away some of his rights, that's too bad but it is restored to him, of course, so it is only temporary. If we are wrong we may not sleep for a couple of nights, [but] if he is just going to wipe out his own family--

In summary, then, among the five county boards, the dominant role perceptions were of delivering mental care services to those needing such care (with passive and assertive variations); protecting society from the potentially dangerous, possibly mentally ill; protecting individual liberties; and resolving or responding to family disturbances. These roles were seen by board personnel as often difficult to fulfill because of their potential conflict with each other, ambiguity, and their at times peripheral relevance to mental health problems.

## Urban and Rural Variations

The urban board, like the rural boards, had a multifaceted definition of its societal role. Still, for each ruban board member, the most important role was getting mental care to those who needed but were not receiving such care. As seen in Table Three, this role definition was almost entirely passive.

Table Three

Board Social Roles: Rural and Urban Subpatterns

| | Rural Boards N=79 | | Urban Board N=35 | |
|---|---|---|---|---|
| Protecting Society | 11% | (9) | 6% | (2) |
| Protecting Individual Liberties | 20% | (16) | 29% | (10) |
| Providing Access to Mental Health Facilities (Passive Delivery of Services) | 34% | (27) | 34% | (12) |
| Delivering Whatever Care Necessary to those with Mental or General Behavorial Problems (Aggressive Delivery of Services) | 15% | (12) | 3% | (1) |
| Responding to Public Disturbances | 0% | (0) | 3% | (1) |
| Resolve or Respond to Social-Welfare Agency Crisis | 1% | (1) | 11% | (4) |
| Resolve or Respond to Family Crises | 15% | (12) | 11% | (4) |
| Provide a Definitive Medical Diagnosis | 0% | (0) | 3% | (1) |
| Ambigous or Other | 3% | (2) | 0% | (0) |
| | 99% | (79) | 100% | (35) |

$z$

CR=.86

In addition to the passive delivery role, urban board members viewed the board's service as a sort of social agency crisis center of last resort:

> We've had alot of contact with them [social agency personnel] because people who may be on welfare and they are checking them out and they find them in these ah . . . ungodly states, you know people sitting in waste, you know, drunk, they got beer and wine -- you know --around them, empty bottles all around the, and they haven't moved from the chair for two, three days, – all they are doing is drinking sitting there in their waste -- These people have to go out and check on it and they come in here and say, "These people need help, can you commit them?"

Along with acting as an "agency of last resort," urban board members also saw themselves as filling important roles in protecting individual rights (.29%). For example, while one board member stressed the delivery of care to those who needed it, he also observed that an individual's dangerousness to himself or to others was an important prerequisite for commitment. No urban board member saw the use of informal or extra-legal pressure to modify board subjects' behavior as an appropriate role. One board member stressed the board's role as an agency of confidential inquiry which protected the rights to privacy of board subjects. All urban board members viewed the probing of the veracity and credibility of potential cases as the board's major activity:

> [I]f we run into a situation in which there is some question in our mind as to the motive of the informant, we have to exercise a certain amount of judgment and try to determine whether it appears that the person being reported upon is possibly mentally ill, and if we can't establish that, then we turn down the informant and will not accept the information.

> Well, we come into contact with the informants, and the way we operate is--they mentioned anybody can sign, you know, and so forth--that isn't true. We listen to the testimony first and then if we think that there is good cause and action should be taken, why then we have them sign. But if we say, 'Well, we don't think you've got a good cause here,' .we refuse to accept the information.

Only one urban board member mentioned protecting society from the mentally ill as among the board's roles. Thus this role may be of lower salience to the urban board members than care delivery, protecting individual rights and aiding social welfare agencies in "crisis" cases. In summary, the urban board members had a positive notion of board role which was indicated by their stress on providing care for those who need it but might not otherwise get it. It was a less positive role than it

might have been, in that the urban board did not see itself as responsible for solving by informal or extralegal means the many non-commitment but genuine social and human problems which came before it. In addition to providing care to the needy, the urban board stressed resolving crisis for social agencies and families, protecting subjects rights, and, somewhat less intensely, protecting society.

As Table Three indicates, rural board role definitions are equally multifaceted. While they clearly parallel urban boards in this respect, differences in emphasis and scope existed between the two types of boards.

The paramount role to rural boards, similar to the urban boards, was securing care for those who need it but who could not or would not get it for themselves. This function was mentioned two and a half times as often by the twelve rural board members as any other function, and included nearly fifty percent of all rural board role descriptions. Protecting individual liberties, though mentioned less often than on urban boards, was the next most frequently mentioned role. Following this role and balanced in emphasis among rural board members were the roles of protecting society and resolving family crises.

Perhaps the clearest and most dramatic difference between rural boards and urban boards was the aggressive, positive manner in which rural boards perceived their care-delivery role definition. Not only did providing care to those who might need it clearly outweigh all possible competing functions, but the rural boards also saw as part of their function the duty to at least suggest other service agencies to individuals coming before them whom they did not commit. Furthermore,

for several members the threat of a "suspended" commitment subject to "reopened" board action was used to push individuals with alcohol and family problems to modify their behavior. Fifteen percent of rural board members' role definitions fit this category.

In summary, the rural boards generally shared similar perceptions of their roles with the urban board. However, they took a more positive, assertive approach to cases. While the urban board members regarded their role as primarily providing care to those who were mentally ill and releasing all others, rural boards were inclined to act when the individuals with serious problems appeared before them. Some were committed; others were threatened with commitment unless they "improved;" and others were referred to social agencies or counselors. Finally, rural board members were somewhat more likely to mention protecting society and resolving family crisis among their roles than urban board members; urban board members, on the other hand, were substantially more likely to mention protecting individual liberties and resolving social welfare agency crisis than rural board members.

## Board External Relations: Summary and Conclusions

While these finding are not conclusive, they do suggest several observations:

1) Both rural and urban boards found their work sufficiently variable and multi-faceted that they developed several role-definitions;

. 2) Rural boards, perhaps because of their many fewer cases, greater face-to-face contact with board subjects, and lower professionalization, were more likely to see board-client relationships as open-ended, and not merely limited to making a legal judgment. Urban boards were,

conversely, more likely to adopt a "binary" decision-making process: a board subject was either committed or released, in neither case with board follow-up;

3) The greater number and diversity of professional social-welfare agencies found in the urban area alone may explain the orientation of urban boards to responding to the needs of such agencies. The urban board had frequent contact with representatives from social-welfare agencies, primarily as filers of "informations," while rural boards rarely had such contact, other than with their local police or sheriff's offices; and,

4) Rural board members more frequently mentioned two roles which appeared to require, according to the perceptions of board members themselves, more ambiguous and difficult decisions. Specifically, rural board members mentioned resolving family crisis and protecting society somewhat more often than urban members; urban members, conversely, mentioned protecting individual liberties much more often than rural board members, a role described in the interviews with much less apparent tension than any except the "care delivery" role. A theoretical argument could be appended to this pattern: "protecting society" is a highly vague goal, given the necessity of conjecture regarding possible mental states, possible future behavior, and possible dangers to "society;" resolving family disturbances-crisis is also an ambiguous area, given the emotional loading associated with intra-familial problems. "Protecting individual liberties," however, can be and was among board members specifically defined in terms of systematized rights and procedures.

Differences between urban and rural boards in societal roles were not great; the ambiguity of the legislative mandate along with the

exigencies of real-world operations appear to have affected them similarly. The variations that did occur between the boards were generally consistent with street-level bureaucratic theory, particularly as it relates to open-ended and ambiguous roles versus defined, circumscribed, and clarified roles. Either, and probably both, professionalization or case load could be operating in these data.

## V. Intra-Board Relations: Task Definitions and Subject Attitudes

### Task Definitions

Mental health boards were composed of individuals of widely differing backgrounds. The physician, the attorney, and the district court clerk brought to the board differences in general education, professional training, ethics and priorities, and, possibly, different conceptions of appropriate board functions. Along with these sources of heterogeneity among board personnel, the boards engaged in several rather different activities while performing their duties. These activities included keeping records, administering legal actions, evaluating testimony, discerning mental health status, and deciding appropriate dispositions of cases. It has been suggested elsewhere that a possibly crucial component of mental health commitment systems which are capable of providing accurate diagnosis ensuring patients' legal rights and avoiding arbitrary decisions is a genuine multi-member, shared-decision institution.[21] This section will address the question of individual, intra-board role definitions: to what extent did each board member see himself/herself as sharing joint decisions with other board members, or in making segmental decisions, and do rural-urban differences affect these patterns?

Lipsky suggests that the typical street-level bureaucrat when faced with ambiguous decisions under pressured circumstances will tend to redefine his own tasks and/or clientelle to develop a less uncertain work situation.[22] It is assumed here that a segmentalized task definition, where each board member is allowed and/or expected to define, discharge and evaluate his tasks for himself, and allows and/or expects the same of his fellow board members, is such a clarifying definition. It is hypothesized, therefore, that segmentalized work definitions would dominate over all the boards, and that the greater case-load pressure on urban boards would lead then to even more segmentalization than found in the rural boards. Professionalization, with its emphasis on specialized competencies, ought to complement and perhaps accelerate this process. Data for the five counties are presented in Table Four.

Table Four[23]

Board Member Task Perceptions

| | All Boards N=87 | Rural Boards N=66 | Urban Boards N=21 |
|---|---|---|---|
| Segmented Tasks Mentioned by Members | 67% (58) | 76% (50 | 38% (8) |
| Shared Tasks Mentioned by Members | 33% (29) | 24% (16) | 62% (13) |
| | 100% (87) | 100% (66) | 100% (21) |

CR=.86

The distribution of task definitions can also be seen by considering he perceptions of individual board members, as presented in Table Five.

Table Five[24]

Task Definitions of Members
*N=14

| Shared Role Dominate | Balanced Role Definitions | Segmented Role Dominate |
|---|---|---|
| (0-35% of each individual task definitions are segmental, the remainder are shared) | (36%-64% of each individual task descriptions are segmental, the remainder are shared) | (65%-100% of each individual's task descriptions segmental, the remainder are shared) |
| % of all board members 29% (4) | 14% (2) | 57% (8) |

*Note: Only fourteen of the fifteen board members were included here as one member had only one codible task perception.

CR=.86

Overall, segmental task definitions were dominant among mental health boards, both in the distribution of task perceptions for all boards (Table Four) and in the breakdown by individuals' dominant task perception (Table Five). While street-level bureaucracy and human services theory would suggest that segmentalized decision making would dominate as a response to the general ambiguity of board duties, which these data fit, it would also suggest that higher levels of such segmentalization ought to occur on the higher case-load, more professionalized urban board, which these data do not fit. Indeed, two of the three urban board members have "shared" task perceptions. This apparently aberrant pattern might be explained by either or both of the following hypotheses:

1) The urban board, by redefining board activity to focus on evidentary questions in a pre-filing hearing and essentially eliminating any subsequent hearing and board decision on the subject's mental health, has removed (by reducing ambiguity and medically-related issues) the major cause of segmented role definitions; and,

2) A high case load over many years has led urban members at least to perceive, if not perhaps to develop, shared expertise across one another's specialities, excluding medical issues which the board only peripherally considered. *In* other words, by means of its procedural adjustments the urban board may have become the board which made the least ambiguous decisions.

## Board Member Attitudes Toward Subjects

The major concern for those interested in organization theory and public policy alike is the performance of human service organizations. As people "processing" agencies, such organizations are highly dependent on organization personnel attitudes toward their clients. These attitudes have the potential to alienate clients, disrupt effective delivery of the organization's services, and disturb the organization's political-social environment.[25] The growing literature on human service organizations emphasizes that the unique environment and characteristics of these agencies and their tasks make staff personnel attitudes both particularly reactive and relevant to organization operations.[26]

Dilemmas of client reactivity, ambiguous and subjective decision making, external interest, and internal tension make attitudes of agency personnel toward clients critical, particularly when organizations are dealing with clients who are defined as malfunctioning and who have been brought involuntarily to the organization's attention. Such clients are quite naturally likely to be hostile, to resist the agency, and they will require value-laden decisions, all of which can psychologically threaten organization personnel and stimulate defensive attitudes.

These attitudes then affect bureau operation.[27]

Within this operating context, several norms of bureaucracy are likely to be strained. The ability of bureaucrats to sustain specificity (limiting the relationship to matters relevant to official business), universalism (decisions on cases made with reference only to specified, defined general rules), and affective neutrality (emotionless transactions) is challenged by both the reactivity and the ambiguity of the bureau's task environment.[28] While it has been established in empirical research that these standards may never be absolutely attained, it is important not to dismiss them as irrelevant. First, different levels of attainment are possible. Second, and more importantly, such qualities are relevant not merely because they are elements of a particularly elegant administrative model, but because they are essential prerequisites to a fair and impartial application of law.[29]

For these reasons the extent to which mental health board personnel perceive subjects with affective neutrality, universalism and specificity will be considered. This section also considers the extent to which board members regard subjects in a directive or interactive perspective: to what extent to board members consider subjects as legitimate participants rather than merely as recipients of board action, a question relevant to substantial recent popular and scholarly criticism of human service organizations. It is hypothesized that the tendencies of these organizations toward affective bias and directivity as people processing agencies such as those discussed above will be accelerated by the strain of high case loads. Professionalization ought similarly to affect directivity. However, since professional norms will probably seek clarity, predictibility,

and reliability in routinizing tasks, professionalization may be expected to operate against diffuseness (wide scope of inquiry) and particularism (inconstancy of decision criteria). The relationship between professionalization and affective bias is not hypothesized.

One hundred and ninety-one comments by board members were identified and categorized according to their relevance to the four attitudinal dimensions. Table Six presents these data.

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Table Six

Board Members Attitudes Toward Subjects By Type of Board

N=191

| | All | Rural | Urban |
|---|---|---|---|
| Affectivity | N=65 | N=48 | N=17 |
| Neutral | 32% (21) | 33% (16) | 29% (5) |
| Biased | 68% (44) | 67% (32) | 71% (12) |
| Specificity | N=39 | N=31 | N=8 |
| Specific | 26% (8) | 16% (5) | 37% (3) |
| Diffuse | 74% (31) | 84% (26) | 63% (5) |
| Universal ism | N=35 | N=28 | N=7 |
| Constant Criteria | 68% (24) | 71% (20) | 56% (4) |
| Varialbe Criteria | 32% (11) | 29% (8) | 44% (3) |
| Directiveness | N=52 | N=44 | N=8 |
| Interactive | 27% (14) | 32% (14) | 0% (0) |
| Directive | 73% (38) | 68% (30) | 100% (8) |

CR=.90

Affectivity: In operationalizing this variable, statements reflecting hostility, criticism toward board, subjects, or implicit or explicit

expectations that board subjects were generally mentally ill were viewed as indicators of affective bias. Opinions of board subjects suggesting neutral or impartial attitudes were scored as reflecting affective neutrality. Clearly all boards, both rural and urban, saw board hearings subjects through affectively biased lenses. Board members were inclined to view subjects in most cases as having at least severe problems and most often as mentally ill. Board members saw such individuals as capable of temporary improvements, but rarely of lasting cure. At times board member statements reflected criticism of subjects for not resolving their problems themselves (primarily alcoholics), and occasionally reflected substantial dislike and hostility toward some types of subjects Commitment records substantiate board orientations, as nearly nine of every ten subjects were committed. Before one concludes, however, that board member attitudes caused this high rate of commitment, one must consider which "direction" causality might be operating. Board members may be commiting, not because their opinions blind them to subjects' mental states, but because most individuals proposed for commitment did indeed have severe problems, were unable to help themselves, and were only incidently personally distasteful to successful, middle-class Americans.

Urban and rural boards did not vary substantially on this variable, with urban board members only slightly more critical of board subjects. This variation may be a product of chance, coding error, or the greater pressure of case load on the urban board.

Specificity: In operationalizing this variable, statements reflect!' limits on those qualities or characteristics of subjects relevant to

board decisions were considered "specific." "Diffuse" perceptions of board subjects included viewing the board hearing as an informal, open-ended inquiry into subjects' entire situation, general habits, and whole lives; the category of diffuse attitudes toward subjects also included emphasis on using informal, first-hand knowledge of subjects, their families and their problems in board decisions, rather than limiting board decisions to formally presented evidence.

Members of rural boards clearly were somewhat more inclined to take a diffuse attitude toward subjects than urban board members. This inclination might be related to differences in case load, time pressure, urban "annonymity," and the absence on urban boards of diffuse knowledge regarding board subjects. It might also be related to the varying levels of board professionalization and the impact of professionalized norms. However, the difference between urban and rural boards is too small and, for the urban board, based on too few perceptions to generalize with confidence.

Universalism: In operationalizing this variable, it became apparent there were two aspects of board decision making pertinent to it. First were the legal rights (to counsel, to call witnesses, to have an independent medical exam, etc.) which boards perceived as appropriate for board subjects. The second were the criteria utilized by the board in deciding questions of mental health. While board attitudes toward legal rights were clearly articulated, criteria of decisions on mental health were not. Most board members identified specific rights available to all subjects. But board members could not, generally, go beyond circular, highly general descriptions of the criteria used to identify the mentally

ill. While board members certainly felt these decision criteria were applied equally to all subjects, the vagueness and open-endedness of the criteria were such that one could not be confident that, in operation, these could be and would be applied consistently among all subjects of board action. Because of this ambiguity, descriptions of health-decision criteria could not be identified as clearly universalistic or particularistic, and were therefore not coded. Regarding legal rights, the data indicated that board members' attitudes toward subjects' legal rights were universalistic, somewhat more strongly so on rural boards. Once again, the difference between urban and rural boards is too small and unstable to generalize upon.

Directiveness: The last aspect of board attitudes toward subjects examined was the extent to which board members regarded subjects only as recipients of board decisions and instructions rather than as participants in deciding the optimal disposition of their cases. Comments suggesting boards allowed some choice to subjects, consulted subjects on preferred dispositions, or allocated subjects' responsibility for their treatment and cures were coded as "interactive." Comments indicating board members saw subjects as properly passive recipients of board determination, and/or saw resistance to these directives as illegitimate, were coded as "directive."

All boards, rural and urban, were clearly "directive" rather than "interactive" in subject orientation. This orientation was consistent with the boards' legal mandate: Providing involuntary commitment for individuals found incompetent to care for themselves. However, the very low level of interactive attitudes even though several boards handled

substantial numbers of self-referred individuals is worth noting. Additionally, while several rural board members expressed some interactive attitudes toward board subjects none of the urban board's members voiced any such attitudes. This finding is consistent with the hypothesis that the large number of cases heard by the urban board would increase both time pressure and cognitive demands and would cause urban board members to seek greater routinization of case decisions by limiting, both in operative and normative terms, the roles of extra-board individuals. Similarly it is consistent with hypotheses that greater levels of "professionalism" would lead to more:directive policies.

### Board member Attitudes Toward Subjects: Summary and Conclusions

Board attitudes toward subjects could be described in general as affectively negative, diffuse, inclined toward universalism in legal rights, but unspecified in criteria of mental health, and directive. When case specificity and directiveness are considered, urban and rural boards differed by degree: however, in no case regarding board attitudes toward subjects did the fundamental relationship between board membership and attitudes change when the urban-rural variable was controlled.

The generally similar pattern among all the boards suggests that attitudes toward clients, case load, and professionalism are not critical variables. Perhaps where ambiguous decisions, vague statutory guidance, little supervision, and social marginality of clients are involved, case load and professionalization have only weak impact on these behaviors. The only substantial difference among the boards, that of directivity appears consistent with predictions that higher case loads and greater professionalism

will cause street-level bureaucrats to circumscribe client contact. Only in the area of legal rights did board attitudes remain clearly consistent with the neutral-administrative model. This last pattern may be explained by the participation of attorneys on each board or by the suits pending in federal court (during the interview period) against the board system, primarily on grounds relating to legal rights.

## VI. Summary and Conclusions

This paper has applied the theory of street-level policy formulation-implementation developed by Lipsky and others to a quasi-judicial, administrative system of civil commitment in Nebraska. In a study of five county boards over a one-year period, radically different levels of case-load pressure and substantially varying degress of professionalization and of availability of professional facilities were found to affect board operation in several ways.

The aspect of board operation most dramatically affected by these variables was board procedures. The urban, high case-load, professionally-oriented board developed a processing system which reduced face-to-face client contact, circumscribed the scope of decisions it had to make, and externalized the most ambiguous of these decisions. Rural boards operated a far more ambiguous, open-ended, and highly tense face-to-face contact system, modified only by defining their tasks as "evaluation," not "commitment."

Board social roles were less clearly affected by rural-urban differences. All boards had multi-faceted role definitions, but rural boards had a more open-ended perception of their functions. The rural boards attempted to modify "anti-social" behavior and to redirect board subjects to

sources of social counseling. Urban boards had withdrawn somewhat from the most ambiguous societal roles that rural boards had retained.

Intraboard tasks varied by the rural-urban distinction. On rural boards a majority of the members' task definitions were essentially segmental, with 76% of the board members perceiving their tasks as primarily making component rather than shared decisions. Urban board members were much more likely to see themselves as making shared decisions. These results may contradict street-level bureaucracy theory, but they may simply be a product of the substantial redefinition of board activity effected by the urban board. Finally, on.all boards, attitudes toward subjects tended to be affectively negative, diffuse, and directive. These findings are consistent with human service organization research. Varying case loads and levels of professionalization had little impact on those attitudes.

These findings, in general, are supportive of the emphasis of the street-level bureaucracy literature. Clearly, critical policy implementation decisions are being made at the "line" level, and these decisions are undoubtedly in reaction to work environment pressures. In some cases (procedures, board roles) case load and professionalism appear associated with agency operations. In other situations, however, (attitudes toward clients) case load and professionalization appear to be of less or no significance. This research can provide no guideline as to how the problem of attitudes might be approached. Perhaps further comparative research will suggest such strategies if such factors as supervisory patterns, task ambiguity, or decision discretion can be controlled.

These conclusions indicate that effective reform must take into account line level administrators' environments. An attempt to modify

the working procedures of the urban board, for example, might substantially clarify the statutory framework, control the scope of tasks allocated

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the board, or reduce the case load. It is also suggested, at the level of theory, that case load and professionalization may be critical factors affecting procedures and routines of street-level bureaucracies, have some impact on the general, social roles adopted by the bureau, but apparently have little impact on attitudes toward those subject to bureau behavior.

+ The empirical research upon which this article is based has been supported by a PHS Grant (No. 1 R01 MH 27438-01) from the National Institute of Mental Health. Points of view expressed herein are those of the authors and do not necessarily represent the official position or policies of the National Institute of Mental Health or Creighton University. Further support was provided by the Dean of the Graduate School, Creighton University.

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One might view empirical-behaviorally oriented research in the general area of public administration as composed of two "waves." Perhaps the most well known of the first wave is James March and Herbert Simon's Organizations (New York: John Wiley, 1963). Other works would include Anthony Downs, Inside Bureaucracy (Boston: Little, Brown, 1967), James Thompson, Organizations in Action (New York: McGraw-Hill, 1967), and Gordon Tullock, The Politics of Bureaucracy (Washington, D.C.: Public Affairs Press, 1965). These works focused on describing and analyzing the internal operations of bureaucracies. More recently, a second "wave," often described as "public policy analysis," has expanded the study of public administration to focus more, among other issues, on the actual delivery and non-delivery of services to the public. Contributors to this area include Herbert Jacob and Michael Lipsky "Outputs, Structure and Power: An Assessment of Changes in the Study of State and Local Politics," Journal of Politics 30 (1968), Theodore Lowi, The End of Liberalism (New York: Norton, 1964), and Jeffrey Pressman and Aaron Wildavsky, Implementation (Berkeley, University of California Press, 1973).

The classic model of the political system is David Easton's A Framework for Political Analysis (Englewood Cliffs, NJ: Prentice-Hall, 1965). which while discussing the multiplicity of input-output-feedback links, tended to emphasize the political process as one where inputs from external agents decline as one becomes close to the "output" point in government.

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See, for example: Elihu Katz and Brenda Danet, editors, Bureaucracy and the Public: A Reader in Official-CIient Relations (New York: Basic Books, 1973); Yeheskel Hasenfeld and Richard A. English, editors, Human Service Organizations: A Book of Readings (Ann Arbor, Michigan: The University of Michigan Press, 1974); Michael Lipsky, "Toward a Theory of Street Level Bureaucracy," in Willis Hawley, et. al., Theoritical Perspectives in Urban Politics (Englewood Cliffs, NJ: Prentice-Hall,1976), pp. 186-212; also David Perry and Paula A. Sornoff, Politics at the Street Level: The Select Case of Police Administration and the Community (Beverly Hills, California: Sage Professional Papers, 1973).

Michael Lipsky and Richard Weatherly, "Street-Level Bureaucrats and Institutional Innovation: Implementing Special Education Reform in Massachusetts" (Presented for Delivery at the 1976 Annual Meeting of the American Political Association), p. 3.

Excellent summaries of this research can be found in "Lipsky and Weatherly" (1976), pp. 1-4; "Lipsky" (1976), pp. 196-208; and Hasenfeld and English, "Human Service Organizations: A Conceptual Overview," pp. 1-24 in Hasenfeld and English (1974).

"Lipsky and Weatherly," (1976), p. 2.

Ibid, pp. 3-4. Also see James Q. Wilson, Varieties of Police Behavior (Cambridge, Mass: Harvard University Press, 1968).

These data were collected during the summer of 1976 by law students from Creighton University and Georgetown University and undergraduates from Creighton University and The University of Southern Mississippi under the supervision of professional project personnel. The analysis of these data has been computer-assisted using the Statistical Package for the Social Sciences (SPSS). It included cross-tabulated frequency counts and a factor and regression analysis of data coded from all cases filed in 1974 in the five county area. Other data sources were direct observation of boards' proceedings and interview with board members, judges, psychiatrists, private attorneys, county attorneys, and others. For a comprehensive report on this system see: Geoffrey Peters, Larry Teply, James Wunsch and Joel Zimmerman, Final Report: Mental Health Commitment in Eastern Nebraska, (unpublished report submitted to the National Institute of Mental Health, August, 1976). A summary of some preliminary findings and an outline of the legal stucture can be found in Peters, Teply, Wunsch and Zimmerman, "Administrative Civil Commitment: The Ins and Outs of the Nebraska System," 9 Creighton Law Review pp. 266-285 (December, 1975). Additional results can be found in Peters, Teply, Wunsch and Zimmerman, "Administrative Civil Commitment: The Nebraska Experience and Legislative Reform Under the Nebraska Mental Health Commitment Act of 1976," 10 Creighton Law Review pp. 243-278 (March, 1977).

See Peters, Teply, Wunsch and Zimmerman, Final Report (1976) "Civil Commitment Statistical Analysis," pp. 1-38, for a comprehensive discussion of these findings.

Nebraska Revised Statutes § 83-328 (Reissue 1971) (repealed 1976). It should be noted that the board's responsibility for making findings in the case is broader than that of the examining physician; the statutory scheme requires the boards to determine whether or not the proposed patient should be admitted to the state hospital. Presumbly this additional determination would include consideration of whether entry into a state mental hospital would be more beneficial than harmful to the proposed patient; perhaps other considerations might be relevant here, such as the effect of proposed patient's family if he is their sole support, the availability of proper facilities, etc.

[11] Nebraska Revised Statutes § 83-306 (3) (Reissue 1971) (repealed 1976). It is informative to note that of the 851 cases before the five boards in 1974, 49.8% of the proposed patients were diagnosed to be mentally ill in terms of a traditional psychiatric diagnosis, 31.8% were diagnosed as alcoholic, 3.4% were diagnosed to be mentally ill from other causes, 9.6% were found to be not mentally ill, and 5.2% of the cases were not executed, i.e., the case did not proceed to the hearing stage.

[12] On December 24, 1975, a three-judge court declared unconstitutional Nebraska Revised Statutes § 83-325, -328 (Reissue 1971) and 83.306 (4) (Cum. Supp. 1974). Doremus v. Farrell, 407 F. Supp. 509, 517 (D. Neb. 1975). The Nebraska civil commitment scheme was found to violate the due clause of the fourteenth ammendment in several respects. For a futher discussion, see Peters, Teply, Wunsch and Zimmerman, Final Report (1976) Chapter I, pp. 36-37.

[13] Kaplan, "Civil Commitment As You Like It," 49 Boston University Law Review, pp. 14-45 (1969).

[14] In some respects, the proposed patients and their attorneys, when the patients had attorneys, might be considered to have "challenged"the commitment system. However, these confrontations were rare (.about 4% of the cases during 1974), ad hoc, and limited to dispositions of individual cases. Issues pertaining to general board policies were not raised.

[15] Katz and Danet (1973); Hasenfeld and English (1974); also "Lipsky" in Hawley, et. al. (1976).

[16] "Lipsky" in Hawley et. al., (1976), pp. 196-208. Also "Lipsky and Weatherly" (1976), p. 2. Also Downs (1966), particularly pp. 191-195 and 208-210 regarding his concept of "performance gap."

[17] See Amitai Etzioni, editor, The Semi-Professions and Their Organization (New York: The Free Press, 1969).

[18] Peters, Teply, Wunsch and Zimmerman, Final Report (1976), Chapter III, "Integrative Summary of Interview Data."

[19] The term "modification" is not used here in any sense to imply mal- or misfeasence. It is used in the public administration, system rationalization sense to describe the unavoidable process of "fleshing-out" statutes with working procedures, priorities and practices. The works cited above, especially in Note 1, are concerned in one way or another with this process.

[20] This discussion is a summary of the comprehensive analysis of board member role definitions presented in Peters, Teply, Wunsch and Zimmerman, Final Report (1976) Chapter III, "Integrative Summary of Interview Data.[11]

[21] "Peters, Teply, Wunsch and Zimmerman" (1975), p. 282

[22] "Lipsky" in Hawley et. al., (1976), pp. 204-206.

[23] In generating these data, professional project personnel identified all portions of the interviews which dealt with personal task perceptions. Four Creighton University undergraduates then coded the items according to the categories of "shared" decisions or "segmeted" decisions. Table Four is simply a percentage breakdown of all task descriptions by the board members.

[24] The same procedures of data analysis were followed for Table Five as for Table four; however, the data here were broken down by board member rather than by board type. Percent guidelines used to define members as "segmental, "balanced" and "shared" task are presented with the table data.

[25] "Hasenfeld and English" in Hasenfeld and English (1974).

[26] Ibid.

[27] Ibid.

[28] Ibid.

[29] See the work cited above (Note 1).

[30] In generating these data, procedures described above (Note 23) were followed. All expressions of attitudes toward board subjects by board members were considered.

[31] An exploration of possible reforms is presented in "Peters, Teply, Wunsch and Zimmerman" (1977).