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Independent Articles

Minding the Gap: The Absence of Pennsylvania's Involuntary Commitment Data

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Abstract

An involuntary commitment is a rights-restrictive procedure that is rarely afforded visibility through useful data. Pennsylvania is a nationally relevant case study on the promises, perils, and misconceptions surrounding involuntary commitment data. In this study, we survey the minimal available Pennsylvania data and then contextualize our results within state laws and norms by (1) framing involuntary commitment data within the state's gun control agenda, (2) implementing the language of undone science, agnotology, and visibility, and (3) discussing the rights and social obligations surrounding privacy, confidentiality, and dangerousness. We find that sensitive administrative data is collected at several points during the involuntary commitment process but is rarely available in a useful, de-identified form. Improved access to useful data about the commitment population would close a major gap in state and national healthcare delivery, policy, and accountability.

Keywords: Civil commitment; Involuntary commitment; Undone science; Publicly available data; Privacy

Introduction

Each US state defines its own medicolegal framework for involuntary commitment. The standard for involuntary commitment is typically met when an individual poses a danger of harm to themselves or others, or is unable to meet their basic needs due to mental illness.[1] The actual implementation of the standard is difficult to measure because "U.S. data on civil commitment are often sporadic, limited in scope, or inaccessible to the public" due to privacy concerns, decentralized reporting systems, and varying commitment criteria.[2] Useful data on involuntary psychiatric treatment are available in just 25 states.[3] Other reports have found that an "obvious need exists for research and efforts from concerned agencies to monitor commitments … States with yearly reports should be commended [and] other states should be studied to understand why they do not release figures regarding such major rights-restrictive procedures."[4]

Useful commitment data is one of the "gaps in our knowledge"[5] that leads to a lack of research on the effectiveness of involuntary commitments.[6] This gap is important because observational studies are one of the few tools available for evaluating an involuntary commitment's effectiveness[7] and the effectiveness of mental health systems.[8] As Miller and Hanson write: "Given the loss of liberty, the personal distress, and the stigma involved, this lack of data is astounding."[9]

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This study offers an overview of the commitment process, surveys Pennsylvania's publicly available commitment data, and follows that data during and after a commitment. The available data were sparse and conflicting, prompting a discussion of causality, including gun control, visibility, and privacy. Using the frameworks of agnotology and undone science, we argue that the lack of data implies a value judgment about who is important that leads to the disenfranchisement of the commitment population. This argument is specifically relevant to other states that do not collect data or poorly report on the commitment population. The investigation has increasing national relevance following a federal move to expand the use of commitments to address substance use disorders and homelessness.[10]

Involuntary Commitment Data in Pennsylvania

This section offers an overview of the commitment process in Pennsylvania, explores available involuntary commitment data in public documents, highlights data dashboards in Centre and Allegheny counties, and summarizes a series of Right-to-Know requests.[11] Our findings suggest the state understands that commitment data are valuable for policy development despite the absence of useful statewide data.[12]

Background

The threshold for involuntary commitment, called the dangerousness standard, is defined in Section 302 of Pennsylvania's Mental Health Procedures Act of 1976 (MHPA) and is met when a patient "poses a clear and present danger of harm to others or to himself."[13]

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The dangerousness standard for involuntary commitment was broadly enshrined in state laws across the country in the 1970s and 80s and reserves significant latitude for provider and judicial judgment.[14] Application of the standard has not been uniform because "danger" is not precisely defined[15] and implementation may be affected by other factors,[16] like a concurrent criminal offense.[17] Since its widespread adoption, numerous critiques have been levied against the utility of the dangerousness standard[18] due to its under-application,[19] over-application, inability to accurately predict future dangerous behavior, and lack of support by social science data.[20]

In Pennsylvania, a person typically meets the dangerousness standard if they exhibit suicidal, homicidal, or self-injurious behavior/intent. Any individual familiar with the person's dangerous behavior can initiate an involuntary commitment petition; if the petition is approved by the county administrator or their delegate, the person will be involuntarily brought to the emergency department by police.[21] Involuntary commitment petitions can also be self-authorized by a physician or police officer. The initial involuntary hold lasts up to 120 hours and may be extended with a separate petition. A commitment may be appealed in court with an attorney and the committing physician present.[22]

Surveying the Data Landscape

Structured internet searches pointed to several potential sources of involuntary commitment data.[23] The searches included a county name plus "involuntary commitment" or "involuntary commitment dashboard" or "involuntary commitment data" or "mental health taskforce" for each of Pennsylvania's 67 counties. These searches did not lead to useful state- or county-level data, except in Allegheny and Centre counties. Other counties occasionally provided rough counts of commitments in block grant reports or newspaper articles, but these records were often confusing or conflicting.[24] The majority of newspaper articles and county webpages identified through the structured searches detail Pennsylvania's involuntary commitment process, direct users to resources, and advocate for funding. While researchers found that some counties have called for tracking of commitment services as a way of including stakeholders, these data were not publicly available.[25] Ultimately, the structured internet searches failed to identify data that would lead to a useful statewide count of involuntary commitments.

Public Dashboards and Data-Sharing Initiatives

The structured internet searches identified a significant amount of media, mostly consisting of newspaper articles and county reports, from Allegheny and Centre counties. In both counties, the violent death of a person with a mental illness brought attention to the issue of involuntary commitment and led to some data transparency. Allegheny County produced lasting visibility for the commitment population while Centre County did not.

The stories behind data transparency are illustrative. In 2012, a man with mental illness diagnoses and a history of involuntary commitments entered the Western Psychiatric Institute in Allegheny County with a firearm, killing one person and injuring several others before being shot by police.[26] The event became part of a larger discussion about guns, mental illness, and involuntary commitment.[27] The initial media responses to the shooting typify the link between mental illness and dangerousness, focusing on the ways the mental healthcare system had failed to protect the public. The media quickly reported on the individual's history of violence[28] and identified systemic failures that might have identified his dangerousness to the public, making him a candidate for involuntary commitment.[29] The County Comptroller responded to public attention[30] with an audit of mental health services, leading to several substantive changes, including a new dashboard for involuntary commitment data.[31] The dashboard is updated daily by Allegheny County's Department of Human Services (DHS) and reports the number of filed/upheld involuntary commitment petitions, location information, and who initiated/authorized the petition.[32]

Allegheny County DHS further links institutional data with county administrative data for treatment oversight and coordination[33] in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the MHPA.[34] Allegheny County's data have been critical for research and policy development. For instance, their data have been used by journalists[35] and researchers, who found that Black young adults are about 2.5 times more likely to experience an involuntary commitment petition than their White peers.[36] Demographic injustices were also found among older members of the commitment population, where "[M]en and Black individuals are disproportionately likely to be subjected to an evaluation for involuntary commitment" with no substantial difference in the likelihood of that commitment being upheld.[37] Most strikingly, within five years of their first involuntary commitment evaluation, researchers found that 20% of the involuntary commitment population had died.[38]

Allegheny County DHS has planned further analyses and policy reviews using their data, suggesting that the project is relevant and worth sustaining.[39] However, there was no uptake when they offered the tracking system technology to other Pennsylvania counties.[40]

Conversely, the death of Osaze Osagie in Centre County attracted similar attention to involuntary commitments without leading to lasting data transparency. On March 20, 2019, State College police served an involuntary commitment warrant on Osagie, a Black man living with schizophrenia whose father had initiated an involuntary commitment petition. Osagie rushed three officers with a serrated knife; they responded by discharging a Taser with no effect and then shot Osagie several times, killing him.[41]

This event caught the attention of local media and the public: community members attended county board meetings, formed an advocacy group, and staged protests that connected Osagie's death with the Black Lives Matter movement.[42] The County responded to the incident with the "Final Report,"[43] best practices guidelines,[44] and a report by the district attorney.[45] These documents addressed community concerns, offered accountability, and advocated for those experiencing mental health crises.

The County's "Final Report" includes some limited commitment data, including the number of involuntary commitment petitions that were submitted, approved, or denied from January to September 2020.[46] The report recommended that the county build a data collection and sharing system. But, at the time of writing, no public data-sharing system could be found, and it was impossible to verify through public sources, communication with county administrators,[47] or by attending advisory board meetings if any concrete steps had been taken toward this recommendation.[48]

In both Allegheny and Centre counties, the violent death of a person with a mental illness who was a candidate for involuntary commitment attracted public attention and motivated officials to make the commitment population visible through data. While reports produced by Allegheny County DHS demonstrated that data-sharing initiatives can play an important role in shaping policy, there was no comparable lasting change in Centre County.

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Administrative Documents and Right-to-Know Requests

The MHPA requires the collection of several administrative documents during an involuntary commitment. The path of two administrative documents, the "Application for Involuntary Emergency Examination and Treatment" and "Notification of Mental Health Commitment," offered two potential avenues for recovering statewide involuntary commitment data. Right-to-Know (RTK) requests submitted to state and county offices did not locate useful commitment data based on these forms.[49]

During an involuntary commitment petition, the first part of an "Application for Involuntary Emergency Examination and Treatment" is completed, including a record of the individual's demographic information, the identity of the petitioner, and the dangerous behavior that supports the petition. In the emergency department (ED), additional sections of the "Application" are completed, including information on whether it was upheld or denied by the physician. If the petition is upheld, the completed form is submitted to the county mental health administrator.

The way the "Application" is handled by county mental health administrators differs across Pennsylvania. In Centre County, for example, the forms are received by an administrator weekly and reviewed to ensure procedural compliance and the protection of patient rights.[50] An administrator claimed that there was a system for tracking statistics and a mechanism for reporting these to the state DHS, but this could not be verified.[51] Researchers submitted RTK requests to assess if Centre County or DHS could provide de-identified information on commitments. DHS responded that "the department does not know of or track all involuntary commitments." Similarly, Centre County found no records responsive to the request.[52]

Another form, the "Notification of Mental Health Commitment," must be submitted to the Pennsylvania State Police (PSP) within seven days of an involuntary commitment. The PSP maintains a database of commitment notifications because it is unlawful for a person who has been involuntarily committed to possess a firearm.[53] This database feeds into the Pennsylvania Instant Check System (PICS), a statewide system for conducting background checks.[54]

An RTK request was submitted to the PSP to recover these data. The PSP responded to the request with the aggregate number of "Notifications" received in every county since 1976.[55] Although the "Notification" requires the collection of demographic information, researchers were informed that "the PSP does not break down Mental Health Commitments by de-identified demographics."

A subsequent RTK request was submitted to the PSP seeking the number of "Notification[s]" received by Allegheny, Centre, and Luzerne counties during 2022. The PSP provided a report with the date of involuntary commitment, the date the form was received by the PSP, and the type of commitment. The authors found numerous discrepancies in these data. In Allegheny County, for instance, the PSP dataset reports receipt of 3,306 involuntary commitment notifications, while the public dashboard notes 3,379 upheld involuntary commitments during the same period. The PSP records from Allegheny County contained 257 entries without information on the type of commitment and 384 petitions from outside the requested date range — the oldest inexplicably from 1935.[56] In general, these data have many incomplete or conflicting records.

This survey of extant data reveals that state and county agencies have a paucity of accurate records on involuntary commitments. Public documents, from block grants to county reports, have little useful data while simultaneously reflecting the state's understanding that data are useful for oversight and transparency. When records were accessible, they lacked demographic information or had questionable reliability. This gap in useful, reliable data exists in concert with calls for accountability and transparency, highlighted in Centre and Allegheny counties, where public attention followed violence to/by the mentally ill.

Guns and Undone Science

The intersection of guns and mental illness provides necessary context for the gap in commitment data. Longstanding public opinion links mental illness and dangerousness, resulting in laws designed to protect the public from mentally ill people — especially those with a gun.[57] Such firearm controls entrench an enduring, inaccurate stigma[58] about the dangerousness of people experiencing a mental illness[59] given that these people are far more likely to commit suicide than homicide.[60] The effort to keep guns away from mentally ill individuals becomes a political performance of public safety that diverts attention away from otherwise loose gun control laws, which, in the wake of court-imposed limits on firearm restrictions, must "regulate dangerous persons rather than dangerous firearms."[61] PICS gives this stigma form insofar as it provides "exclusive access"[62] to Pennsylvania's largest repository of commitment data for the purpose of firearm control and public safety.

The tragedies in Allegheny and Centre counties traded this stigma for better patient care and transparency. In both cases, high-visibility events involving guns and mental illness led to public demands for accountability. County officials then attempted to make the emergency mental health system legible to the public by mapping the contours and gaps of the system. Both counties made use of commitment data and considered improved tracking, centering patients by setting improved patient care and transparency as valuable endpoints. These counties made notable moves to see the commitment population as patients, not as threats to public safety. This departs from the status quo, symbolized by PICS and a recent federal executive order,[63] which use commitments and commitment tracking as public safety interventions[64] interested in control.

Undone Science and Agnotology

In Pennsylvania, commitment data are characterized by a tracking system motivated by firearm regulation and countervailed by the absence of a patient-focused database. The language of undone science and agnotology clarify the implications of this gap. Undone science reads the gaps between knowns and unknowns as "historical products of disciplinary practices"[65] located in "the institutional matrix of governments, industries, and social movements."[66] This theory suggests that the absence of a measurement, in this case patient-focused commitment data, is not a neutral category — instead, the presence/absence of "indicators are inevitably political, rooted in particular conceptions of problems and theories of responsibility. They represent the perspectives and frameworks of those who produce them, as well as their political and financial power. What gets counted depends on which groups and organizations can afford to count."[67] The association between undone science, the state, institutions, and laws also benefits from a discussion of agnotology, a program of study interested in the norms that create ignorance and the absence of knowledge.[68]

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This characterization of present/absent data requires a description of the attributes of ignorance, including granularity, scale, and intentionality:[69]

(1) Granularity measures the quantization of knowledge, from "atomic propositions"[70] and "[a]bsent bits of information in communication streams"[71] to specific redactions, classes of documents, and whole domains of knowledge. Granularity frames the PSP data, which includes some relevant information but lacks demographics. The available quantitative data have low granularity, are unreliable, and do not relate any qualitative information about an individual patient's subjective experience.

(2) Scale pertains to "the components and systems in which that knowledge, whatever its granularity, might circulate."[72] The scales of ignorance appear in the individual, middle, and upper ranges. In the setting of involuntary commitment, the state recognizes the relationship between rights and accountability for the commitment population in the individual range. For the patient in the clinic or ED, the state explicitly defines benefits, harms, responsibilities, and modes of redress.[73] The middle range contains pathologies and cultures around who maintains data, bears responsibility, and can respond to injustices. The commitment population becomes less recognizable in the middle range, where intra-/inter-organizational actors — hospital systems, offices of county administrators, and state departments — experience intense variation in available information about the population. The upper range consists of "frameworks which articulate deep epistemological rifts in knowledge,"[74] places where ignorance is inflected in general theories of understanding. This includes the common language for describing illness[75] and the frames used to communicate about mental illness.[76]

(3) Intentionality maps whether absences or omissions are conscious, intentional, and willful, or unconscious, surprising, and unknowable.[77] These vertices include knowledge, knowledge that is known not to exist, and unknowns. Commitment data is knowledge that is known not to exist. This type of absent knowledge may be produced by a privileged group that controls the discourse, throttles the spread of information, or simplifies complex stories in the service of select interests.[78] In cases where it is known that knowledge does not exist, it is possible to theorize a process of "active production" that reveals disciplinary practices and the function of power.[79]

Granularity in particular helps make sense of extant involuntary commitment data. Middle range actors have the capacity to collect meaningful data on commitments as evidenced by statute, crisis reporting,[80] county efforts,[81] and anecdotal evidence.[82] But the only statewide commitment database belongs to the PSP — and the granularity of that data is extremely low. The absence of reliable data, or even a reliable count of the commitment population, is thus a meaningful enumerative omission.[83] This classification gives shape to a population that might be counted but is not, further "underscore[ing] the positive, active political and symbolic work being done by the ostensibly negative, inactive state behaviors of not registering, not documenting, not counting, and otherwise not recognizing."[84]

Even if a rigorous commitment database, like Allegheny County's, were built using the administrative documents currently collected by the state, an analysis of granularity reveals another omission. The lack of patient perspective in administrative documents means that the data are complicated by a kaleidoscope of imbalanced power relations. In the current system, patients must wait to seek redress in court if they disagree with the physician's judgment — and, notably, it is the physician's perspective that is the focus of the "Application for Involuntary Emergency Examination and Treatment." Very little information about the patient's subjective experience is collected on the "Application." Similarly, tracking systems that only record quantitative data are unable to relate the richer qualitative data that may provide a better picture of the patient's experience of involuntary commitment.[85] The function of these omissions is that a patient subject to an involuntary commitment may be seen by a physician in the ED and never be fully seen by the state.

Visibility and Privacy

In this section, the ways the commitment population is seen/unseen is conceptualized through a reading of the MHPA and an analogy to carceral censuses. Privacy is then considered and discarded as a reasonable argument against visibility. We argue that enumerative data enable a bottom-up, collective approach that make the individual count and supports recognition in terms of policy, power, and justice.[86]

The MHPA and Carceral Censuses

State regulatory regimes, like the MHPA, influence research priorities and the way the state sees its residents.[87] Regulatory omissions fall into two broad categories: formalized omissions, which are "enacted in the letter of the law or policy," and discretionary omissions, which rely on subjective interpretations of policy "in ways that lead to the denial of persons from being registered or enumerated."[88] The MHPA operationalizes both types of omissions by formally limiting access to patient records to the patient, provider, county administrator, court, and payors,[89] while making a discretionary allowance for disclosing de-identified information.[90] The state's intentional or unconscious choice to not exercise this discretionary allowance is significant because data transparency and enumeration would provide a route for the commitment population to lobby for recognition, accountability, and policy remedies.

While visibility through enumeration does not inherently affirm rights, it provides a scaffolding for individuals to assert recognition through their collective carceral, racial, or health identities.[91] Disciplinary systems and prison reform movements have historically been shaped by the visibility[92] of those subject to the state's power: the population must first be seen before the system can change.[93]

Broadly, involuntary commitment and criminal detention share a loss of autonomy, stigma, and restriction of rights — but the prison population is visible through enumeration. The US Census Bureau counts national prisoner "admissions and releases by type and sex during each calendar year, as well as the number of prisoners in custody by sex and sentence length."[94] Over time, the National Prisoner Statistics Program has adapted its data collection system to meet the changing needs of the incarcerated population, researchers, and the government.[95] It is striking that the commitment population is not afforded the same visibility. As Morris notes, "[c]ivil commitment is not equivalent to criminal justice in structure or function, and criminal justice data reporting is not perfect; still, it is difficult to imagine a similar situation in which such basic information about the criminal justice system, such as the numbers of people incarcerated annually, remain a mystery."[96]

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The responsiveness to community informational needs appears at the intersection of policing and involuntary commitment in Centre County. The State College Police Department (SCPD) began tracking involuntary commitment warrant services after Osagie's death in 2019. An SCPD Assistant Chief emphasized that the department did not previously recognize the utility of tracking involuntary commitment warrant services and suggested that the data may be useful for understanding system utilization and identifying officer bias.[97] The Assistant Chief likened this change to the addition of a racial demographics question to forms related to traffic stops, a methodological shift that became widespread in the early 2000s to make discriminatory policing visible.[98]

Most middle range actors in Pennsylvania have not demonstrated a similar willingness to look for methodological inconsistencies across the commitment population. This is, in part, because the MHPA protects the rights of individuals and never resolved the numerous gaps, vague language, and varying interpretations[99] that affect the population when they interact with middle range institutions.[100] The emphasis on preserving individual rights became the only possible check in the system, licensing an active production of different practices under the same standards. For instance, "an individual can be committed for a specific set of behaviors in one community while not committed forty miles away in another community."[101] This is a middle range implementation failure where the institutional cultures and legal strictures intended to produce homogeneous treatment of individuals fail to secure uniformity.[102] When the state uses porous laws and norms to protect the rights of individuals, it may create issues that only appear when the population is made visible and enumerated. If there is no population-level visibility, the state creates the appearance of justice at the individual range while giving rise to suspected, but largely unknown, injustices in the middle range.

Privacy, Confidentiality, Visibility, and Dangerousness

Because mental health is sensitive, might the absence of data and patient invisibility be understood as a necessary deference to privacy? The ethical territory is contested and, perhaps, some definitions are in order. Privacy is classically understood as "the right to be let alone."[103] There are three principal usages of privacy: physical privacy, informational privacy, and decisional privacy.[104] While related, confidentiality typically refers to the way private information travels once shared.[105] Privacy and confidentiality have been hallmarks of medical care since antiquity and are an integral part of medical ethics.[106]

In Centre County, it was hard to tell whether individuals or institutions were principally served by deferring to informational privacy and confidentiality. When prompted, officials repeatedly cited privacy as their rationale for the continued absence of involuntary commitment data, arguing that it is impossible to produce meaningful data without compromising patient privacy.[107] These officials share a position with commentators who favor an absolutist view of privacy which, they suggest, is a necessary precondition for medical autonomy.[108] The officials' statements contrast with the aspirations of Centre County's post-2019 data-sharing initiatives and effectively shields the county from public oversight.

Non-sharing is problematic, in part, because absolute privacy protects the individual at the expense of the population if information about the individual has relevance to the group. This departs from the classic principles of bioethics — respect for autonomy, nonmaleficence, beneficence, and justice[109] — which center the individual patient and their web interactions with physicians "without considering the collective processes of health. This focus on the individual and interpersonal then allows processes that produce inequality to avoid consideration, critique, confrontation and change. In essence, the focus on the individual allows the engines producing inequality to continue unchallenged."[110]

Although a patient experiences an involuntary commitment as an individual, information about their care has utility to the commitment population. The point is chiasmatic: social utility alone is an insufficient rationale for the state to override the right to privacy, but rights should not necessarily function as an "absolute barrier to the pursuit of collective goals."[111]

The modern public health apparatus regularly balances privacy and collective goals through a far-reaching medical surveillance infrastructure that manages diseases, illnesses, and public health problems by making them visible without authorization. In cancer studies, for instance, authors have long "indicate[d] the social harm that could result if use of multiple sources in cohort epidemiology were curtailed. For example, insistence on prior permission from all members of a cohort, would render unthinkable most of the present undertakings."[112] Involuntary commitment is an outlier insofar as institutional preference skews toward strict observation of decisional and informational privacy. Large healthcare reporting centers and county mental health offices collect a wide variety of sensitive health data but remain unwilling or unable to collect and share useful data on involuntary commitments.[113]

Absolute privacy and strict confidentiality are not written into commitment laws. State and federal policies permit breaches in privacy for select collective, socially important reasons beyond an individual's medical treatment. The MHPA outlined acceptable uses of "anonymous" patient information long before the national standards for using patient information were codified by HIPAA in 1996, carving out specific acceptable uses of de-identified patient information.[114] HIPAA allows institutions to enter into agreements with researchers to disclose "limited data sets" of healthcare information for research purposes.[115] Public health laws do not require reporting of involuntary commitment data but also do not specifically limit public access to de-identified individual or aggregate data.[116]

For involuntary commitment patients, the circumstances that typically lead to breaches of privacy are bound up in the issue of public safety, not with the goal of improving healthcare. The Code of Ethics of the American College of Emergency Physicians states that "[e]mergency physicians shall respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law."[117] The duty to protect others compels a provider to violate patient privacy and medical record confidentiality when a patient exhibits violent intent, in line with the dangerousness standard. The duty reappears in Kendra's Law, Laura's Law, and the *Tarasoff* Rule. These laws were born out of shocking deaths and curtail the confidentiality of mental health patients, favoring information sharing and public safety under certain circumstances. The thrust is that laws and norms lead to information sharing when an individual could be dangerous to the public, not for the benefit of the patient.

While these laws and norms might achieve public safety in certain limited cases, the unfortunate fact is that the dangerousness standard's language of "danger of harm to others or to himself" is unintentionally revealing.[118] For mentally ill individuals, especially those who might be violent, protecting "others" comes before protecting "self." This aligns with the emphasis on public safety that makes patient-centered information sharing and visibility a secondary aim.

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Mental health laws are often rationalized as beneficent policies that preserve privacy, but the predictable outcome of this deference to privacy is invisibility. These laws exist in concert with middle range implementation failures and upper range social frameworks/stigmas that favor invisibility and control.[119] This logic is reflected in the current administration's "compassionate" policies[120] toward the unhoused and mentally ill individuals who will be rendered invisible through forcible removal from public spaces.[121] Acts of control in the name of compassionate care regularly target the unhoused by using mental illness[122] and disability as proxies for removal.[123] A similar visibility logic is displayed in the Supreme Court's recent ruling in *City of Grants Pass v. Johnson*, which reversed decades of precedent by permitting the criminalization of sleeping in public.[124] In both cases, the state favors solutions that turn a visible condition into an invisible one[125] — being unhoused or mentally ill in a shelter bed is preferable to being visible in public.[126]

Moving Forward

It is challenging to identify root causes and perhaps unwise to definitively resolve the specific motives behind involuntary commitment's numerous invisibilities and undone sciences. One must be cautious about assigning blame when knowledge doesn't exist because "there is often no 'smoking gun,' or more correctly no smoking memo, pointing to specific guilty political actors."[127] In part, this is because a state may violate laws, conduct norms, or cause social injury through the complex, interwoven "consequences of an economics-politics-culture nexus that produces a normalized exercise of bio-power that is frequently deeply injurious to particular segments of the society, or even the society as a whole."[128] To name the exact historical forces behind the absence of data would require a fluid investigation that may find logic and rationality in processes where there was none.

Furthermore, such a history would be insufficient — working on an exhaustive institutional history of involuntary commitment policies would not necessarily affect the much-needed changes to policy and norms. The status quo, which defers to privacy and confidentiality, maintains numerous gaps, injustices, and indignities independent of intentionality — leaving researchers, patients, and the public to grapple with the consequences. Considering the administrative documents that must be produced during each involuntary commitment, available technology, legal points of data capture, and the value to care and health policy, the state should move to collect and analyze involuntary commitment data. A decades-old observation about medical records applies: "the challenge is no longer technological, as the technology has already been developed. Rather, the issues are moral and political."[129]

Conclusion

Using an examination of involuntary commitment data in Pennsylvania, we have made an ethical case that the lack of data is an organized ignorance that reflects a value judgment about who counts. The current system favors understanding the commitment population through the prism of perceived dangerousness to the public without a focus on visibility and data-sharing for the benefit of patients. This argument is specifically applicable to the many states that lack useful involuntary commitment data and is increasingly pressing as, under the current administration, the national mood shifts toward coercive policies.[130]

Here, we need to confess our *noblesse oblige* and, as researchers, be clear about our aims. An ideal commitment database should serve the intended population and not our own personal or institutional interests.[131] We recognize that measurements are not neutral and may reproduce the biases of those collecting, reporting, and analyzing. Extreme caution must be taken to ensure that data are non-exploitative while acknowledging that indicators and enumerations "typically conceal their political and theoretical origins and underlying theories of social change and activism."[132] We are acutely aware that visibility through data does not necessarily constitute change. Moreover, data initiatives may be superseded by other interests: perhaps a reasonable conclusion, for the moment, is to recognize the absence of commitment data as a conceptual artifact that motivates better policies with swifter benefits.

That said, our desired outcome for data collection involves a "two-way exchange" between patients and institutions that explicitly recognizes relevant data, develops projects that offer individuals respect, and does not solely focus on compliance with institutional norms.[133] Visibility should not condemn the commitment population to homogeneity; rather, it should illuminate patients' myriad stories and needs. Data collection should carefully balance the many competing individual and institutional interests, while remaining transparent, relevant, and respectful. The state needs to move from active ignorance toward a two-way exchange that balances privacy and useful data so that researchers, institutions, and providers can offer effective, evidence-based services — toward a system that identifies disparities, is relevant to the commitment population, and remains compliant with HIPAA. While seeing the commitment population has not been a priority of the state, now is the time to close the gap.

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4. Gi Lee and David Cohen, "How Many People Are Subjected to Involuntary Psychiatric Detention in the U.S.? First Verifiable Population Estimates of Civil Commitment," Society for Social Work and Research 23rd Annual Conference, San Francisco, January 18, 2019, https://sswr.confex.com/sswr/2019/webprogram/Paper34840.html.
5. Dinah Miller and Annette Hanson, *Committed: The Battle Over Involuntary Psychiatric Care* (Johns Hopkins University Press, 2016), 265.

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6. Nathaniel P. Morris and Robert A. Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization," *Psychiatric Services* 74, no. 4 (2022): 431–33, https://doi.org/10.1176/appi.ps.20220296.
7. Morris and Kleinman, "Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization."
8. Tim A. Bruckner et al., "Involuntary Civil Commitments After the Implementation of California's Mental Health Services Act," *Psychiatric Services* 61, no. 10 (2010): 1006–11, https://doi.org/10.1176/ps.2010.61.10.1006; Ralph Catalano et al., "Psychiatric Emergency Services and the System of Care," *Psychiatric Services* 54, no. 3 (2003): 351–55, https://doi.org/10.1176/appi.ps.54.3.351.
9. *Committed: The Battle Over Involuntary Psychiatric Care*, xvii.
10. Exec. Order 14321, 3 C.F.R. 35817 (2025), https://www.whitehouse.gov/presidential-actions/2025/07/ending-crime-and-disorder-on-americas-streets/; S.B. 962, 2023–2024 Gen. Assemb. Reg. Sess. (Pa., 2023), https://www.palegis.us/legislation/bills/text/PDF/2023/0/SB0962/PN1172; Jennifer Ludden, "White House Says Dozens of Homeless Encampments Cleared from Washington, D.C.," *NPR*, August 19, 2025, https://www.npr.org/2025/08/19/nx-s1-5506285/white-house-says-dozens-of-homeless-encampments-cleared-from-washington-d-c; Mark Walker and Nicholas Bogel-Burroughs, "Officers Clear More Homeless People from Sites Around Washington," *The New York Times*, August 15, 2025, https://www.nytimes.com/2025/08/15/us/politics/dc-homeless-encampments-police.html.
11. A more detailed account of the methodology and findings can be found in a separate white paper available at: https://sites.psu.edu/neuroethicslab/research/involuntary-commitment-project/.
12. While we are unaware of any study that specifically resolves what data are most useful in observational or retrospective analyses of involuntary commitments, a myriad of sources indirectly suggest the types of data other researchers have found useful, including patient demographics, treatment specifics, and outcomes. See Natalia Emanuel et al., *A Danger to Self and Others: Health and Criminal Consequences of Involuntary Hospitalization*, Staff Reports, no. 1158, (Federal Reserve Bank of New York, 2025), https://doi.org/10.59576/sr.1158; Kristin Neylon and Robert Shaw, *Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum*, (National Association of State Mental Health Program Directors, September 2022), https://library.samhsa.gov/sites/default/files/pep22-01-03-001.pdf; Timothy Shea et al., "Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment," *Psychiatric Services* 73, no. 12 (2022): 1322–29, https://doi.org/10.1176/appi.ps.202100342; Parvati Singh, "Psychiatric Emergencies Following the 2008 Economic Recession: An Ecological Examination of Population-Level Responses in Four US States," *Journal of Mental Health Policy and Economics* 24, no. 1 (2021): 13–30.
13. Mental Health Procedures Act, Tit. 55 Pa. Code § 5100 (1976).
14. The Act has remained mostly intact since its passage during deinstitutionalization, a period of national statutory reforms that shifted away from medical paternalism and toward patient autonomy. See Steven B. Datlof, "The Law of Civil Commitment in Pennsylvania: Towards a Consistent Interpretation of the Mental Health Procedures Act," *Duquesne Law Review* 38, no. 1 (1999). During deinstitutionalization, the number of state hospital beds was steeply reduced (Miller and Hanson, *Committed: The Battle Over Involuntary Psychiatric Care*, 48) as the locus of treatment responsibility shifted from the state to local governments and the family. See Neil Gong, "Between Tolerant Containment and Concerted Constraint: Managing Madness for the City and the Privileged Family," *American Sociological Review* 84, no. 4 (2019): 664–89, https://doi.org/10.1177/0003122419859533.
15. Alexander D. Brooks, "Notes on Defining the 'Dangerousness' of the Mentally III," in *Dangerous Behavior: A Problem in Law and Mental Health* (U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health, Center for Studies of Crime and Delinquency, 1978); Miller and Hanson, *Committed: The Battle Over Involuntary Psychiatric Care*, 105–6.
16. Some commentators argue that, in practice, the dangerousness standard is discarded in favor of a commonsense approach to involuntary commitment in which the family members, attorney, judge, and mental health provider cooperate to reach a desired outcome; the plasticity of the actual implementation of the standard might explain why its addition to mental health statutes did not dramatically affect the size or composition of the commitment population.See Paul S Applebaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (Oxford University Press, 1994).
17. Gwen A. Levitt et al., "Civil Commitment Outcomes of Incompetent Defendants," *Journal of the American Academy of Psychiatry and the Law Online* 38, no. 3 (2010): 349–58, https://jaapl.org/content/38/3/349/tab-article-info.
18. Dinah Miller and Annette Hanson, "Violent Behavior and Involuntary Commitment: Ethical and Clinical Considerations," *Psychiatric Times* 37, no. 2 (2020), https://www.psychiatrictimes.com/view/violent-behavior-and-involuntary-commitment-ethical-and-clinical-considerations.
19. Darold A. Treffert, "Dying with Their Rights On," *American Journal of Psychiatry* 130, no. 9 (1973): 1041–1041, https://doi.org/10.1176/ajp.130.9.1041.
20. George E. Dix, "'Civil' Commitment of the Mentally Ill and the Need for Data on the Prediction of Dangerousness," *American Behavioral Scientist* 19, no. 3 (1976): 318–34, https://doi.org/10.1177/000276427601900306.
21. Across the country, police participate in involuntary commitments by providing transport; there are salient critiques of this practice. See Katie Lazar et al., "Changing the Route: Seeking Compassionate Alternatives to Police Transport in Involuntary Civil Commitment," Wilson Center for Science and Justice, October 2024, https://wcsj.law.duke.edu/wp-content/uploads/2024/10/Changing-the-Route.pdf.
22. Evelyn Whitehill, ed., *Involuntary Commitment Petitions in Allegheny County*, (Allegheny County Department of Human Services December 2015), https://www.alleghenycountyanalytics.us/wp-content/uploads/2015/12/Involuntary-Commitment-Petitions-in-Allegheny-County.pdf.
23. Similar assessments of language and representations in public reports have been useful in framing involuntary psychiatric commitment in other states. See Alex V. Barnard, "From the 'Magna Carta' to 'Dying in the Streets': Media Framings of Mental Health Law in California," *Society and Mental Health* 12, no. 2 (2022): 155–73, https://doi.org/10.1177/21568693211068841.
24. For instance, Bucks County sometimes provides basic involuntary commitment statistics in its annual block grant reports, writing that:

> In 2021, there were 7,071 crisis events. Of those events, 2,218 individuals were admitted to inpatient either voluntarily (201) or involuntarily (302). There were 1,988 individuals that were involuntarily committed via 302 to inpatient. As of June 2022, there have been 3,434 crisis events with 1,125 admitted to psychiatric inpatient. There have been 276 that admitted on a 302. [*sic*]

See Robert J Harvie et al., *County of Bucks Human Services Block Grant*, (County of Bucks, August 16, 2022), https://www.buckscounty.gov/DocumentCenter/View/10223/County-of-Bucks-HSBG-FY2022-23-Plan-?bidId=. These data conflict with a newspaper article that claims to use data from the county's mental health department. The article states that "[In 2022,] 1,657 involuntary commitment petitions — roughly 32 a week — were filed in Bucks County." See Jo Ciavaglia, "With Crisis Centers Overwhelmed, Bucks County Changes How Mental Health Emergencies Are Handled," *PhillyBurbs*, February 18, 2023, https://www.phillyburbs.com/story/news/local/2023/02/18/why-bucks-county-changed-where-its-sending-psychiatric-emergencies/69893293007/. This calls into question the accuracy of both sources. The block grant and Mental Health and Developmental Programs Department data simply do not match, in part because the phrasing is vague: What defines a "crisis event"? Does "committed via 302 to inpatient" account for individuals whose involuntary holds were extended or upheld? If there were only 276 involuntary commitments that led to inpatient treatment in the first half of 2022, as the block grant states, it seems unlikely that there were a total 1,657 involuntary commitment petitions with 900 upheld as reported in the newspaper article and its infographic. Similarly, the 2021 involuntary commitment numbers are not equivalent—the block grant reports 1,988 involuntary commitments "via 302 to inpatient" while the newspaper article, citing the Mental Health and Developmental Programs Department, reports 1,815 involuntary commitment petitions with only 1,018. At a glance, the

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numbers provide the imprimatur of transparency but, upon inspection, prove to be conflicting and unreliable.

25. This is exemplified by Luzerne County, which has called for tracking involuntary commitment petitions as method for including stakeholders. See *Fiscal Year 2013–14 County Human Services Plan Assurance of Compliance* (Luzerne County Commissioners, June 2013), https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/block-grants/documents/bg-13-14/Luzerne%20County.pdf. The structured internet searches did not identify any current tracking system of involuntary commitment petitions, although, according to a mental health administrator, the county does hold some records of involuntary commitments. Tara Fox, personal communication to authors, August 25, 2025.
26. Sadie Gurman et al., "Two Dead, Seven Injured in Western Psych Shooting," *Pittsburgh Post-Gazette*, March 8, 2012, https://www.post-gazette.com/breaking/2012/03/08/two-dead-seven-injured-in-western-psych-shooting/stories/201203080382.
27. Mark L Ruffalo, "Remembering the Western Psych Shooting: A Need for Reform," *Psychology Today*, March 9, 2019, https://www.psychologytoday.com/us/blog/from-freud-to-fluoxetine/201903/remembering-the-western-psych-shooting-a-need-for-reform.
28. Kevin Begos, "Western Psych Shooter Called Gifted, Troubled Student," Associated Press, March 13, 2012; Lillian Thomas, "Special Report: Western Psych Shootings Followed Volatile Years for John Shick," *Pittsburgh Post-Gazette*, March 18, 2012, https://www.post-gazette.com/local/city/2012/03/18/special-report-western-psych-shootings-followed-volatile-years-for-john-shick/stories/201203180274.
29. Noah Brode, "Details Emerge on Western Psych Shooting," 90.5 WESA, March 28, 2012.
30. A woman injured during the shooting brought a case against two physicians involved in the gunman's care, alleging that they ought to have recognized that he met the dangerousness standard and should have been subject to an involuntary commitment. See Leight v. Univ. of Pittsburgh Physicians, et al., 243 A.3d 126 (PA Sup. Ct. 2020). This contributed to a general interest in an audit of the involuntary commitment process, which

> found gaps in paperwork processes, incomplete call logs and insufficient tracking of 302 authorization warrants, leading [the Controller] to call on DHS to strengthen its controls surrounding documentation of the 302 involuntary commitment process. These internal deficiencies cause breaks in the process, that could result in residents in need to fall through the cracks and not receive the help they need… Mental health services, including involuntary evaluation and commitment, can help save a person's life, as well as the lives of others, as seen in the Shick incident in March 2012.

The audit identified that, of a sample of 30 authorized involuntary commitments, 4 (13%) of the warrants were not returned to DHS and that DHS was unaware that 2 of these individuals had been evaluated/committed at all. See Chelsa Wagner, "Contract Compliance Procedures for Behavioral Health Crisis Services Applied to Contracts Between Allegheny County's Department of Human Services and Western Psychiatric Institute and Clinic," County of Allegheny Office of the Controller, July 18, 2014, https://alleghenycontroller.com/reports-audits/contract-compliance-procedures-for-behavioral-health-crisis-services-applied-to-contracts-between-allegheny-countys-department-of-human-services-and-western-psychiatric-institute-and-clinic/.
31. Wagner, "Contract Compliance Procedures for Behavioral Health Crisis Services Applied to Contracts Between Allegheny County's Department of Human Services and Western Psychiatric Institute and Clinic."
32. "Involuntary Commitment Process in Allegheny County," Allegheny County, accessed August 3, 2025, https://tableau.alleghenycounty.us/t/PublicSite/views/InvoluntaryCommitmentsandPetitionsinAlleghenyCounty_v4/Home?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y#1.
33. *Data Sharing Between Contracted Providers and DHS* (Allegheny County Department of Human Services, February 2024), https://analytics.alleghenycounty.us/wp-content/uploads/2024/02/24-ACDHS-03-DataSharing.pdf.
34. *Allegheny County Data Warehouse*, (Allegheny County Department of Human Services, July 2018), https://www.alleghenycountyanalytics.us/wp-content/uploads/2018/07/18-ACDHS-20-Data-Warehouse-Doc_v6.pdf.
35. Amelia Winger, "Healing or Dehumanizing: Experts Explore the Rise in '302' Involuntary Psychiatric Commitment Petitions," *Pittsburgh's Public Source*, October 31, 2022, https://www.publicsource.org/allegheny-county-302-involuntary-outpatient-treatment-western-psych-mental-health-pa/.
36. "Involuntary Commitment Petitions in Allegheny County," Allegheny County Department of Human Services.
37. Pim Welle et al., *Analysis of Allegheny County's Involuntary Hospitalization (302) Program*, (Allegheny County Department of Human Services, October 2023), https://www.alleghenycountyanalytics.us/wp-content/uploads/2023/11/23-ACDHS_Involuntary-Hospitalization.pdf.
38. Welle et al., *Analysis of Allegheny County's Involuntary Hospitalization (302) Program.*
39. Welle et al., *Analysis of Allegheny County's Involuntary Hospitalization (302) Program.*
40. Christina Matsook and Pim Welle, video conference with authors, May 22, 2024.
41. Bernie Cantorna, *In Re: Osaze Osagie: Report of Investigation*, (Centre County District Attorney's Office), https://centrecountypa.gov/DocumentCenter/View/5963/Report-of-investigation-and-Appendix?bidId=.
42. Melissa Manno, "BLM Memorial Rededication Kicks off Week of Events to Mark Anniversary of Osaze Osagie's Death," *Centre Daily Times*, March 16, 2022, https://www.centredaily.com/news/local/community/state-college/article259381699.html; Sarah Rafacz, "Remembering Osaze," *State College Magazine*, March 1, 2020, https://www.statecollegemagazine.com/articles/remembering-osaze/; Lilly Riddle, "Osagie Family, Hours-long Sit-in Part of Latest Black Lives Matter Protest in State College," *Centre Daily Times*, June 14, 2020, https://www.centredaily.com/news/local/community/state-college/article243526847.html.
43. *Task Force on Mental Health Crisis Services: Final Report*, (Task Force on Mental Health Crisis Services, November 10, 2020), https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/services/mental-health-in-pa/documents/behavioral-health-commission/2022-09-Centre%20County%20MH%20ID%20EI%20Testimony.pdf.
44. *Behavioral & Mental Health Crises Response Best Practices Guideline*, (Centre County District Attorney's Office, October 4, 2023), https://centrecountypa.gov/DocumentCenter/View/21532/Behavioral-and-MH-Crises-Response-Best-Practices.
45. Cantorna, *In Re: Osaze Osagie: Report of Investigation.*
46. *Task Force on Mental Health Crisis Services, Final Report.*
47. Cathy I. Arbogast and Helen S. DeFilippis, personal communication with authors, July 2023; Mental Health Task Force Recommendations Public Dashboard, State College of Borough, June 2023, https://performance.envisio.com/dashboard/MHTF/Goal-10084.
48. There is evidence that Centre County may not have acted on this recommendation. The County created dashboard that tracks their progress on the Task Force's recommendations, but the most recent update on data-sharing, from June 2023, reads:

> Centre County MH/ID/EI-D&A continues to analyze its current data systems as well as data that is collected/reported for its various grants and is looking for better ways to extract this information and then report out this data in a way that is meaningful. There are many existing sources of this information — it is a matter of pooling this material together in a way that can be used and shared.

See Mental Health Task Force Recommendations Public Dashboard. Interestingly, the dashboard has recorded no further updates to any of the in-progress recommendations since the summer of 2023. And, more generally, local momentum around involuntary commitment reforms have diminished: for instance, researchers contacted a local reporter who was planning on writing an article about the changes in the county in the five years since Osagie's death. The article was never published, an absent artifact that seems to indicate that county's accountability for its involuntary commitment practices is no longer a salient local issue. Brett Pallotto, personal communication with authors, March 2024.

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49. We acknowledge that access to commitment data via RTK requests may reasonably be precluded by a reading of the specific RTK laws that defer to patient privacy and the non-disclosure of sensitive health information.
50. This follows 55 Pa. Code § 5100.86 (j)(8) (1976).
51. Arbogast and DeFilippis, personal communication with authors.
52. Our RTK requests intentionally solicited de-identified information to comply with HIPAA and the specific language in the MHPA, which reads that the law "shall not restrict the collection and analysis of clinical or statistical data by the department, the county administrator or the facility so long as the use and dissemination of such data does not identify individual patients." Additional information, including the text of the RTK requests and agency responses, can be found in our whitepaper at: https://sites.psu.edu/neuroethicslab/files/2024/07/Inaccessible-Involuntary-Commitment-Data-7_13.docx.
53. The relevant law reads that no person shall possess a firearm if: "The person has been adjudicated as an incompetent or who has been involuntarily committed to a mental institution for inpatient care and treatment. This shall not apply to any proceeding under section 302 of the Mental Health Procedures Act unless the examining physician has issued a certification that inpatient care was necessary or that the person was committable" (18 Pa. Stat. and Cons. Stat. Ann. § 6105(c)(4) (2019)).
54. This is pursuant to MHPA § 109(d).
55. Notably, PICS became operational in 1998, meaning that county administrators or another state office was able to provide historical records on commitments to the PSP at some point in the 1990s. In fact, the MHPA was amended in 1996 to align with the requirement that the PSP be notified "of the identity of any individual who before the effective date of this act had been adjudicated incompetent or had been involuntarily committed" (MHPA of 1976 § 109(d)).
56. Researchers compared the PSP data to county Open Records data and found similar conflicts. Separate RTK requests seeking the number of "Application[s]" received during calendar year 2022 were submitted to Allegheny, Centre, and Luzerne counties. Centre and Allegheny County found no records responsive to this request. Luzerne's Open Records Officer responded that, during the specified period: "There were 842 involuntary committments [*sic*]. Unfortunately, we do not have the rest of the information requested in a list form. They would have to be gone through individually and we do not have staff that would be able to perform that task." This conflicts with the PSP's reported 372 involuntary commitment notifications in Luzerne County during the same period; the PSP only recorded a total of 567 total commitments in Luzerne County that year, including all extensions or cases where the individual was adjudicated incompetent.
57. Lawrence O. Gostin and Katherine L. Record, "Dangerous People or Dangerous Weapons: Access to Firearms for Persons With Mental Illness," *JAMA* 305 (2011): 2108–9, https://doi.org/10.1001/jama.2011.688.
58. The public tends to mistakenly connect dangerous acts of gun violence with mental illness, favoring coercive policies and a growing "stigma complex" which seemingly cannot be corrected by scientific evidence. See Bernice A. Pescosolido et al., "Evolving Public Views On The Likelihood Of Violence From People With Mental Illness: Stigma And Its Consequences," *Health Affairs* 38, no. 10 (2019): 1735–43, https://doi.org/10.1377/hlthaff.2019.00702.
59. Jeffrey W. Swanson et al., "Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy," *Annals of Epidemiology* 25, no. 5 (2015): 366–76, https://doi.org/10.1016/j.annepidem.2014.03.004.
60. Concurrent firearm ownership and mental illness are more closely associated with suicide than homicide. See Jeffrey W. Swanson et al., "Gun Violence, Mental Illness, and Laws That Prohibit Gun Possession: Evidence From Two Florida Counties," *Health Affairs (Project Hope)* 35, no. 6 (2016): 1067–75, https://doi.org/10.1377/hlthaff.2016.0017. Gun control laws principally interested in public safety may therefore have the unintended consequence of safeguarding patients from self-inflicted firearm morbidity and mortality — but the point is that these laws are not designed for this purpose. This unintended, positive consequence forces policymakers and providers to engage with an unfortunate "Faustian bargain": buy into an inaccurate stigma complex that provides more mental health services/funding while entrenching the gun violence and mental illness connection, or try and change the tide. See John S. Rozel and Edward P. Mulvey, "The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice," *Annual Review of Clinical Psychology* 13 (May 2017): 445–69, https://doi.org/10.1146/annurev-clinpsy-021815-093459.
61. Gostin and Record, "Dangerous People or Dangerous Weapons: Access to Firearms for Persons with Mental Illness."
62. Pa. Senate Committee on Law and Justice, 2010–2011 Regular Session (May 11, 2011) (statement by Major Scott R. Snyder, Acting Deputy Commissioner of Staff, Pennsylvania State Police), https://law.pasenategop.com/wp-content/uploads/sites/47/2014/03/snyder.pdf.
63. In alignment with the stigma that reads the mentally ill and unhoused populations as dangerous, the Trump Administration implemented an Executive Order that prioritizes stigma, surveillance, and control. See Exec. Order No. 14321. As described by the ACLU, the executive order entitled "Ending Crime and Disorder on American Streets":

> calls for sweeping federal data collection on unhoused people and those with mental health disabilities, raising serious concerns about surveillance, privacy, and how such data could be used to justify further criminalization. Instead of funding services or support, the administration is prioritizing profiling and control.

See Scout Katovich, "ACLU Condemns Trump Executive Order Targeting Disabled and Unhoused People," *American Civil Liberties Union*, July 24, 2025, https://www.aclu.org/press-releases/aclu-condemns-trump-executive-order-targeting-disabled-and-unhoused-people.
64. Natalia Emanuel et al., "Frequently Asked Questions (FAQ) for 'A Danger to Self and Others: Health and Criminal Consequences of Involuntary Hospitalization,'" preprint, n.d.
65. Scott Frickel and M. Bess Vincent, "Hurricane Katrina, Contamination, and the Unintended Organization of Ignorance," *Technology in Society* 29, no. 2 (2007): 181–88, https://doi.org/10.1016/j.techsoc.2007.01.007.
66. Scott Frickel et al., "Undone Science: Charting Social Movement and Civil Society Challenges to Research Agenda Setting," *Science, Technology, & Human Values* 35, no. 4 (2009): 444–73, https://doi.org/10.1177/0162243909345836.
67. Sally Engle Merry, "Measuring the World: Indicators, Human Rights, and Global Governance," *Current Anthropology* 52, no. S3 (2011): S83–95, https://doi.org/10.1086/657241.
68. Robert N. Proctor and Londa Schiebinger, eds., *Agnotology: The Making and Unmaking of Ignorance* (Stanford University Press, 2008), https://www.sup.org/books/history/agnotology.
69. Jennifer L. Croissant, "Agnotology: Ignorance and Absence or Towards a Sociology of Things That Aren't There," *Social Epistemology* 28, no. 1 (2014): 4–25, https://doi.org/10.1080/02691728.2013.862880.
70. Galison (2008), p. 50, qtd in Croissant, "Agnotology."
71. Croissant, "Agnotology."
72. Croissant, "Agnotology."
73. Paul A Lundeen, "Pennsylvania's New Mental Health Procedures Act: Due Process and the Right to Treatment for the Mentally Ill," *Dickinson Law Review* 81, no. 3 (1977): 627–47.
74. Croissant, "Agnotology."
75. Susan Sontag, *Illness as Metaphor* (Farrar, Strauss and Giroux, 1978).
76. Barnard, "From the 'Magna Carta' to 'Dying in the Streets.'"
77. Croissant, "Agnotology."
78. Alexis Shotwell, *Against Purity: Living Ethically in Compromised Times* (University of Minnesota Press, 2016), https://www.upress.umn.edu/9780816698646/against-purity/.
79. Nancy Tuana, "Coming to Understand: Orgasm and the Epistemology of Ignorance," *Hypatia* 19, no. 1 (2004): 194–232, https://doi.org/10.1111/j.1527-2001.2004.tb01275.x.
80. *Task Force on Mental Health Crisis Services Final Report.*
81. Welle et al., *Analysis of Allegheny County's Involuntary Hospitalization (302) Program.*
82. Arbogast and DeFilippis, personal communication with authors.
83. Cheong argues that enumerative omissions are coverage errors which underestimate a population and figure into the assertion that:

> Omitted populations, rather than indicating an absence of state power operating over them—like the anarchic stateless peoples that

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> Scott (2009) studies—may conversely be outcomes of the concerted accumulation and exercise of state power. It is the kind of power to determine the parameters of what statuses or identities can be claimed and who can credibly claim them. My highlighting of omissions as inherently power-laden processes parallels Bachrach and Baratz's (1962:948) attention to what they call "the second face of power" and the "unmeasurable elements" of social and political life—that is, the use of "nondecision-making" that restricts the very scope of possibility for political action at the outset.

See Amanda R. Cheong, "Theorizing Omission: State Strategies for Withholding Official Recognition of Personhood," *Sociological Theory* 41, no. 4 (2023): 377–402, https://doi.org/10.1177/07352751231206838.

84. Cheong, "Theorizing Omission."
85. Michele Mekel, et al, "Next Directions – Moderated Open Dialogue," Symposium, Involuntary Commitment Data: Challenges and Opportunities, University Park, March 19, 2025.
86. Kyle Velte, "Straightwashing the Census," *Boston College Law Review* 61, no. 69 (2019), https://doi.org/10.2139/ssrn.3358453.
87. James C. Scott, *Seeing like a State: How Certain Schemes to Improve the Human Condition Have Failed* (Yale University Press, 1998).
88. Cheong, "Theorizing Omission."
89. Lundeen, "Pennsylvania's New Mental Health Procedures Act: Due Process and the Right to Treatment for the Mentally Ill."
90. HIPAA later carved out similar protections for patient data while permitting de-identified aggregation for research purposes. See John C. Moskop et al., "From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part I: Conceptual, Moral, and Legal Foundations," *Annals of Emergency Medicine* 45, no. 1 (2004): 53–59, https://doi.org/10.1016/j.annemergmed.2004.08.008.
91. Cheong, "Theorizing Omission."
92. Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (Random House, 1977).
93. Prison reforms that rely on inmate visibility has a long history in Pennsylvania, where:

> A modification of the old and severe criminal code was projected by the Pennsylvania constitution of 1776 and effected by an act passed ten years later. This act of September 15, 1786, called for hard labor "publicly and disgracefully imposed" upon prisoners, which appears to have resulted chiefly in the pitiful sight of prisoners in "distinctive garb" working on the streets of Philadelphia. Such public display of social retribution produced little good excepting that it aroused the sympathy of kindly Quakers and helped lead to the formation, in 1787, of the enduringly influential Philadelphia Society for Alleviating the Miseries of Public Prisons, an organization which as the Pennsylvania Prison Society today continues its humanitarian activities.

See Leroy B. DePuy, "The Walnut Street Prison: Pennsylvania's First Penitentiary," *Pennsylvania History* 18, no. 2 (1951): 130–44.

94. Stephanie Minor-Harper, "State and Federal Prisoners, 1925-85," Bureau of Justice Statistics, October 1, 1986, https://bjs.ojp.gov/content/pub/pdf/sfp2585.pdf.
95. "Corrections Statistical Analysis Tool: Methodology," *Bureau of Justice Statistics Bulletin*, last accessed August 20, 2025, https://csat.bjs.ojp.gov/resources/#.
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101. Pa. Senate Public Health and Welfare Committee, 2015–2016 Regular Session (September 30, 2015) (statement by Chris Wysocki, Administrator, Juniata Valley Behavioral and Developmental Services), https://pasenategop.com/wp-content/uploads/2016/12/Wysocki-Juniata-Valley-Behavioral-Developmental-Services-Testimony.pdf.
102. The 2015 presentation to the Pennsylvania Senate Public Health and Welfare Committee, from which this quotation is drawn, stated that "[i]t is incumbent upon the Office of Mental Health and Substance Abuse Services to establish guidelines and/or regulations for appropriate application of the MHPA." Statement by Chris Wysocki.
103. "The Right to Privacy," *Harvard Law Review* 4, no. 5 (1890), https://groups.csail.mit.edu/mac/classes/6.805/articles/privacy/Privacy_brand_warr2.html.
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106. Moskop et al., "From Hippocrates to HIPAA."
107. Arbogast and DeFilippis, personal communication with authors; *Mental Health & Intellectual Disabilities Advisory Board Meeting: Hearing before the Mental Health & Intellectual Disabilities Advisory Board* (2024).
108. Anita Allen, "Privacy and Medicine," in *The Stanford Encyclopedia of Philosophy*, Spring 2021, ed. Edward N. Zalta (Metaphysics Research Lab, Stanford University, 2021), https://plato.stanford.edu/archives/spr2021/entries/privacy-medicine/.
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110. Jaime Breilh, "The Social Determination of Health and the Transformation of Rights and Ethics," *Global Public Health* 18, no. 1 (2023), https://doi.org/10.1080/17441692.2023.2193830.
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112. Howard B. Newcombe, "Cohorts and Privacy," *Cancer Causes & Control* 5, no. 3 (1994): 287–91.
113. A query of PHC4, a large state-supported reporting council that collects hospital discharge and outpatient procedure records in Pennsylvania, found four records between 2010 and 2018 with ICD-9 or ICD-10 codes related to involuntary commitment.
114. The HIPAA Privacy Rule "recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The Rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the Rule permits covered entities to disclose protected health information without authorization for specified public health purposes." See "Disclosures for Public Health Activities," U.S. Department of Health and Human Services, April 3, 2003, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-public-health-activities/index.html.
115. Moskop et al., "From Hippocrates to HIPAA."
116. Jennifer K. Wagner, "Data and Legal Considerations," Symposium, Involuntary Commitment Data: Challenges and Opportunities, University Park, March 19, 2025.
117. "Code of Ethics for Emergency Physicians," *Annals of Emergency Medicine* 70, no. 1 (2017): e7–15, https://doi.org/10.1016/j.annemergmed.2017.03.032.
118. Mental Health Procedures Act, Tit. 55 Pa. Code § 5100 (1976).
119. Armand Mattelart, *The Globalization of Surveillance* (Polity, 2010) is useful for unpacking how the state justifies surveillance and control. While Mattelart's *longue durée* history is told under the specter of 9/11, his theory is relevant to the ways the state responds to the "moral panic" of the homelessness/public mental illness crisis. See Carl Wu, "Out of Sight, Out of Mind: Removing Unhoused People by Proxy of Mental Illness," *Journal of Law and Social Change* 26, no. 3 (2023), https://doi.org/10.58112/JLASC.26-3.2. Mattelart is chiefly interested in the ways state surveillance expanded post-9/11 by building on conditions of permanent exception developed after World War II, when loose definitions of national security and danger, coupled with disintegrating boundaries between military/

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police, combatant/civilian, and individual/criminal produced a state of continual, grimly accepted human rights violations. The point with respect to America's never-ending homelessness and mental health crises is that surveillance is rationalized by the same conditions of permanent exception and used to bolster select state interests, like the exercise of control, without safeguarding public interests like genuine compassionate care or evidence-based services.

120. Exec. Order 14321.
121. This removal standard follows a compassionate care argument that fails when targeting individuals on the street because such policies are both "severely underinclusive and overinclusive… [and] will ensnare individuals who are not a danger to themselves or others and merely choose the safety of public places instead of the dangerousness of city shelters while ignoring those in shelters who may need help." See Wu, "Out of Sight, Out of Mind."
122. Francine Kiefer, "Care Courts: California Focuses on Mental Illness to Reduce Homelessness," *Christian Science Monitor*, November 3, 2022, https://www.csmonitor.com/USA/Society/2022/1027/Care-Courts-California-focuses-on-mental-illness-to-reduce-homelessness; Susan Schweik, "Kicked to the Curb: Ugly Law Then and Now," *Harvard Civil Rights-Civil Liberties Law Review* 26 (2011), https://journals.law.harvard.edu/crcl/wp-content/uploads/sites/80/2013/01/Schweik_Vol46_Amicus.pdf; Wu, "Out of Sight, Out of Mind."
123. Breakages between social classes are further highlighted in consumers of addiction rehabilitation, where low-income users are subject to tolerant containment and high-income users receive less invasive, personalized services. For low-income users, disciplinary tactics try to achieve basic harm management and render the patient invisible by getting them off the street (which solves a perceived social problem of disorder and dangerousness).See Gong, "Between Tolerant Containment and Concerted Constraint."
124. City of Grants Pass v. Johnson, 603 U.S. 520 (2024), https://www.supremecourt.gov/opinions/23pdf/23-175_19m2.pdf.
125. The result, for one unhoused person cited in the minority's opinion, was: "The only way I have figured out how to get by [in Grants Pass] is try to stay out of sight and out of mind."
126. Gong, "Between Tolerant Containment and Concerted Constraint."
127. Raymond Michalowski, "In Search of 'State and Crime' in State Crime Studies," in *State Crime in the Global Age*, ed. William J. Chambliss and Ronald C. Kramer (Willan Publishing, 2010), 21, https://www.ojp.gov/ncjrs/virtual-library/abstracts/state-crime-global-age.
128. Michalowski, "In Search of 'State and Crime' in State Crime Studies," 26.
129. Judith Wagner DeCew, "The Priority of Privacy for Medical Information," *Social Philosophy and Policy* 17, no. 2 (2000): 213–34, https://doi.org/10.1017/S026505250000217X.
130. Exec. Order 14321.
131. "Exploring the Ethical Imperative for Data Sharing," in *Sharing Research Data to Improve Public Health in Africa: A Workshop Summary* (National Academies Press (US), 2015), https://www.ncbi.nlm.nih.gov/books/NBK321546/.
132. Merry, "Measuring the World."
133. Verna J. Kirkness and Ray Barnhardt, "First Nations and Higher Education The Four R's—Respect Relevance, Reciprocity, Responsibility," *Journal of American Indian Education* 30, no. 3 (1991): 1–15.

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