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PSYCHIATRY AND THE LAW

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Psychiatry And The Law

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Psychiatry And The Law

Historical Background

In all recorded history, societies have indicated the limits of the conduct of individuals with one another and have devised sanctions, primarily in law, as a response to those whose behavior seems to deviate from acceptable norms. Also throughout recorded history, certain persons and agencies have been designated as being responsible to apprehend, examine, mediate, and decide upon the formal institutional responses to those deviations. Such persons usually have a formal connection to a social system of sanctions. A second group of persons has also helped in decisions concerning sanctions (or the absence of them) by attempting to account for men's behavior with theological, biological, psychological, or social reasons, or some combination of these. This second group has included theologians, shamans, physicians, and, more recently, psychiatrists. Thus two institutions, that of legal justice and that of health care, together with the men empowered to represent the agencies that provide their services, came together about certain critical issues:

1. The capacity of a person to be responsible for his act(s) or act responsibly in certain settings.

2. The distinctions between deviant behavior due to biological, psychological, and social causes.

3.The prediction and treatment of dangerousness.

4.The rights of persons designated as patients.

Madness (insanity, unreason, mental illness) has been and continues to be a complex social phenomenon (Scheff, 1963; Wilkins, 1964). It is accepted that there are at least four different empirical systems for viewing human behavior: physicochemical, motivational, social, and cultural. Each of these is separate and understandable in its own terms. The motivational system is useful primarily in explaining certain kinds of behavior known as mental illness, regardless of whether mental illness can be explained in psychological terms alone.

During the Middle Ages the mad were segregated into two groups, the raving and the feeble-minded, primarily for the purpose of protecting the security of the citizens of a given society. The raving were further categorized as criminal or possessed, depending on whether their actions contravened legal or social conventions, respectively. If criminal, they were usually subjected to those sanctions reserved for criminal behavior. If possessed, they were either ritually excluded or sent on pilgrimages to seek cures at various holy places. Subjected in this way to the "test of the return"—travel in the Middle Ages was extremely dangerous and required the use of one's strength and wits—such persons were felt to be well if they returned. The feebleminded were a large, varied group composed of the wretched, infirm,

senile, mentally retarded, and probably neurotic.

After the Middle Ages, once madness was unlinked from theology, other qualities were imputed to the mad: first, in the sixteenth century, shamefulness—from the English poor laws associating madness and pauperism; then, in the eighteenth century, the concept of dangerousness and nonhuman qualities—a kind of social Darwinism. Finally, at the end of the eighteenth century and the Age of Reason, humanness was again imputed to the mad, and "modern" (humane) treatment began. (See Foucault [1965] for a complex elaboration of the historical development of "madness" into the Age of Reason.)

However, beginning with the asylums and workhouses of the seventeenth century, segregation of the mad became so central and organized that, by the end of the nineteenth century, treatment was conceived of only within institutions, and confinement remained the rule. This practice became regulated by laws, with a view to protecting society and supporting treatment while avoiding too many abuses of individual liberty. The latter concerns (treatment and liberty) were decidedly secondary, based on erroneously held views of the dangerousness and untreatability of the mentally ill. One of the most common mental illnesses, dementia praecox, using the paradigm of general paralysis of the insane (CNS—central nervous system—syphilis), was seen as a hopelessly progressive deterioration of mental functioning. This

was not helped by the concept of “alienist” as developed by Auguste Forel, or the mystification about the mentally ill that seemed to characterize the work of Jean-Martin Charcot and Hippolyte-Marie Bernheim in their use of hypnosis with some forms of mental illness.

In England, the Lunacy Act became law in 1828, and in France, the Regimen of the Alienated was promulgated in 1838. Roth provided for the protection of the rights of persons held and treated for mental illness. In the United States, the rapid growth of public asylums for the care of the mentally ill was the result of a crusade led by Dorothea Dix. This effort raised the numbers of persons in mental hospitals far beyond the bed capacities of the hospitals and ended their selective admissions policies; within a short time, patient turnover all but ceased. However, despite these increasing numbers of persons (a distinct and separate group for whom the government had broad responsibilities), procedures for commitment remained uncertain and undefined. Some increasing concern for the rights of individuals committed to such facilities began to develop. This interest was first stimulated by public concern over the wrongful detention of the sane rather than by a concern for the rights and liberty of the mentally ill.

In the 1860s, Mrs. E. P. W. Packard led a vigorous campaign for strict commitment laws. She had been confined in an Illinois mental hospital for three years under an Illinois law which stated:

> Married women and infants, when in the judgment of the medical superintendent are evidently insane or distracted, may be received and detained in the hospital on the request of the husband, or the woman, or parent, or guardian of the infants, without the evidence of insanity or distraction required in other cases (Illinois Laws, 1851).

Consequently, during the next decade, a number of states enacted fairly vigorous commitment laws, some of which included a jury determination of insanity (Dewey, 1913). This overly legalistic approach to civil commitment for mental illness contributed largely to the stigma already attached to mental illness (Deutsch, 1949, p. 438). In addition, the use of a criminal-justice model promoted the public identification of civilly committed persons with criminals, significantly impeding any treatment approaches as well as increasing the anxiety and isolation of persons so designated.

Advances in psychiatric knowledge proceeded slowly into the twentieth century, with a major impetus being observed during and immediately following World War II. Because of the increased concern for social justice, stimulated in part by the purposes of the war, there was an increased desire to eradicate many social ills. Concern for the rights of the mentally ill was one aspect of this desire. Another, related concern had become intertwined as well: the public health interest in reducing the morbidity of mental illness and, if possible, eradicating and preventing mental illness altogether. Thus the quest for social justice and the concern for public mental health have remained bound together; freedom and treatment have become inseparable.

There are some (Szasz, 1957; Wollheim, 1966) who believe that the lack of freedom is incompatible with treatment.

Because of the enlargement of this field of concern from forensic psychiatry (Davidson, 1965)—the practice of which was limited, for the most part, to the courtroom or prison (see Halleck [1965] for an historical elaboration of this period)—into something variously called social-legal psychiatry (Robitscher, 1972) or simply psychiatry and the law, it has become more truly interdisciplinary, dealing with ethical, psychological, medical, and legal problems with a variety of components. The interest in education and research in these areas exists in an increasing number of law and medical schools in conjunction with different legal agencies. The literature (Allen, 1968; Katz, 1962; Redlich, 1966) has correspondingly begun to show less emphasis on the older, tired distinctions between free will and psychic determinism and the nature of criminal responsibility.

Psychiatry and Civil Law

When a person's freedom is abrogated or his civil liberties are denied him, this power should be exercised for compelling reasons, at the most propitious moment, and for a minimum period of time. It should be clear that such power is exercised only if the person is definitely mentally ill *and* a danger to others or himself. To compel another person for less than those

reasons—as, for example, to help them, to do "good," or to tyrannize them because their behavior offends us—is insupportable.

Prediction of Dangerousness

Commitment of the mentally ill has always been closely associated with their purported dangerousness. In fact, the association has often been so close that to make these determinations separately has at times been difficult or impossible. In part this has been due to a combination of the notions that a "beast" is released in man by mental illness and that the doctor has a responsibility to exclude all possibilities of dangerousness before opting for release. Therefore the psychiatrist, rather than attempting to carefully assess dangerousness, usually takes a safe course—that is, commitment. The other reason for the difficulty in separating mental illness from dangerousness has been the use of commitment laws for other purposes: for example, the removal of public nuisances from the open community, and the provision of treatment under the guise of benevolence.

The law requires that the civil commitment of a mentally ill patient depend on psychiatric testimony: The patient must be held to be in need of mental treatment and dangerous to himself or others. The problem is not a small one. Although the number of civil commitments to mental hospitals has been markedly reduced since the late 1960s, approximately mentally ill

persons per year are still predicted to be dangerous and are preventively detained, both for their own and society's protection, and for their treatment. In addition, an average of about 5 percent of the total mental hospital population of the United States (approximately 390,000) are kept in maximum security sections on the basis of the assessment of their potential dangerousness (Scheidmandel, 1969).

Szasz (1960) has compellingly written that the behavioral sciences have not yet been able to solve simple and operational definitions of eccentricity and dangerousness. Because of this, he (1957) feels that psychiatrists have been motivated in large part to be counter-aggressive to very provocative patients. Such aggressiveness can be related to the psychiatrist's identification with prevailing societal sanctions regarding the certain deviant behavior, to an unwillingness by the psychiatrist to share power, and to the psychiatrist's personal readiness to respond to provocative behavior. Szasz's answer is to reject the concept of dangerousness and to argue that the psychiatrist, in the conflict between the patient's and society's rights, should always side with the patient.

For some psychiatrists there is a naive certainty that prediction is an accomplished fact. This naive certainty has not been supported by empirical studies nor by the few evaluations of the results of such prediction. Even in the most careful, painstaking, laborious, and lengthy clinical approaches to

the prediction of dangerousness, false positive evaluations may be at a minimum of 60 to 70 percent (Kozol, 1972). The ability to predict dangerousness is in fact related to the basic capacity to understand disordered behavior and to intervene in those circumstances in which the result will be an increase in social good—that is, where society's members will be reasonably protected, and where effective rehabilitative efforts can be made.

A myth and a misconception stand between the problem and its possible solution. The myth is that of individual clinical judgment, which demands that each case be taken in its own right. Nevertheless, many authors (Ervin, 1969; Halleck, 1969; Kozol, 1972) who can recognize a need for the prediction of dangerousness insist on individual clinical judgment, intuition, and unexplained hunches. The misconception is that particular psychiatric disorders are dangerous per se, which is encouraged when certain mental disorders are characterized by some kind of confused, bizarre, agitated, threatening, frightened, panicked, paranoid, or impulsive behavior. That misconception and the view that impulse—that is, ideation—and action are interchangeable support the belief that all mental disorder must, of necessity, lead to inappropriate, antisocial, or dangerous actions.

In a staff report to the Commission on the Causes and Prevention of Violence, Ervin and Lion (1969) note that "Violence refers to assaultive or

destructive acts of ideation. The term 'ideation' is included because patients with fears and fantasies of violence sometimes act them out." Later they make a very doubtful, unsubstantiated statement connecting violence with psychological disorder: ". . . our impression has been that the largest group of patients complaining of violence fall into the classification of 'borderline' or 'schizoid' personality types" (1969, p. 1187). Another author, Muller (1968), while arguing that "more specific criteria need to be established for imposing involuntary mental hospitalization" and that the "degree of likely damage must be great," then states his criteria: "These [two kinds of criteria] are the psychoses, both functional and organic, and conditions in which there is permanent or temporary impairment of cerebral cortical functioning so that at the time the person is not considered fully responsible for his own behavior." Thus the author confuses psychosis (and/or the absence of responsibility) with dangerousness. The argument is not very compelling. The criteria remain vague and inaccurate.

Part of the problem may be that psychiatrists use mental disease as a concept that relates to treatment, as Shah (1969) noted. Labeling deviancy as mental illness or predicting dangerousness is just a convention to get someone treatment. Once the person is in treatment, the concept of dangerousness is forgotten. It is a device that enlarges and thereby confuses the apparent size of the problem. The confusion of serious psychological impairment with dangerousness, and the dialogue of misunderstanding

between the law and psychiatry about this, is best illustrated by the judge who asks the psychiatrist if the patient is dangerous, to which the psychiatrist responds, “Yes, she is psychotic” (Hough v. United States, 1959).

The United States Court of Appeals, District of Columbia Circuit, in a series of cases dating from 1958 to 1969, refined the character of danger as it relates to the dangerously mentally ill. The cases included persons accused or found guilty of violent crimes as well as those civilly committed. First, there was the concept of reasonable foreseeability; that is, the dangerous act must occur in “the community in the reasonably foreseeable future” (Rosenfield v. Overholser, 1958). Not only must the dangerousness occur soon, it must also be based on a “high” probability of substantial injury. Thus, the term “dangerous to others” cannot simply be a way of singling out anyone whom we would prefer not to meet on the streets. Possibility of injury is not enough. It must be likely, and the threatened harm must be substantial. Thus the psychiatrist must define “likely” as meaning “virtual certainty” rather than mere chance (Cross v. Harris, 1969; Millard v. Harris, 1968).

Given the present reality, it is unlikely that dangerousness can be predicted in a person who has not previously acted in a dangerous or violent way (Halleck, 1965; Kozol, 1972; Rubin, 1972). However, until statistical data and prediction tables allow for more reliable and accurate prediction, it is mandatory that a clinical examination be carried out. This examination

should utilize all ancillary data from family, friends, police, and onlookers, as well as prior information from other physicians, psychologists, and hospitals. It should also include special tests (projective tests, EEGs, and so forth) to determine whether or not mental illness is present, and its nature if found. The diagnosis of mental illness is critical. There is some disagreement; indeed, controversy concerning diagnosis versus labeling has been an intermittent and useful commentary on the mental disorders. (Most recently, see Rosenhan and other commentators [1973].) But the preponderance of opinion seems to be that, for legal purposes, psychoses of all types and the more severe character disorders (borderline and narcissistic) constitute the mental illnesses. That, and the determination of dangerousness, provide the information that will allow a court to make a judicial determination of the need for treatment.

Civil Commitment

Within a psychiatric hospital, sanatorium, or psychiatric section of a general hospital, freedom is limited, both for those being treated voluntarily and those being treated against their will. For this reason, laws have been devised to balance the needs of the rest of society against the needs and civil rights of the mentally ill. These laws, at first preoccupied with protecting society, began in the 1950s to redefine and enlarge the protection of the rights of patients (Bellak, 1971; Harvard Law Review, 1966; Kumasaka,

1972). This shift in emphasis was stimulated, in part, by social concerns generated during World War II, and by the work of social scientists, who found that prolonged mental hospitalization was pernicious. In fact, new treatments were becoming available for the mentally ill that shortened hospitalization or made it unnecessary. In England, the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, which spent three years examining needed reforms, published its report in May 1957. This was followed by the Mental Health Act of 1959. By the middle of the 1960s, most of Western Europe and the many states of the United States had modified existing laws or brought about sweeping reforms (Brakel, 1971).

An example of this reform is the Mental Health Code of the State of Illinois, which went into effect in July 1964. It is “person and crisis oriented” and offers early and easy access to treatment and easy movement in and out of the treatment system. It includes:

1. Revised hospitalization procedures.

2. Protection of civil rights.

3. Protection from civil and criminal liability for persons signing petitions associated with commitment.

4. Periodic review of all persons under the care of the facilities licensed by the Illinois Department of Mental Health.

With some modifications,[1] the following administrative admission procedures were introduced between 1964 and 1971 (Illinois Rev. Stat., 1972):

Informal admission. An individual presents himself to a facility for treatment. If, after examination, the physician deems him suitable for admission, care and treatment, he is admitted without formal application or medical certification. The individual requesting treatment need only indicate a desire for help. No signature is required. Informal admission is simple, fast, inexpensive, with no court procedure needed. The individual is free to leave at any time during the hospital's normal business hours. This admission procedure is not available to minors. [Sect. 4]

Voluntary admission. For an individual of lawful age (in Illinois, 18 years), be or any relative or attorney with the individual's consent may file a verified application requesting voluntary admission for treatment. If the individual is a minor, his parent or guardian may file. He is admitted for treatment if, in the physician's judgment, he is suitable for voluntary admission. Voluntary admission is relatively fast and simple with no initial court procedure needed. The patient is free to leave after giving notice in writing of his desire to leave. The patient cannot be detained for further treatment unless he withdraws his notice to leave in writing or if a petition for hospitalization on court order is filed. If the court petition is filed, the patient may be kept for five days pending the outcome of court proceedings. [Sect. 5]

3. *Admission on the certificate of physician.* This is a formal admission in

which the individual does not object to treatment. He is admitted for treatment upon his application (if 18 years or over) and the certificate of a physician who has examined the individual not more than 72 hours prior to admission. The individual is then examined within 24 hours at the hospital by a psychiatrist to confirm the need for hospitalization. Within five days such a patient may further request an informal judicial hearing, which must be held in five days. If the patient does not protest, he can remain for 60 days. At this time the physician may apply to the court for an order of continued hospitalization which the court can grant without a hearing unless the patient or someone on his behalf requests a hearing within ten days of the above application, which then must be held in five days. [Sect. 6]

4. *Emergency admission.* This procedure permits immediate and protested hospitalization for a mentally ill person 18 years or older for the protection from physical harm to such persons or others, on the basis of the petition of a concerned citizen alone. While a physician's certificate is eventually required, a person may be admitted on the basis of the written petition alone. If no certificate is available in 24 hours, the patient must be released. Within 24 hours, a psychiatrist must examine the patient and his examination [be] made part of the record. Proceedings for a court hearing must be made immediately and must be held within five days. [Sect. 7]

5.*Petition for examination and hearing upon court order.* When a person 18 years or older is asserted to be mentally ill, on petition the court may order an examination for which the person may be detained no more than 24 hours. If, as a result of that examination, a

certificate by a physician asserts that person to be in need of treatment and that certificate filed with the court within 72 hours, a hearing is set. At least ,36 hours before the time of the examination fixed by the court, the person must receive notice of such examination. If the court finds it is necessary in order to complete the examination that the person be compelled to be hospitalized, the court may order a peace officer or other person to transport the person to a hospital. [Sect. 8]

6.*Hospitalization upon court order.* After hearing any person thought to be mentally ill, who is represented by counsel and other witnesses, including psychiatrists and other mental health professionals, the court may order hospitalization. The patient, spouse, relative or friend may demand that the question of hospitalization be heard by a jury selected in the same manner as in other civil proceedings. [Sect. 9]

Under all of the above procedures, individuals retain their civil rights. In addition, their rights in relation to the code must be explained in simple and understandable language. Fair notice must be given to the patient and to others concerned with his welfare. A court hearing with a jury trial can be requested. Counsel must be made available. If necessary, a judicial review can be ordered. While hospitalization on court order is no presumption of competency and does not affect civil rights, a *separate* judicial hearing can be held concerning competency. Earlier versions of the Illinois Mental Health Code contained various provisions under which persons committed to facilities of the Department of Mental Health or the Department of Public

Welfare automatically lost their civil rights. This was alien to the basic premise of a democratic society, which provides that civil rights be protected for all individuals except in the event of overwhelming circumstances (Kittrie, 1972; Rawls, 1971). At present, the court order states only that the person is “in need of mental treatment” and does not comment directly upon loss of civil rights, loss of sanity, or loss of competence.

It is important to note here that legal discrimination was made in the code (Illinois Rev. Stat., 1972) between the following interdependent but separable factors in an illness: (1) need for treatment; (2) treatment requiring hospitalization; (3) need for involuntary submission to examination; (4) need for involuntary submission to treatment; and (5) competency to make a will, enter into contracts, vote, drive a motor vehicle, and so forth. Balancing the usefulness of a crisis-oriented response to the need for mental treatment for any person, against the danger of someone maliciously or fraudulently having a person detained or treated as mentally ill, the code supports the action of any citizen who petitions, on the basis of his personal observations, for the detention of another person as mentally ill. The Code protects him from civil and criminal liability if he acted in good faith. [Sect. 7-3] However, the penalties for perjury still pertain. [Sect. 15-1] All cases that have been admitted or hospitalized, whether by medical certification or by court order, must be reviewed every six months, and that review must be made part of the record. A more extensive review, done once the first year and once every two

years subsequently, provides for a physical examination, mental status examination, behavioral evaluation, and a general social and life situation review. The findings on general health, mental health, and need for continued hospitalization are evaluated and reported to the patient, his attorney, his nearest relative, two other persons designated by the patient, and the court. [Sect. 10]

The Illinois Mental Health Code, in some ways a model of reform legislation, provides three separate grounds for commitment: [Sect. 1-11] (1) dangerousness to others;

dangerousness to oneself; and (3) inability to meet one's physical needs. The first is based on a threat to society and the latter two on the concept of *parens patriae* (the state acting to protect the individual from the active or passive harm he may do himself). The threat to society is clearly the stronger justification. (Yet commitment standards, when read broadly, often allow mental illness and dangerousness to be used interchangeably. Thus the threat to society is not always supported by the evidence.) The right of the state to confine persons dangerous to themselves rests on different grounds. In spite of John Stuart Mill's maxim from his 1859 *Essay on Liberty,* the state frequently intervenes with the mentally ill who are dangerous to themselves:

> That the only purpose for which power can be rightfully exercised over any member of a civilized community against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient

warrant.

The earliest American judicial statement that a person may be locked up for his own good came in the case of Josiah Oakes in the nineteenth century in Massachusetts (Matter of Josiah Oakes, 1845). The opinion stated, ". . . it is a principle of law that an insane person has no will of his own. In that case it becomes the duty of others to provide for his safety . . ."

When one cannot care for himself, commitment may have drastic consequences not only in relation to liberty but also in regard to the rights over one's body and the management of one's property. Therefore it seems best that the standard for commitment in this group be that the risk is substantial and that the person is so disabled as to render him almost incapable of objecting. The most difficult case is that of a threatened or an attempted suicide. Commitment may be justified for one reason; to provide time for reflection—so that, hopefully, the individual will accept the help he may have been seeking. If, after a short period equivalent to those for other emergencies, the individual wants to leave the hospital, there seems little justification for holding him. However, most mentally ill persons, when acutely troubled, will readily accept help when it is offered with dignity and without threats.

In 1972 a lower federal court held (Lessard v. Schmidt) for the first time, in a case concerning the Wisconsin Commitment Laws, that in addition

to requiring notice, hearing, and the right to counsel, the Constitution mandated three other procedural protections for persons protesting involuntary commitment: (1) a beyond-a-reasonable-doubt standard of proof; (2) a warning ("Miranda"-type) to enforce Fifth Amendment rights to remain silent; and (3) a principle favoring the least restrictive alternative, with the burden on proponents of hospitalization to prove that necessity. The beyond-a-reasonable-doubt standard of proof has been further supported by a decision (Psychiatric News, 1973) of the Federal Appeals Court, District of Columbia. With this new delineation of rights and restrictions concerning the involuntary detention and treatment of the mentally ill, reexamination of the legality and scope of all mental health laws has continued.

In contrast to the United States, the European experience of commitment is medical (Greenland, 1969). That is, it tends to be informal, and it vests in the physician immense powers for involuntary hospitalization. It has been argued (in England, for example) that when dealing with potential hospital patients, the doctor should decide, without inquiry, who should be hospitalized. It has also been argued that safeguards can come into play at a later stage. This view seems to be supported in part by the fact that a high proportion of patients against whom compulsion is used do not object at a later state. Their civil liberties are felt to be protected by providing adequate machinery both for reviewing the need for continued detention and for securing release. Such reviews are generally carried out by tribunals or

boards, which are usually a combination of medical, legal, and lay persons.

However, there are several problems inherent in giving the physician the power to limit freedom as well as the power to treat. First, the physician's role is to discover and treat illness, and often his decisions are made "for the patient's own good." Thus he may limit freedom in spite of the fact that the person does not want or need treatment. Second, the physician who is given the power to restrict freedom must implicitly struggle with the question of serving society versus serving the patient. This becomes a serious problem whenever any delinquent or antisocial behavior is known in the patient's history. The European experience, with easy access to hospitalization, has the further danger of denying the protesting patient his right *not* to be hospitalized. In addition, such ready access to hospitalization, which is supported by liberal mental health acts, causes alternatives to hospitalization to be the more easily ignored.

What seems clear is that neither the medical nor the legal approach to the problems of involuntary detention and treatment of the mentally ill answers all of the many questions raised. In any society, interventions are at times necessary during periods of crisis. But such power, when taken, should be exceedingly brief, providing medical and procedural safeguards at many points along the way. Only by continually re-examining the problems and the proposed answers for protecting society and the mentally ill can the

limitations of freedom be minimal and the opportunities for treatment interventions be optimal.

Civil Commitment of Special Categories of Persons

From time to time, commitment categories have been broadened to include persons whose behavior was socially troublesome and felt to be treatable, but who were unable to voluntarily submit to treatment or were potential offenders and therefore dangerous. These special categories of persons enlarge or contract depending on: (1) public sentiments about certain kinds of behavior—for example, drunkenness, which is punished as illegal at certain times and treated as illness at others; and (2) the humanity and/or grandiosity of psychiatrists who are willing to treat the causes of any kind of deviant behavior and the resultant suffering it might cause.

The categories are broad and include groups termed as psychopaths, sexual psychopaths, defective delinquents, narcotics addicts, and chronic alcoholics. These special groups grew out of the history of the study of the criminal and were attempts to isolate a group of potential criminals and prevent or treat the incipient criminality. In the nineteenth century, the search for organic determinants of behavior led to the concept of a "criminal brain." This concept was supported by such terms as "inherited perversion of the moral senses" and "congenital feeblemindedness," which also fitted in

well with certain moral attitudes about deviancy at that time. Lombroso's (1899) concept of a criminal type of brain, which related physical characteristics, degeneracy, and crime, and was based on anatomical and physiological findings, was strongly adhered to in this country.

With the rejection of Lombroso's findings at the turn of the century, the attention of psychiatrists turned to mental defectives as a unitary factor explaining criminal behavior. In a classic paper, Fernald maintained that every feeble-minded person, particularly the high-grade defective, was a potential criminal needing only the proper environment and opportunity to manifest his criminality. The feebleminded were given such labels as "moral imbecile" and "defective delinquent," and few disagreed with Fernald, who stated, "Feeblemindedness is the mother of crime, degeneracy and pauperism" (1909). With the introduction of the Simon-Binet Intelligence Test in this country, and the subsequent testing of criminals, the incidence of feeble-mindedness in various prison populations was reported at 25, then 50, then 98, and lastly 100 percent, going higher each time with the skill of the tester. Along with the doctrine of hereditary criminality came sterilization as a technique of prevention, control and punishment. In 1917 William Allison White, as head of a study committee on the sterilization of criminals, concluded that there was insufficient evidence to continue the practice.

As the spotty methodological foundation of these studies became

apparent and was devastatingly attacked by Murchison's (1924) classic study comparing the intelligence of criminals with the general adult population, environmental theories began to grow. Psychopathic laboratories proliferated, and Benjamin Karpman (1929) began his studies of that special class of offenders in the decade of the 1920s. From his work there was adduced a personality type, the definition of which varied from a legal to a medical one. As recently as 1964, a text states that "most social scientists postulate a common core of psychopathy . . . An asocial, aggressive, highly impulsive person who feels no guilt and is unable to form lasting bonds of affection with human beings" (McCord, 1964, p. 3). The American Psychiatric Association, in its *Diagnostic and Statistical Manual* of 1952, has a category called "Sociopathic [a term to replace the more pejorative one of psychopathic] Personality Disturbances":

> Individuals to be placed in this category are ill primarily in terms of society, and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relation with other individuals.

The subheadings under this category are: (1) antisocial relations, which include cases previously classified as "constitutional psychopathic states" and "psychopathic personalities"; (2) dyssocial reactions, which include "psychopathic personalities with asocial and amoral trends"; (3) sexual deviations; and (4) drug and alcohol addictions (American Psychiatric Association, 1952, pp. 38-39). In 1968, in *Diagnostic and Statistical Manual II*

(American Psychiatric Association), the category of “Sociopathic Personality” no longer exists. Under the major heading of “Personality Disorders,” however, there is the following:

> *Antisocial personality.* This term is reserved for individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups or social values. They are grossly selfish, callous, irresponsible, impulsive and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behavior. A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis, [p. 43]

Sexual deviations, alcoholism, and drug dependence are now diagnostically separate categories, unrelated to those of psychopath, sociopath, and antisocial personality.

Most often psychopathy is diagnosed by entering the class of apprehended offender. Such labeling contains aspects of the discarded hereditary and constitutional theories of criminality. At other times the diagnosis seems to be simply name calling of persons whose behavior is troublesome to others. Thus almost any deviance becomes psychopathy. Yet in 1972, in an otherwise thoughtful and careful study of the problem of predicting dangerousness, Kozol (1972) states:

> Our concept of the dangerous person is nearly identical with the classical stereotype of the criminal or antisocial psychopath. These terms are

> synonyms with sociopath, character disorder or antisocial personality, [p. 379]
>
> What is a psychopath? He is at one and the same time an abstraction, a generalization, and a specification. He is a member of a larger class of unique individuals, [p. 380]
>
> The state of being a psychopath is neither static nor exclusive, [p. 380]
>
> Not all nonconformists are psychopaths, whether they are single social offenders or admired geniuses, but it is undoubtedly true that all psychopaths are nonconformists, [p. 382]

The concept of sexual psychopath (sexually dangerous person, sexual offender) is even more vague and probably invalid from a scientific viewpoint. The terms embodied in law usually follow some outrageous sex crime. In the past three decades, thirty states and the District of Columbia have enacted special legislation for commitment of sex offenders who, although not insane, are defined as mentally abnormal. A careful study (Craig, 1967) of this category of offender indicates that they are often not dangerous, are minor deviates, are less recidivistic, and (contrary to popular belief) do not progress from minor sexual offenses to more serious offenses.

The “defective delinquent”—a term coined by Fernald in 1909 to describe the feebleminded offender—has broadened in use in Maryland and elsewhere to include a wide variety of deviants. The older definitions always included mental retardation and a substantial amount of moral content. Branham, in 1926, reported four well-defined groups of defective delinquents

on the basis of prognosis: (1) community conscious types (social); (2) community indifferent types (asocial); community antagonistic types (antisocial); and (4) community irresponsible types (which include drug and alcohol abusers [Branham, 1926, pp. 201-203]). In spite of Branham's work, subsequent studies emphasized the almost impossible task of arriving at meaningful definitions. Lurie and his associates (1944) were almost alone in arguing that the defective delinquent was a distinct clinical entity. Even their data did not support their contention. Now most statutory definitions of defective delinquent are only related to the issue of legal control of offenders.

There has also been an increasing trend toward the civil commitment of persons designated as alcoholics and drug abusers. In spite of the Robinson decision (1962) of the Supreme Court, that it was a violation of the Eighth Amendment to imprison a person for his status as a narcotics addict, a number of jurisdictions permit civil commitment.[2] Contrarily, in Powell versus Texas (1968), it was held that an alcoholic could be prosecuted if drunk in public. It is most often recommended that alcoholism not be considered a criminal offense and that detoxification procedures be developed that may become part of comprehensive programs of treatment. Hutt (1967) recently pointed out, in the *Task Force Report on Drunkenness,* that compulsory treatment following commitment for alcoholism would be medically unethical. There is no more a constitutional basis for depriving a chronic alcoholic of his freedom to choose or reject medical treatment than

there is for depriving any other ill person suffering from a noncontagious disease of his freedom of choice. Whether or not a medical model of intervention is useful—and the evidence is inconclusive—most data support the finding that forcing an alcoholic or drug abuser to submit to treatment is useless.

A 1967 review (Cuomo) of status crimes (narcotics and alcohol addiction, vagrancy, and sexual psychopathy) seemed to indicate an abandonment of the *mens rea* (criminal intent) concept in defining crime. The categories were so broad and vague as to make questionable the notion that treatment alone justifies commitment. Civil commitments based on uncritical and often untested criteria of dangerousness become quasi-criminal, showing a serious disregard for the due process rights of the individuals involved. Special statutes relating to these categories generally fail, in that they neither protect society nor provide for the selection of persons on the basis of dangerousness. Rather, they encourage indeterminate commitment, often without sentencing or regard for due process. A better solution would be to select persons only *after conviction,* on the basis of dangerousness. These persons would then be sentenced to terms adequate for the protection of society, and they would also have the opportunity to be treated (National Institute for Mental Health, 1971).

The Right to Treatment

Law is interpreted, modified, expanded, and changed through statutes. As a rule, broad legal change is effected through legislation. Mental health laws are the result of such legislation. Judicial decisions also affect laws in a limited and remedial way, by determining the rights and obligations of particular persons or parties. While historically there have been decisions relating to the wrongful detention of patients in mental hospitals, the treatment of the mentally disabled has only more recently become a matter of judicial concern. It is now possible for the mentally disabled to use the judicial system as both a forum of expression for legitimate grievances and an effective and responsible vehicle for social change. The class action suit has emerged as a mechanism for accelerating these changes (McGarry, 1973).

A major new legal thesis is that adequate treatment for the institutionalized mentally ill and mentally retarded is a constitutional right (Yale Law Journal, 1967). The legal doctrines that: (1) persons in custody for mental illness have a right to treatment; (2) they may not be held without treatment; and (3) treatment can be legally defined, have been elaborated in several courts (principally the Second Federal Appeals Court and the Alabama Federal District Court).

The first major judicial concern over the treatment and rights of hospitalized patients began with the cases of Catherine Lake (1964 and 1966) and Charles Rouse (1966). Both were considered by the Second Federal Court

of Appeals, with the opinions stated by Judge David Bazelon. Catherine Lake was committed to St. Elizabeth's Hospital in 1962, suffering from a chronic brain syndrome due to arteriosclerosis, with a psychotic reaction. She appealed a District Court denial of relief in habeas corpus. Psychiatrists said that Mrs. Lake was prone to "wandering away" and demonstrated "difficulty with her memory." Mrs. Lake, on the other hand, testified that she felt able to be at liberty to a certain degree. The District Court, in denying the appeal for relief in habeas corpus, noted the appellant's right to "make further application in the event that the patient is in a position to show that there would be some facilities available for her provision" (Lake v. Cameron, 1964) Mrs. Lake contended, in the appeal, that a *suitable alternative* to "total confinement" in a mental hospital was warranted. She was agreeable to some form of restraint, either at home or in another institution or hospital. At the habeas corpus hearing, a psychiatrist testified that Mrs. Lake did not need "constant medical supervision" but only "attention" and that there would be no objection if she were in a "nursing home or place where there would be supervision." The Appeals Court ruled that it did not appear "that the appellant's illness required complete deprivation of liberty that results from commitment to St. Elizabeth's as a person of 'unsound mind.' " The case was remanded to the lower court for an inquiry into an "alternative course of treatment."

Judge Bazelon's opinion (Lake v. Cameron, 1966), in summary, was:

1. When the question arises as to whether fulltime confinement is appropriate, the lower court must explore alternatives and request assistance from public agencies. It should not rely upon the patient to bring this information to its attention. . . . this is related also to the obligation of the state to bear the burden of exploration of possible alternatives as an indigent cannot bear.

2. The court should attempt to find a course of treatment that would be acceptable to the individual. Among the alternatives available are public health nursing care, foster care, private care subsidized by welfare payments, community mental health day care, or even the simple requirement that the patient carry an identification card.

3. It was not an issue whether the constitution would prohibit a complete deprivation of a patient's liberty in the event that there were no treatment alternatives available.

In the other cited case, Charles Rouse was committed to St. Elizabeth's Hospital, Washington, D.C., as criminally insane. He sought release on the grounds that he was not receiving treatment. The District Court denied relief in habeas corpus on the grounds that it did not have a right to consider whether or not Rouse was getting enough treatment. The Appeals Court decision reversed the lower court and remanded the case for further proceedings.

Judge Bazelon's opinion (Rouse v. Cameron, 1966) can be summarized

as follows:

1. Hospitalization, after a finding of insanity, is treatment, not punishment.

2. Custody without treatment is similar to punishment.

3. Shortage of staff and facilities furnish no excuse for inadequate treatment.

4. When a patient claims his treatment program is inadequate, the courts have a responsibility to bring together pertinent evidence to determine what kinds of treatment would be adequate, and whether the treatment program supplied meets these standards. If the patient is indigent, it is up to the courts and the government to supply experts who can aid in the decision as to whether or not the treatment is adequate.

5. The permissible range of treatment alternatives in a given case depends upon the particular needs of the patient; i.e., adequate treatment for one might not be sufficient treatment for another.

6. If the lower court determines that a patient is not receiving adequate treatment, it should give the hospital a reasonable opportunity to develop a program.

7. The extent of the hospital's opportunity will depend upon such factors as the length of time adequate treatment has been withheld, the length of the custody, and the nature of the patient's mental illness.

8. In some cases, an order of conditional or unconditional release may be

the appropriate remedy.

The American Orthopsychiatric Association entered the case of Rouse versus Cameron as *amicus curiae* (friend of the court [1966]). The brief stated that the most promising method of upgrading the inadequate treatment afforded to persons involuntarily committed to mental institutions for the criminally insane was to recognize that such persons had a judicially enforceable right to adequate treatment. It was agreed that the criminally insane generally failed to receive adequate treatment and that substantial reform would not occur until a right to adequate treatment was recognized in that area. The political constituency of the mentally ill was nonexistent. Only a judicial recognition of their constitutional rights would afford them the hope that their ultimate reentry into society may be effected. The brief contended further that a right to treatment was guaranteed by the Constitution and that the recognition of such a right would not create undue problems of judicial administration. Since the deprivation of liberty without treatment is identical to criminal punishment, such an incarceration of a mentally ill person must constitute the infliction of cruel and unusual punishment upon him. In addition, unless treatment were guaranteed to those persons detained by the government as a result of their mental or physical status, their detention would violate the due process clause of the Constitution, in that they were denied access to the sole means of attaining their liberty.

Therefore, the brief concluded, in determining whether treatment is adequate, a court would be called upon to answer five questions, all capable of objective analysis:

1. Does the treatment involved fall within an accepted school of medical thought?

2. Does the mode of treatment comport generally with the accepted procedures of the school of thought to which it belongs?

3. Do the procedures adhered to in administering the treatment in question reasonably insure an ordered and rational program of care?

4. Are adequate records kept concerning the care afforded the patient?

5. Are the physical facilities of the institution adequate to provide the treatment?

In 1971 a class action suit was filed in the Alabama Federal Court by the guardians of civilly committed patients at, and by certain employees of, the Bryce State Mental Hospital, against the Commissioner of Mental Health, members of the Alabama Mental Health Board, and others. These defendants were charged with providing inadequate treatment to the approximately 5000 patients who resided there. Later this action was amended to include Searcy Mental Hospital and the Partlow School for the Mentally Retarded. The court based its decision (Wyatt v. Stickney, 1971) on a constitutional

guarantee of a right to treatment: “To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and fail to provide adequate treatment violates the very fundamentals of due process,” and ordered the State Department of Mental Health to provide an effective treatment program within six months. Dissatisfied with the state plan for the improvement of facilities required by the court in its first order, and utilizing contributions and suggestions of a panel of national mental health experts, the court issued an order (Wyatt v. Stickney, 1972) in April 1972 that detailed the criteria for adequate treatment: (1) a humane psychological and physical environment; (2) qualified staff with sufficient numbers to administer adequate treatment; and (3) individualized treatment plans. Most recently a federal district court in Florida assessed damages against two psychiatrists for holding a non-dangerous patient fourteen years without treatment. A federal appeals court affirmed this on the principle that when a non-dangerous patient is involuntarily hospitalized, the only constitutionally permissible purpose is to provide treatment, and that the patient has a constitutional right to such treatment.[3] This was further affirmed in another decision by the same appeals court.[4]

All of the above cases involve patients involuntarily hospitalized. The increasing utilization of voluntary hospitalization substantially reduces the numbers of those involuntarily incarcerated. However, there is no

justification for compromising quality of care and treatment because of the legal status of the recipient. Minimum standards for adequate treatment should apply equally to voluntary and involuntary patients.

Questions persist about the efficacy, as well as the wisdom, of the courts persisting in their effort to define and enforce adequate treatment standards. Psychiatrists, too (Robitscher, 1972), often are at odds about defining treatment standards, and they frequently feel that those outside the field of mental health are more in the dark than they are. In addition, the courts themselves are not unanimous in this extension of their power. In the same federal circuit as Alabama, a district court (Burnham v. Dept. Pub. Health, 1972) held that determinations of the quality of mental health services and the adequacy of treatment rests with the "elected representatives of the people" and not with the courts.

Perhaps the more basic problem is a dual—public and private—treatment system. Resources, while not abundant in the private area, unquestionably exceed those available to the public system. A single system of care is being developed in California, with the hope of closing out the public mental hospitals. This may end further class action suits by patients in that state's mental health system. In 1967-1968, Illinois introduced a state insurance plan for the indigent and medically indigent that guaranteed their treatment in community hospitals and day treatment programs by removing

any financial barriers. This program shows promise of eventually reducing or eradicating the dual treatment system in those areas where quality care for any citizen can be purchased.

Regardless of whether treatment is adequate, questions (Katz, 1969) concerning the usefulness of involuntary commitment continue. Given our present predictive capacities, it has been argued that commitment hearings that require a complete application of the beyond-a-reasonable-doubt standard would eliminate civil commitment, due to the impossibility of meeting that standard. The Lessard case (1972) demonstrates another procedural reform necessary in view of the often contradictory views of a patient's capacities: the incorporation of the Fifth Amendment right, which protects the individual against self-incrimination. About to be committed because he is incompetent to decide whether to accept treatment, he is (once warned of the consequences) considered competent to decide, without the aid of an attorney, which of the psychiatrist's questions it is in his best interest to answer. The last Lessard procedural innovation, as in Lake versus Cameron, was to make hospitalization a last resort. In that context, the question of voluntary hospitalization can be reexamined. Sometimes the coercion applied to have persons voluntarily admit themselves, rather than be legally committed, results in an inadequate examination of the need for hospitalization and an insufficient exploration of the alternatives. Of necessity, these areas receive more thorough consideration in the case of

involuntary hospitalization.

Right to Refusal of Treatment

In the matter of the choice of a type and method of treatment, patients' rights also continue to be reexamined and defined. It has been argued that a patient, even though committed involuntarily for treatment, should retain absolute right over the use of medication, electroconvulsive shock, and similar treatment. At the present time, separate informed consent is required in most states before electroconvulsive therapy can begin, no matter whether a person is voluntarily or involuntarily hospitalized. However, the right of a patient to stop electroconvulsive treatments, after having initially consented to them, has stirred strong debate in at least one case. In that case a woman, voluntarily admitted and diagnosed as involutionally depressed, was informed in detail about the nature of ECT as prescribed. She consented, but after the first treatment she refused to permit a second. The hospital staff felt she could not withdraw her consent on the grounds that "once the patient consented she became the responsibility of the medical staff . . . [and] the permissions papers were legal and gave the staff the right to act in her interest.'' Jonas Robitscher, a lawyer and psychiatrist at Emory University (Georgia), charged that the manner in which the patient was forced to continue ECT "is not only a violation of the patient's legal rights (assault and battery), but also an example of how mental patients ought not to be treated."

Robitscher felt that ECT posed special problems in that it "makes the patient increasingly incompetent and unable to exercise his legal rights" (Psychiatric News, 1972) In another case, one involving New York City's Bellevue Hospital, Justice Gellinoff decided that while the patient who refused electroshock therapy was "sufficiently mentally ill to require further detention," such a finding "does not imply she lacks the mental capacity to knowingly consent or withhold her consent to electroshock therapy" (New York Times, 1972)

When persons have been hospitalized against their will for an examination, their right to refuse treatment—for example, drugs, physical restraints, and isolation—can be contravened if their maintenance (not treatment) requires the application of physical or chemical restraints or the use of isolation. Legal safeguards are then required to see that these procedures are used only minimally. In New York, a woman committed for observation for sixty days was forcibly treated with oral and intramuscular medications in spite of her objections based on religious beliefs. Upon release she brought suit, which resulted in relief for damages. The court (Winters v. Miller, 1971) noted that, in forcing medication on the patient, there was grave doubt that the state was protecting the interests of third party or society.

Psychosurgery, which is experiencing a renaissance (particularly in relation to violent behavior [Mark, 1970]), poses an even more difficult problem. While there have always been proponents (Freeman, 1972) of the

use of lobotomy (a form of psychosurgery) for chronic mental problems from schizophrenia to alcoholism, it had become a discredited treatment for the most part. However, it is now returning to use as a means of curbing violence. It is being recommended for the control of violent behavior in persons considered dangerous, including those mentally ill and hospitalized, and those non-mentally ill or mentally ill and in prison. Disregarding for the moment both the imprecision of determining dangerousness and the absence of treatment for such persons, who are then labeled as intractable or untreatable, it is unlikely that an incarcerated person (whether an involuntarily hospitalized patient, indeterminately sentenced offender, or long-term prisoner), can give his informed consent to psychosurgery. This is particularly true when the patient is held involuntarily and is led to believe that consenting to be the subject of such a surgical procedure will result in his early or immediate release (Rawls, 1971).

Legal Competence

At the present time, in almost all legal jurisdictions, persons involuntarily hospitalized (legally committed) retain their rights, particularly those relating to their person, property, and civil liberties (Chayet, 1968). Explicit statutory recognition of the civil and personal rights of the mentally ill and mentally retarded constitutes a significant and needed reform. It also indicates the kind of discrimination and illegal restrictions that have been

placed on the mentally disabled in the past. In recent legislation, various rights have been explicitly enumerated (Chayet, 1968; McGarry, 1973), such as:

1. The right to communicate with persons outside the facility by telephone, correspondence, and visits.
2. The right to keep clothing and personal effects.
3. The right to religious freedom.
4. The right to vote.
5. The right to be employed, if possible.
6. The right to execute instruments, such as wills.
7. The right to enter contractual relationships.
8. The right to make purchases.
9. The right to education.
10. The right to habeas corpus.
11. The right to independent psychiatric examinations.
12. The right to civil service status.
13. The right to retain licenses, privileges, or permits established by law.

14. The right to marry.

15. The right to sue and be sued.

16. The right not to be subjected to unnecessary mechanical restraint.

Mental illness does not necessarily impute any incompetency in exercising one or more of these rights. To be found incompetent requires a special and separate judicial determination. A number of statutes clearly differentiate between mental illness and mental incompetency, and some states (Illinois and New York) make reference to that distinction in their catalog of patients' rights.

The right to legal representation has been incorporated into a number of new mental health statutes to protect the rights of patients in commitment hearings. Legal representation ensures that they will no longer be subjected to any legal, economic, or social difficulties as a consequence of their illness. It also allows patients to affirmatively and actively maintain control of their own lives. Mechanisms for review, appraisal, and explanation of patients' rights have been established in several states. The Mental Health Information Service(Rosenzweig, 1971), a court-affiliated service established in New York in 1965, has been a pioneer in attempting to safeguard patients' rights and enforce legal procedures for hospitalization and release. In Minnesota, review boards (1972) examine admission and retention of mental patients in

hospitals. California has instituted the use of a nonprofit legal services group (Thorn v. Sup. Ct. San Diego County, 1970) to apprise involuntarily hospitalized patients of their legal rights. In Illinois, a pilot project (Cook County Legal Assistance Foundation, 1972) of legal services (concerning a variety of civil matters) for hospitalized patients, has demonstrated a largely unserved legal need of all the hospitalized mentally ill.

At times the question of legal competence is raised concerning a person whose judgment about himself or his property seems faulty. It has been raised in regard to the execution of instruments (wills), the dissipation of property and money, and the inability or unwillingness of a person to allow lifesaving medical or surgical procedures. Such people may be found in the community, or as patients on medical or surgical services, as well as in mental hospitals.

Since the finding of legal incompetence is an adjudicatory process, data can be collected from a number of sources, including family, friends, business associates, lawyers, physicians, and psychiatrists. It is a mistaken notion that only—or even preeminently—the psychiatrist can give testimony that will decide legal competence or incompetence. Should power over his person or properties be taken from an individual, either temporarily (as for surgery) or permanently (as in the case of the estate of an elderly, senile person), that power is usually vested in another family member, a lawyer, or the court,

rather than in the physician. It is this other person who then gives permission for a particular procedure or manages as a conservator. Unfortunately, the law in the matter of legal incompetency is an all-or-none affair. Either you are legally competent or legally incompetent. From our knowledge of mental functions, we know that some functions remain more intact than others and that a person's capacities may diminish or increase from time to time under differing conditions. Nevertheless, once an adjudication of incompetency has occurred, all rights are vested in another. Therefore such proceedings should be entered into with care, since for a person with some intact mental functions, the psychological consequences of being declared legally incompetent may be to accelerate the process of psychological debilitation. This is certainly an area in which lawyer and psychiatrist should confer before proceeding with incompetency hearings, in order to protect a person's psychological and physical integrity.

Psychiatry and Criminal Law

Psychiatrists have collaborated with the criminal law system in two ways: as expert witnesses in various trial phases; and as therapists, primarily within conventional penal institutions. To date, this collaboration has not been particularly productive or happy. Typically, psychiatrists have become involved at the request of members of the legal profession, yet the tasks to be performed have often been delineated by the legal system without effective or

even adequate consultation with psychiatrists (Suarez, 1972).

Part of the problem has been a difficulty in communication characterized by different terminology, different purposes, and different frames of reference (that is, sociocultural versus motivational). To that has been added an almost caricatured view of the concepts of psychosis versus insanity, legal responsibility versus psychic determinism (Lewy, 1961), and the legal model (innocent until proven guilty) versus the medical model (suspicion of illness until proven innocent [Shah, 1969]). Nevertheless there has now developed a more meaningful and thoughtful dialog between criminal law and psychiatry. This in turn has resulted in an appreciation of the fact that the issue of "criminal responsibility," although it raises many interesting and complex moral and philosophical questions relating law and psychiatry, has not deserved the overwhelming preponderance of attention it has received.

The criminal law system, like any other legal system, is composed of a framework of legislation that represents a culture's or society's values and sentiments concerning abhorrent behavior, and the hierarchy of penalties assigned on the basis of the degree to which such behavior is abhorred. Within the framework of the laws, the police enforce the law, the courts attempt to determine culpability and punishment, and the correctional system provides confinement and community probation and parole. This

system is complex, and the areas of possible interreaction between psychiatry and the laws are many (President's Commission on Law Enforcement, 1967). Nonetheless psychiatry—perhaps at the insistence of lawyers and jurists—has attended to issues more philosophical than psychiatric, resulting in inattention to pressingly difficult but perhaps more valuable areas.

One such area is *crisis intervention* in the community, which may be accomplished through a variety of agencies, including the police. Such agencies use power as a crime-preventive measure, getting closest to the point of difficulty and remaining there for the shortest possible period of time. Another area of interaction involves working with legislative groups to modify existing laws and promulgate new ones regarding extended sentencing for mentally disturbed individuals found guilty of violent crimes. Psychiatrists may also examine defendants for pretrial and presentencing data collection and diagnosis, in order to offer the court help in deciding what course of action or setting would be most helpful before trial or after conviction. They could also do research in the prediction of dangerousness and its relationship to treatment programs for such persons, both within the correctional setting and in the open community.

The Police

There are about 16,000 police in Chicago—to take a sample big city—of

which 9,000 to 10,000 are patrolmen. The policeman's everyday life requires that he make many decisions quickly under crisis circumstances, decisions that are later subjected to detailed review by many different people. There is an unfortunate conflict between his understanding of his role and his understanding of the usual observer's interpretation of his role. On the one hand he is expected to be bright, strong, and brave. On the other hand he is expected to be cowardly, on the take, bumbling, and oppressive to members of minority groups.

The official job description for policemen in Chicago lists twenty items of expected excellence. Among them are the ability to tolerate long periods of boredom and monotony while maintaining a readiness for quick, competent responses; the capacity to learn the behavior of the people and social institutions within a territory; the ability to exercise mature judgment and discretion, making no error in police procedure that might subject the man or his police department to criticism; familiarity with the many procedures and reports of the police department; and the exhibition of a high level of personal integrity. Much of the policeman's time is spent filling out reports of his work and justifying his activities, following highly detailed police procedures. Indeed, training sessions reflect a heavy emphasis on reporting properly and managing events according to correct procedure. The policeman's social role is ambiguous and his psychological environment is complex and subject to scrutiny, and at the same time he is asked to behave in a procedurally correct

and detailed manner. In spite of all this, he is allowed and encouraged to use a large amount of discretionary judgment.

The police are important social agents to the poor in poverty areas of the city. They are available twenty-four hours a day, seven days a week; they have no waiting list; and they are called about everything from broken elevators to stopped-up toilets. In certain districts, 80 percent of police calls are for miscellaneous services not associated with disturbances or commissions of crime.

The Chicago police make 6000 arrests per year in which the arresting policeman believes that the person is, or may be, mentally ill. A misdemeanor charge is used as a device to get the person to treatment. Thus, for these 6000 cases—mostly poor people—their life crises become associated with an arrest leading to a separation from family and local social network, a separation from job and income resulting in the family's loss of support, and a loss of self-esteem. A different management of these crises might result in more effective intervention and diversion (Lemert, 1971) from the legal-justice to a health-care system. The police could benefit from a more open dialog about their beliefs, values, and roles, which would aid in their understanding of human behavior and the paradoxes between their own self-image and their day-to-day functions (Bittner, 1970).

Because of their enormous discretionary power in the area of crisis intervention, the police can act as agents who prevent crime and expedite treatment for persons showing early evidence of mental disturbance. In New York City's 30th Precinct, a project using a police team as specialists in family crisis intervention has innovatively demonstrated possibilities of crime prevention and early mental health intervention. (One of the most difficult police functions is that of intervention in family crises. It has been shown that police calls for family disturbances lead to 20 percent of police deaths and account for 40 percent of time lost due to disabilities resulting from injuries.) In conjunction with the police department, the City College of New York trained a selected group of police, known as the Family Crisis Intervention Unit (FCIU [Bard, 1970]) in interpersonal skills to attempt to effect constructive solutions for family situations requiring police intervention. In a two-year experimental period involving 1400 interventions with 950 families in a police patrol area of 85,000 population, no injuries were sustained by members of the FCIU, and their basic professional identity as police remained intact. More crisis calls were processed in the demonstration precinct, as compared with a control precinct; more repeat interventions occurred; and fewer assaults occurred in families and against police. Mental health problems of a wide range frequently manifest themselves in domestic disturbances, and police with knowledge of this can provide helpful insights and make appropriate referrals, without compromising their peace-keeping

mission.

Legislation

Psychiatry generally has had little to do with the legislative process. Nevertheless, as a result of an interest in community mental health and a continuation of the quest for social justice that reemerged after World War II, increasing numbers of modern psychiatrists have played significant roles in the development of legislation concerning mental health codes. These codes concern themselves with: (1) the rights of persons held both voluntarily and involuntarily for mental treatment; (2) laws relating to privilege and confidentiality; and (3) laws relating to determinations of dangerousness and indeterminate sentencing for treatment. Most recently, in Illinois, psychiatric data was used in the preparation of a Unified Code of Corrections, particularly in the areas of sentencing and community supervision.

The Trial

Pretrial Reports

After a person has been charged with a crime, facts can be gathered regarding his motivation, extenuating circumstances, past and present social history, and medical and mental health information, and allowance can be made for special testing. This information and data from other sources can be

used by the court to determine: (1) whether there is sufficient cause to proceed with a trial; or (2) whether the case may be diverted from the legal-justice system to a health-care and/or social welfare system.

Competency to Stand Trial

The psychiatrist has become increasingly involved in the area of whether a trial should or should not take place in the context of competency to stand trial. The concept of competency to stand trial originally was developed to help the defendant. It was felt to be unjust and even cruel to try a person who was so disturbed that he really did not know what was happening, or who could not cooperate meaningfully with his defense counsel. It was hoped that, with time and treatment, the accused individual would be able to make the *best* defense possible—something that could not be accomplished while he was acutely and distressingly mentally ill. In fact what occurred was that, although not convicted of crimes or civilly committed, many incompetent criminal defendants had been, in effect, serving life sentences in mental hospitals. Among psychiatrists a bias exists against returning the mentally ill for trial, arising in part from the fact that the system of criminal justice is seen as punitive and antitherapeutic. In practical terms, this has led to considerable wasting of human life and unnecessary deprivation of freedom. A study (McGarry, 1971) in Massachusetts found that, of all incompetent defendants committed to Bridgewater, more left by death

than all other avenues combined.

The doctrine of mental incompetency has its roots deep in common law (United States v. Chisholm, 1906; Hale, 1778). It means that the defendant, because of the existence of mental disease or defect or other reasons, does not understand the nature and object of the proceedings pending against him; or cannot appreciate or comprehend his own condition in relation to the proceedings; or is unable, for some other reason, to competently assist his attorney in his own defense. If the defendant is found to be incompetent, all criminal proceedings are suspended, and the state is denied the power to proceed against him. Prosecuting an incompetent has been held (Pate v. Robinson, 1966) to be a denial of his right to due process of law. Even if the mental defect is not discovered until after the defendant has been convicted and his time for appeal has expired, the issue of incompetency can be raised collaterally; if it is proven, the entire proceedings may be voided and set aside. Thus, one may also be found incompetent to serve his sentence or be executed. This principle is so fundamental that incompetency may not be waived even with the consent of the court. Consequently, incompetency proceedings are sometimes initiated by the prosecution or the trial judge. This can result in a major abuse of the incompetency procedure, for in most states, commitment of a defendant adjudicated as incompetent to stand trial is mandatory (Harvard Law Review, 1966). The prosecutor or the court may use incompetency proceedings as an expedient substitute for criminal

prosecution and as a final disposition of the case.

There has been an absence of detail in statutory law regarding competency, and although psychiatrists are frequently delegated the responsibility for decision-making regarding competency, they demonstrate confusion and a lack of understanding of the issue. (It has been suggested[Slovenko, 1964] that lawyers might be better suited than psychiatrists to make such determination.) The psychiatrist should know the common-law criteria stated above. Psychiatric reports to the court commonly confuse issues of illness and competency, competency and commitability, and competency and dangerousness. The evidence seems to indicate that both psychiatrists and lawyers are weak in their knowledge of the law and in the application of psychological data to findings of competency (Rosenberg, 1972). In Illinois in the 1970s, the term “incompetence” has been replaced by the term “unfitness.” [Sect. 1005-2-1; also including commentary, pp. 92-93] (Illinois Unified Code of Corrections, 1972) It was felt that “fitness” speaks only to the person’s ability to function within the context of the trial, whereas the term “competence” is often used in establishing whether an individual should be committed to an institution as mentally ill and excludes considerations of physical fitness.

Two issues require further elaboration. The first, amnesia, presents the court with a special problem: the defendant who claims amnesia concerning

the events of an alleged crime is at least theoretically unable to assist his counsel in the preparation of his defense. Nevertheless, case law indicates (Yale Law Journal, 1967) that defendants suffering solely from amnesia, who are otherwise competent to stand trial, are adjudicated competent insofar as they can assist counsel in a number of other ways. It has been suggested (Koson, 1973), however, that temporary amnesia should be distinguished from permanent amnesia, and that the temporary variety is distinguishable by knowledgeable psychiatrists and may warrant a finding of incompetency.

The second issue is that of the medicated mental patient, and whether a person in such a "drugged" state is, in fact, competent to stand trial or return to trial. In a number of jurisdictions, medicated patients with a prior incompetency finding have not been allowed to return for trial. A Louisiana trial judge noted that such a defendant was "only synthetically sane." In Illinois the same was the case, and patients returning for hearings of competency prior to trial had to have medication terminated at least seventy-two hours prior to court examination. The arguments for allowing defendants to stand trial while receiving medication are:

1. Psychotropic drugs make a mentally ill person more, not less, normal.

2. Other jurisdictions have allowed defendants to stand trial when found competent with medication.

3. Failure to allow them to stand trial violates the equal protection clause

of the Fourteenth Amendment, in that, other than mentally ill defendants, persons requiring medication for chronic illnesses are allowed to stand trial.

4.The denial of a trial permits indefinite commitment.

The Supreme Court has concerned itself with this issue of indefinite commitment following a determination of incompetency. In 1968 Theon Jackson was arrested for two purse snatchings involving a total of $9.00. He was a deaf mute with almost no capacity to communicate, and he was found incompetent to stand trial on the basis of a moderately severe mental deficiency. In reversing the State Supreme Court's affirmation of a denial of a new trial, the court stated, with reference to the due process issue (Jackson v. Indiana, 1972, p. 738, note 13):

> We hold, consequently, that a person charged by a state with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal.

In 1973, in an extension of the Jackson decision, the Supreme Court affirmed a decision (Psychiatric News, 1973) by a three-judge appeals court in New York that a criminal defendant, judged incompetent to stand trial

because of mental illness, could not be committed to a New York State mental hospital operated by the Department of Corrections unless a jury also determined him to be dangerous. Burt and Morris, in a 1973 proposal for the abolition of the incompetency plea, argued that in the wake of the Jackson decision we will be tempted to resort to civil commitment proceedings rather than dismiss charges against and permanently release incompetent defendants. This, they say, may serve to continue or increase the damage of the results of incompetency proceedings in the past. Rather, they argue, incompetency should be grounds for obtaining a trial continuance, during which time the state must provide resources to assist the defendant toward greater trial competence. If trial competence is not achieved within six months, the state should be required to dismiss charges or to proceed to a trial governed, where necessary, by procedures designed to compensate for the incompetent defendant's trial disabilities. The risk to society posed by such rapid disposition of these offenders, whether by trial or release, seems to be no greater (and possibly even less great) than that posed by other groups of offenders.

The Defense of Insanity

It has been felt that the insanity defense serves an important symbolic role in our legal system. It long preceded the development of psychiatry; the first recorded insanity acquittal in English law occurred about 1000 years

ago. However, it was not until after the famous M'Naghten Rule was enacted by the House of Lords that this defense came to be so closely tied to psychiatry.

In the seventeenth century, among the papers of Sir Matthew Hale, Chief Justice of the Court of King's Bench, was the following: "Human beings are naturally endowed with these two great faculties, understanding and liberty of will. . . . The consent of the will is that which renders human actions commendable or culpable. . . . And because the liberty or choice of the will presupposeth an act of understanding to know the thing or action chosen by the will, it follows that where there is a total defect of the understanding there is no free act of the will . . ." (Hale, 1778, pp. 14—16). Hale was explicitly aware of the difficulty of devising rules for the practical application of his test, in that the problem was not only *what* to excuse, but *how much.* Meanwhile, judges had begun to charge juries that a defendant was not to be held responsible for his actions unless he possessed the capacity to distinguish good from evil (Rex v. Arnold, 1724). In May 1800, James Hatfield fired a shot at George III, believing he was commanded by God to sacrifice himself for the world's salvation. His counsel argued that in spite of his not having a raving madness, his delusion was a true characteristic of madness. The trial was stopped and the jury urged to return a verdict of not guilty by reason of insanity. Hatfield's case (Rex v. Hatfield, 1800) settled only what to do with Hatfield, until January 20, 1843, when Daniel M'Naghten shot Daniel

Drummond, Secretary to Prime Minister Robert Peel. The testimony and arguments (1843) eventuated in the M'Naghten Rule.

Notwithstanding public satisfaction, the M'Naghten test was criticized almost from its inception as nothing more than a restatement of the "right and wrong" test. As early as 1838, Isaac Ray, in his *Medical Jurisprudence of Insanity,* called the right and wrong test "fallacious," because "the insane mind is not entirely deprived of [the] power of moral discernment, but in many subjects is perfectly rational, and displays the exercise of a sound and well balanced mind" (Ray, 1871). Ray attempted to formulate his own rule for a defense of insanity. He was pleased with the results of a New Hampshire State Supreme Court decision in which Chief Justice Perley instructed the jury (State v. Pike, 1869):

That, if the killing was the offspring or product of mental disease in the defendant, the verdict should be 'not guilty by reason of insanity;' That neither delusion nor knowledge of right and wrong, nor design or cunning in planning and executing the killing, and escaping or avoiding detection, nor ability to recognize acquaintances, or to labor, or transact business, or manage affairs is, as a matter of law, a test of disease; but that all symptoms and all tests of mental disease are purely matters of fact to be determined by the jury.

This resulted in a rule[5] in New Hampshire in which acquittal by reason of insanity would follow if the felonious act were the "offspring" of a mental disease.

Although most American jurisdictions approved M'Naghten, an increasing number of states began to supplement the M'Naghten language as time went by with: "If he had a mental disease that kept him from controlling his conduct." This rule, often called the "irresistible impulse test," quieted psychiatric criticism, but only temporarily. The earliest decision (United States v. Davis, 1895) of the Supreme Court of the United States on the subject of the criminal responsibility of persons allegedly insane was made in 1895. This decision departed substantially from the M'Naghten Rule, holding that if all the evidence does not exclude beyond a reasonable doubt the hypothesis of insanity, the accused was entitled to acquittal.

In an attempt to deal with psychiatric criticism by allowing a less restrained use of psychiatric testimony, the Second Federal Appeals Court held, in the case of Durham versus United States in 1954, that "an accused is not criminally responsible if his unlawful act was the *product* of mental disease or mental defect" (Durham v. United States, 1954)This broadened the concept of the defense of insanity to a point where it appeared meaningless. Except for the District of Columbia, Maine, and the Virgin Islands, there were no jurisdictions that accepted the Durham test. The American Law Institute,

in its Model Penal Code of 1962 (American Law Institute, 1962), stated that "a person is not responsible for criminal conduct if at the time of such conduct, as a result of disease or defect, he lacked substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law." This modification of the M'Naghten rule has been accepted in most jurisdictions, including most federal ones. The Second Federal Appeals Court in the United States versus Brawner case decided in 1972, repudiated its own Durham stance. The American Psychiatric Association (APA), filing an *amicus curiae* brief in the case, favored the American Law Institute test of criminal responsibility because it allowed psychiatric testimony to elucidate more fully and clearly the history, development, adaptation, and function of the patients' behavioral processes and the results of all other medical tests, in order to evaluate the clinical symptoms of the disease in relation to the alleged criminal acts. Further, the APA argued (Psychiatric News, 1972) that it did not recommend that the testing of criminal responsibility distinguish between psychological, emotional, social, and cultural sources of impairment.[6] Lastly, the APA favored (with appropriate safeguards) the ultimate abolition of the insanity defense.

Arguments for Abolishing the Insanity Defense

The defense of insanity, notwithstanding arguments for its abolition or

enlargement, has always centered on what the appropriate definition can be of legal insanity. Essentially it has excluded from punishment those who, by definition, could not be deterred by punishment or those who, because of mental illness, were unable to distinguish between right and wrong. The feeling was that it would be unjust as well as futile to punish them.

Beginning with the M'Naghten case and continuing with Durham and then the American Penal Code, each attempt at a definition has been subjected to vigorous and continuing criticism. Some have seen the defense of insanity as providing a loophole in the law, while others have felt it should be broadened to include as exculpatory a variety of social and cultural factors. The M'Naghten test held that there was a criminal insanity when a person was laboring under such *defect of reason*, from disease of the mind, as not to know the nature and quality of the act he was doing—or if he did know it, he did not know he was doing wrong. The concept of "defect of reason" is difficult to define in psychiatry as well as in law. In fact, attempts by psychiatry to define defect of reason have simply confused the issue. The concept of responsibility cannot be translated into psychiatric terms, and these same psychiatric terms are very often used to attack people who are deviant rather than to explain their responsibility, or lack of it, in relation to some particular behavioral act. Psychiatry has not even yet comfortably defined mental illness.

For these reasons, there has been a strong case made for the exclusion of the defense of insanity. An argument has also been made for the use of psychological insights in pre-trial and pre-sentencing information to the court. A number of authors such as Barbara Wooton, Norval Morris, Chief Justice Weintraub of New Jersey, Seymour Halleck, H. L. A. Hart and Thomas Szasz all argue for the abolition of the defense of insanity. (The positions for abolition are summarized by Morris [1968].) A few authors, most notably Kadish (1968) and Fingerette (1909), insist that innocence and mental illness continue to have a very close relationship.

The arguments for abolition are persuasive. First, the defense of insanity has often led to indeterminate incarceration in a mental hospital, which makes the notion of exculpation seem hollow. Second, rather than serving to reduce stigmatization, the defense of insanity doubles it, as the person is seen as both “mad” and “bad.” Third, it is a rare defense since the absence of the death penalty, used more as a sop to conscience than because of the presence or absence of psychopathology in the accused. And last, why should psychological factors be more exculpatory than sociological ones that have been shown to be much more likely to lead to crime? What should be relevant is the accused’s mental condition at the time of the act. Did he or did he not have the prohibited *mens rea* of the crime with which he is charged? The answer to this question would be relevant to his sentence, and to his correctional treatment in the event of conviction.

Rather, what seems to have happened is that the psychiatrist's role has become prominent because he has been seduced into being an expert in the insanity defense. It has become a public ritual in which he is used to help deal with society's guilt about punishment. This may explain the development of certain folklore about the psychiatrist's capacity to know the psychic states and their causal relationships at the time of a criminal act. The limitations of psychiatry and the misuse of psychiatric testimony, of course, do not invalidate areas in which that testimony can be helpful. Nevertheless, it seems likely that the limitations of psychiatry will persist in the area of determining responsibility, and that most evidence seems to support the impossibility of a psychiatrist's determining whether or not an individual was responsible at the moment of a particular criminal act (Weintraub, 1963). The commonsense view that has persisted over 2000 years—that the mad are unreasonable and therefore innocent of intent to do harm—ignores other data that have accumulated in that same period of time and have modified some of the same folk views of madness and the degree of exculpation they afford. Therefore, it seems more sensible to make available to the court all relevant social, psychological, and biological data. The court could then use that information in the determination of accountability for the crime and the determination of the best and most effective sentence if the accused is found guilty. Even if the concept of criminal insanity were understandable, it would not necessarily ensure an accurate or even adequate separation of groups of

persons whose lack of reason makes their innocence clear and certain.

Paraphrasing one commentator (Becker, 1973), if fault cannot be eliminated from the criminal process, then the defense of insanity can be considered but one aspect of the general problem of fault. It is one of a number of devices that allow the accused to show either that he did not know the true state of affairs or that he did not intend the consequences of his actions. The defense of insanity forces the institutions of criminal law to examine the validity of assumptions about responsibility and blameworthiness.

Treatment of the Offender

Criminality and the criminal mind have always intrigued the psychiatrist. The criminal often bears a resemblance to those called mentally ill, and incarceration (that is, punishment) causes distress and suffering similar to that experienced by the institutionalized mentally ill. Psychological mechanisms have been sought that could explain and, by intervention, attenuate criminal behavior. A humane desire to help improve conditions for the incarcerated criminal has drawn the psychiatrist to his treatment.

The nineteenth century was characterized by attempts to isolate biological determinants of crime and separate the ordinary offender from the insane criminal. Hospitals for the criminally insane were constructed in

Illinois (Chester), Massachusetts (Bridgewater), Michigan (Ionia), and New York (Auburn, later moved to Matteawan). Isaac Ray considered (1871) problems of mental illness and motivation as they related to law. In 1909, William Healy began a court clinic for juvenile offenders in Chicago. His experiences led to the development of new theories and techniques—principally the use of the case study method (Healy, 1915; Healy, 1926) for the individual delinquent, which had a profound impact on the field. Bernard Glueck (1918) examined a large population of prisoners at Sing Sing in New York and reported that 58 percent demonstrated some form of nervous or mental disease.

By the second decade of the twentieth century, the monistic theories of crime and criminality began to change, leading to the employment of a variety of organic and environmental theories. This interest persisted and increased, characterized by the work of William Allison White (1923), Benjamin Karpman (1929) and Winfred Overholser (1928). Particular interest in the psychopathic personality—as being useful in explaining and understanding criminal behavior—grew with the many comprehensive studies of this special group of offenders. In 1921 the Briggs law passed in Massachusetts required psychiatric examination of offenders charged with capital offenses and those charged with felonies who had previously been convicted of felonies. In 1927, Karl Menninger recommended the following to the American Bar Association (Halleck, 1965):

1.That a psychiatrist be available to every court.

2.That psychiatric reports be made available before sentencing any felon.

3.That there be psychiatric services in every correctional institution.

4.That a psychiatric report be done on every felon before release.

5. That a psychiatric report be available before any parole or transfer between institutions.

These recommendations were accepted in 1929, and the agreement between the legal and psychiatric professions was excellent. However, it was not destined to be maintained. Although psychiatric criminology was exciting, and eighty-three full- or part-time psychiatrists were reported to be working in American prisons in 1934, interest unfortunately began to decline by 1939 and failed to revitalize after World War II. Two issues probably accelerated this loss of interest: (1) a strong emphasis on diagnosis and disposition, with little or none on treatment, resulting in the psychiatrist doing little more than supporting the operations of the correctional institutions; and (2) the rise of psychoanalytic theory as a basis for psychotherapy with motivated individuals. How to apply this theory to an unmotivated person, who had to learn to conform to the law, was not understood. Halleck presents (1965) a good summary of the history leading to and following this change in interest in treating offenders.

The major development after World War II centered around specialized programs for certain classes of offenders. The possibility of releasing prisoners after treatment and recovery appealed to psychiatrists. Indeterminacy had particular appeal when applied to behavior that could be labeled as dangerous. The first laws involving such indeterminate sentencing were passed without sufficient regard to defining dangerousness (see below) or developing sufficient legal safeguards. In addition, no provisions for treatment were offered. When these rarely-utilized laws were used, they frequently dealt with social nuisances rather than with persons who seriously endangered others. By 1955, prison psychiatry in Maryland (Defective Delinquent Law), Wisconsin (Sex Crime Law), California (Vacaville Medical Facility), and the Federal Bureau of Prisons had developed to try and treat the most difficult offenders.

The problems have been and continue to be immense. The issue of defining “deviant” and “dangerous” offenders grows more difficult. The mentally retarded offender poses special problems for treatment. First, the data on the numbers, problems, and treatment of such offenders in penal and correctional institutions in the United States are either inaccurate or insufficient. Brown and Courtless (1971) estimated 20,000 prison inmates with IQ scores below 70, with 3300 of that group having IQ scores below 55. The authors recommended (1971):

1. Collection of data on the magnitude of the retardates' involvement with criminal law, epidemiologic data, and knowledge of offense patterns.

2. Elucidation of the relationship between intelligence and antisocial behavior.

3. Clarification of responsibility for retarded offenders.

4. Clarification of terminology used for retardates, in order that some appropriate strategies regarding intervention might be accomplished.

Systems of indeterminate sentencing can be abused if full legal rights through due process are denied and treatment is not available. In the absence of an adequate definition of the group to be treated, and in the absence of legal safeguards and realistic facilities for treatment, such programs use psychiatry for questionable preventive detention and punishment.

Dangerousness

Treatment interventions depend on predictions of the likely consequences of such interventions. The prediction of dangerousness is expected of the psychiatrist. This belief in the psychiatrist's capacity to make such predictions is firmly held and constantly relied on, in spite of a lack of empirical support.

Of the approximately 600,000 persons who are apprehended and accused of index crimes against persons (homicide, aggravated assault, forcible rape, and robbery) in a year, about 5 percent to 10 percent (30,000 to 60,000) will be examined (pretrial or presentence) to advise the court of their potential future dangerousness and to determine appropriate intervention (prison or hospital, and so forth). About 10,000 of these will be designated as mentally ill offenders and will be committed. Two thirds of them will be in special hospitals for the criminally insane, one sixth will be in ordinary mental hospitals, and one sixth will be in correctional institutions. These include persons who are: (1) charged with a crime and held, pending determination of their competency to stand trial; (2) charged with a crime and found incompetent to stand trial; (3) found not guilty by reason of insanity; (4) convicted of a crime and found mentally ill at the time of sentencing; (5) found to be mentally ill while serving a sentence; and (6) sex offenders, not included in the above. Of these categories, those in the last five require yearly or more frequent examinations or reviews to determine whether their state of potential dangerousness has altered, been modified, or disappeared (Scheidmandel, 1969).

Morris and Hawkins (1970, pp. 185-192) note that the American Law Institute's Model Penal Code provides that a criminal sentence may be extended if the person is a "dangerous mentally abnormal person." In the Model Sentencing Act of the Advisory Council of Judges of the National

Council on Crime and Delinquency (1963), dangerous offenders are defined as those who have committed or attempted certain crimes of physical violence and who are found to be “suffering from a severe personality disorder indicating a propensity toward criminal activity.” The Durham decision in the District of Columbia has led to the commitment of those acquitted by reason of insanity until (1) their sanity is recovered and (2) they will not in the foreseeable future be dangerous to themselves or others. The authors insist that the above requires an operable concept of dangerousness, and they correctly conclude that not until such predictions can be made can policy questions be answered concerning the degree of risk that the community should bear.

In Hough versus the United States (1959), the psychiatrist testifies, states that he can, and yet cannot, predict dangerousness:

> [Dr. Karpman]: I urged her father to hospitalize her, but of course he wouldn’t do it. I predicted, I told him personally, that we never can tell what measures of what a person of this type of psychosis might do. It may be something very drastic. But I didn’t think of murder, because I am not an astrologer and I couldn’t predict in advance; but I said something drastic might happen.
>
> Q: You thought she had a psychosis at that time? A: Yes.
>
> Q: What psychosis?
>
> A: Paranoid schizophrenia.
>
> Q: In your opinion, is Edith L. Hough the aggressive type of paranoid?

A: Yes, she is the aggressive type—as evidenced by the fact that she took measures of her own in killing the man. That is aggressiveness.

Q: In your opinion, is an aggressive paranoid potentially dangerous?

A: It is conceded universally that an aggressive paranoid is dangerous. I would say that universally we think that any paranoid schizophrenic is potentially dangerous, because one can never tell when the meekness and submissiveness may suddenly turn around and become aggressive.

Q: Would you say that Edith L. Hough at this time is dangerous because she has schizophrenia, paranoid type?

A: I would rather not answer this question directly. Ask me whether a paranoid schizophrenic is potentially dangerous and I would say yes.

Q: You would say yes?

A: Yes.

Arguments about dangerousness are frequently circular, and so, before proceeding, there should be some agreement as to what kinds of behavior are sufficiently threatening and damaging to be called dangerous. The National Commission on the Causes and Prevention of Violence defined violence as "overtly threatened or overtly accomplished application of force which results in the trying or destruction of persons or property or reputation or the illegal appropriation of property" (National Commission on the Causes and Prevention of Violence, 1969). A narrower and more specific definition of dangerousness is used in the new Illinois Unified Code of Corrections, which describes it as (1972, Sec. 1005-8-2) inflicting or attempting to inflict serious

bodily injury, using a firearm in the commission of an offense (or fleeing from an offense), and continuing to cause apprehension of physical harm to the public.

Trying to Predict Dangerousness

Given the present reality, it is unlikely that dangerousness can be predicted in a person who has not already acted in a dangerous or a violent way. What information is available about such dangerous behavior and its genesis that might be helpful in making valid predictions about its reoccurrence? What are the characteristics of danger, and what are their relative weights in assessing the probabilities of dangerous behavior?

Violent crime is primarily a phenomenon of the youth of larger cities who are, for the most part, male, uneducated, and black. There are certainly criminogenic forces—poverty, inadequate housing, overcrowded living conditions, poor employment opportunities, reduced family functions, and broken homes—that can be implicated as forces in making the young, inner-city population a risk. Yet these demographic characteristics, while indicating some direction that can be pursued to reduce or remove criminogenic factors, do not help in developing subpopulations in which predictions of dangerousness (as defined above) have any reliability, much less validity. Sociological concepts such as criminal subcultures, opportunity, deviant role

models, and a lack of “stake” have no predictive value, just as anthropological explanations related to territoriality and the frustration-rage continuum also fail to be useful. Violence is a form of social interaction, and attitudes to it are learned. For that reason, culture provides the triggering mechanism for human aggressive response to frustration, just as it provides the inhibiting mechanisms (Bohannon, 1969; Wooten, 1955). The data (Graham, 1969) showing that the United States has a culture that celebrates violence may help to explain the comparatively larger numbers of violent crimes in this country. But this in itself has no predictive value.

The reports associating violent crimes with biological defects have not been persuasive. Episodic dyscontrol with violent behavior has been associated with minimal brain damage and temporal lobe disorder and seizures (Bach-y-Rita, 1971; Maletsky, 1973; Monroe, 1970). Chromosomal defects (XYY [Hook, 1973]) and even testosterone overproduction (Ervin, 1969) have been implicated. In these cases, the presence of these defects in known criminals has no predictive value in terms of their possible future violent behavior. At best, they are found only in from 10 to 50 percent of the known criminal population samples studied—that is, those apprehended and found guilty.

Psychiatry and psychoanalytic theory and studies have given very conflicting evidence[7] having no predictive value. Hypotheses concerning a

"destructive drive" are used to develop models to explain human development, in particular the effect of aggressive fantasies on intrapsychic conflict. This has provided retrospective explanations about some mechanisms of inhibition, but little or nothing about predicting violent behavior. Notions such as "destructiveness is probably at its most perfect in early childhood and all later manifestations are, for most people, dilutions or mitigations" (Waelder, 1966) which describes the theoretical civilizing of destructive impulses, and "there is one representative of the destructive instincts that is accessible to observation, mainly sadism" (Nunberg, 1962), as well as, "the destructive instinct appears most clearly in negativism," seem to be describing either violent fantasy, or action which is not truly violent. The nature of innate aggressiveness in man (if it exists) has yet to be fully explored, and the vicissitudes of such a drive and its possible relations to violence have yet to be described and understood. Operational relationships between the concepts of anger, hate, rage, and violence are poorly differentiated. It is repeatedly noted (Duncan, 1971; MacDonald, 1963; Mulvihill, 1969; Steele, 1968) that violence and violent crimes are associated with childhood familial brutality and violence. A number of authors (Hellman, 1966; MacDonald, 1963) have reported that the triad in children of enuresis, fire setting, and cruelty to animals is predictive of adult crime.

The abuse of alcohol and drugs (amphetamines in particular) have been implicated in violent behavior (Ellinwood, 1971; Guze, 1962; Mulvihill, 1969),

and some have sought to prove that those particular drugs are the cause of violent crime. While their use may be associated with persons who engage in violence and violent crime, it is more likely that a particular predisposing personality is necessary. And the nature of that personality (and of what triggers violence in it) is unknown. Blum (1969), in a compelling study of drugs and violence for the Commission on the Causes and Prevention of Violence, finds that one cannot link amphetamines to crimes of violence, sexual crimes, or accidents. Drugs do act as releasers or facilitators and in that sense can trigger violence in a person predisposed to it. Megargee (1969), in a critical review of theories of violence, shows that (as seen above) few studies test theories of human violence. What is strikingly clear is that there is no unidimensional topology of violence.

What about the possible relationship between mental illness and violent acts? Certainly a strong relationship is implied. Nevertheless, epidemiological data indicate that (1) the major mental illness rates are not comparable to violence rates, and (2) the distribution of major mental illness is not the same as the distribution of violence. Negative data support Morris and Hawkins (1970), who correctly state that “at present there is no operable concept of dangerousness, and when it is used it usually is for retributive purposes.”

Because social labeling makes the prediction of dangerousness self-fulfilling (Blake, 1961; Halleck, 1971; Scheff, 1963), prior prediction seems to

have dangers that outweigh its usefulness. What is needed is the design of morbidity-experience prediction tables, which can be systematically tested to determine the possibilities of dangerousness in various subpopulations. Predictions of violence in mentally ill criminals will have importance in the rehabilitation programs of the criminal justice system, should they be in terms of various prison subpopulations.

The first quantitative data on a significant subpopulation considered to be a risk in the sense of engaging in violent behavior concerns a group of prisoners, all designated as "dangerous," who were released in New York because of a Supreme Court decision (Baxstrom v. Herold, 1966). In this case, the Supreme Court declared unconstitutional the New York State practice of administratively committing offenders to Dannemora and Matteawan (Department of Corrections hospitals for the criminally insane). They declared that offenders such as Johnnie K. Baxstrom, who became mentally ill while serving a sentence, or others who at the end of their sentences were retained as dangerously mentally ill, were denied equal protection under the Fourteenth Amendment. As a result of that decision, 967 prisoners were transferred from Dannemora and Matteawan to state mental hospitals. During the first three months, six times the number of Baxstrom patients were released to the community as were retransferred to a security institution as dangerous, even though they were all alleged to be dangerous prior to the Supreme Court decision and release.

A four-year follow-up was conducted, asking: (1) Where were the Baxstrom patients and what were the circumstances of their locations? (2) What was the level and type of criminal activity of the released prisoner-patients? The sample consisted of all 47 of the Baxstrom women and a 22 percent (199) random sampling of the 920 Baxstrom men.

The major findings (Steadman, 1972) of the study substantiated the initial impression that these prisoners were less dangerous and posed fewer problems than initially expected. Over the four-year period, twenty-three patients (2 percent) of the 967 were retransferred to high-security institutions for the mentally ill, indicating a 98 percent false positive prediction (Steadman, 1973) of these men and women as dangerously mentally ill. Of the sample, 117 (47.6 percent) remained in public mental hospitals, ten (4.1 percent) were in contact with community clinics, and twenty-nine (11.7 percent) had died.

The conclusion of non dangerousness was further borne out by the fact that only thirty-nine (19.6 percent) men and twelve (25.5 percent) women had any assaultive behavior in mental hospitals after transfer. In looking at the criminal activity of the sample after release, we find that 121 of the sample of 246 were released to the community and that twenty-one patients were arrested forty-six times, twenty-three of which were felonies.

These patients had been in the community an average of two and a half years each. There were sixteen convictions involving only nine patients, with only two convictions for felonies.

Several factors are responsible for the low incidence of dangerousness among these patients. First, the Baxstrom population was middle-aged at the time of their transfers (average age of sampled men, 49.S years; average age of women, 51.9 years). The second—major—factor is that the bulk of Baxstrom patients became mentally ill while serving sentences. The original crime could have been innocuous; it was the mental illness that was felt to render them dangerous. Once prisoners were in mental hospitals, their prior crime had 110 value as an indicator to the examining psychiatrist of their dangerousness. If they were assaultive in the mental hospital, the psychiatrist tended to retain them as dangerous—which raises serious questions about the role of the psychiatrist and his application of unarticulated criteria for release. The major conclusion that can be drawn from this study is that the subsequent behavior patterns of the hospitalized and released Baxstrom prisoners cast serious doubts upon the classification of the "dangerous mentally ill offender" and the extended or indefinite sentence resulting from that classification. Further data may be useful in correlating violence with personality factors as well as with precipitating factors.

A second set of data has been provided by eighteen prisoners in the

Illinois penitentiary system who were retained in prison by “administrative error” beyond the time when they were to be transferred from prison to the mental health system. The author (1972) studied seventeen of these prisoners who had spent a cumulative 425 years in prison. From the data, it was impossible to establish a connection between mental illness and the nature of the crimes committed by these men. Their cases indicated that dangerousness is over predicted in the presence of mental illness and/or by the nature of the crime. There was little evidence in the men (with one exception) to support continued prediction of dangerousness after two years of imprisonment.

Possible Definitions of Dangerousness

Various legal definitions of dangerousness have been used and implemented through special institutions for the care and treatment of dangerous offenders. Since all penal codes have been moving in the direction of extended sentences for the persistent offender, the professional criminal, and the dangerous and mentally abnormal offender, it may be useful to examine some different tests for dangerousness and the practical results of confinement and/or treatment, both in the United States and Europe. The rationale for identifying the dangerous offender is that (1) others can then be given shorter terms or probation, and (2) the dangerous offender would be easier to treat if separated from the ordinary prison population and placed in

special institutions. Although the second of these premises is still in some doubt, there is 110 question that the quality of life in the United States would improve if fear of bodily harm from violent behavior were substantially reduced by being able to adequately define, predict and modify such behavior.

As succinctly stated in *Standard Minimum Rules for the Treatment of Prisoners (1970):* "The purpose and justification of a sentence of imprisonment or a similar measure of deprivation of liberty is ultimately to protect society against crime. This end can only be achieved if the period of imprisonment is used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life."

*The Model Penal Code*46 defines the abnormal offender by having a psychiatrist show that the offender:

a. possesses a gravely abnormal mental condition;

b. has engaged in criminal conduct which has been characterized by a pattern of repetitive or compulsive behavior or by persistent aggressive behavior with heedless indifference to consequences; and

c. as a result of the above two conditions, is a serious danger to others.

If the judge concurs in the diagnosis of dangerousness, the offender is labeled a dangerous, mentally abnormal person. Two problems are immediately apparent. Too much responsibility is shifted to the psychiatrist, and there is 110 provision for the mentally normal violent offender.

The Proposed Federal Criminal Code[8] (National Advisory Commission on Criminal Justice Standards and Goals, 1973) provides for “dangerous special offenders.” Extended sentences up to twenty-five years may be imposed on a number of special groups, including a separate category for the dangerous, mentally abnormal offender. This category requires a finding that:

a. the offender possess an abnormal mental condition,

b. such mental condition makes him a serious danger to the safety of others, and

c. he committed a felony as an instance of aggressive behavior with heedless indifference to consequences.

A psychiatric report is required but is only advisory to the court. Another category of dangerous special offender includes those who use firearms or destructive devices in the commission of an offense or flight therefrom. No abnormal mental state is required to satisfy this criterion. There is also a special category that presumes dangerousness of criminals involved in a conspiracy. In general, the proposed Federal Code develops a

diffuse, overly large concept of dangerousness.

The Model Sentencing Act (1963) developed by the National Council on Crime and Delinquency extends the maximum sentence to thirty years for dangerous offenders. Specifically, an offender can be sentenced as dangerous if:

> a. he inflicted or attempted to inflict serious bodily harm, and has a propensity to commit crime as indicated by a severe mental or emotional disorder; [and]
>
> b. he committed a crime which, intended or not, seriously endangered the life or safety of another, he was previously convicted of a felony, and he had a propensity to commit crime as indicated by a severe mental or emotional disorder. [Sect. 5]

There is an optional Sect. 8, which deals with certain atrocious[9] crimes for which the defendant, if convicted and failing to fall under the "dangerous person" section, may nonetheless be sentenced up to ten years without meeting the psychiatric and other criteria of Sect. 5. This act defines dangerousness more narrowly than the previous ones discussed, in that only assaultive offenders (mentally normal and abnormal) may be defined as dangerous.

The Illinois Unified Code of Corrections (1972) provides for doubling the ordinary maximum sentence for convicted felons, who:

a. must be at least 17 years old and have been convicted of a felony in which he inflicted or attempted to inflict serious bodily injury, or in which he used a firearm in the commission of an offense or flight therefrom; [and]

b. must present a continuing risk of physical harm to the public. [Sect. 1005-8-2]

Unlike any of the preceding codes, the Illinois Code specifically defines serious bodily harm to mean risk of death, disfigurement, or impairment of health. The most striking feature is that the Illinois Code requires no mental abnormality or defect to classify an offender as dangerous. This approach makes it clear that the first priority of defining dangerousness is the protection of society. The second step is to determine what sort of therapy, if any, the offender shall receive during confinement. Psychiatric help is felt to be useful in predicting dangerousness, but the presence or absence of mental illness alone, aside from its predictive value, is irrelevant in Illinois in deciding which assaultive offender to confine for extended periods.

Greenland's Criminal Code (1970) was written in 1954 as a practical testing of progressive penological ideas. There are 110 sentences attached to individual crimes. Instead, every offender is treated according to his particular personal make-up. The judge has a wide range of different sanctions available. However, placement in an institution, the severest measure, is only used "when regard for public safety or general respect for

the law renders it necessary and no other measure is found suitable.” [Sect. 107] The offender’s degree of dangerousness is the only justification for segregating a person from contact with others. [Sect. 108] There are no special provisions for “dangerous offenders,” but dangerousness is considered an important element in the process of deciding every case.

Treatment Settings

The empirical evidence on the correct diagnosis and successful treatment of dangerous offenders is varied, but it gives some reasons for optimism concerning the rehabilitation of a class of criminals who, until recently, were thought to be untreatable (Wilkins, 1964).

The European experience can be characterized by three institutions, each headed by a psychiatrist. Two of these are prisons. The third is a curious mixture of prison and mental hospital.

The Herstedvester Detention Centre at Albertslund, Denmark, following a new Danish Penal Code established in 1930, allowed for the detention and treatment of certain male prisoners not susceptible to punishment, in the interest of public safety. (A sister institution, Horsens, now closed, took women prisoners for detention and treatment.) It was opened in 1935, first with a psychiatric consultant and later with a psychiatric superintendent. But it was not until 1942, when Georg K. Stürup succeeded to the

superintendency, that a treatment program (1968) evolved for chronic criminals (excluding psychotics and severe mental retardates). This prison has accepted and treated prisoners on the basis of the chronicity of their deviant or dangerous behavior (20 percent are deemed dangerous) and their inability to respond to usual prison life. The prison has a population of approximately 170 prisoners, 170 guard staff, and 60 clinical staff. Using a psychosocial therapeutic approach that is one-to-one and individualized, such prisoners are treated principally by the guard staff (who are not considered custodial); the Stürup innovation was to decide that the guards were the key to successfully changing deviant behavior.

While it is a prison, Herstedvester possesses a humane atmosphere. The overall stay of prisoners is two years, with home visits, furloughs, and work release providing a graduated stepwise return to the open community. Anxious prisoners may return either early from visits or during their parole. After ten years, 95 percent of any cohort will have finished with criminal behavior. Formerly a law of indeterminate sentencing, the law was changed to fixed sentencing as of July 1, 1973. Political changes in Denmark, plus Stürup's retirement, then left Herstedvester in a state of flux in relation both to leadership and to mission. The treatment organization became more group-oriented and decentralized, with a greater emphasis on social and individual strengths.

There is obviously some controversy over the Danish practice of voluntary castration in the treatment of some sexual offenders—“persons for whom the sexual drive entails considerable psychic suffering or social devaluation” (Stürup, 1968) A summary of the rationale and findings of castration by Stürup indicated that over a thirty-year period, only twenty of 900 sex offenders so treated were recidivists.

The Dr. H. van der Hoeven Kliniek, founded in 1955 and situated in the center of the town of Utrecht, the Netherlands, is one of seven institutions for the care of criminal psychopaths in that country. Housing seventy prisoners (called patients)—seven men to one woman—the institution provides treatment by eighty-five non uniformed, fulltime staff and approximately ten part-time staff, in an equal mix of men and women. Treatment is in small groups, with emphasis on (1) frustration-aggression, (2) self-confidence, and (3) self-image. Highly organized in groups, with vocational and study opportunities, the largely dangerous (approximately 50 percent) and repetitive criminals stay an average of two years and are reported to lead less criminal lives after returning to the open community. Opportunities for furlough and work release are excellent and well-supervised. Eighty percent of the prisoner-patients are indeterminately sentenced (Ministry of Justice, the Netherlands, 1971). The setting, staff, and prisoners are innovative and creative in their approach to problems of architecture, staffing, and prisoner rehabilitation. A. M. Roosenburg, the superintendent, summarized the

treatment position of the van der Hoeven Kliniek as follows (1965):

> To make the criminal realize his responsibility for his deeds, it is necessary to make him bear his responsibility throughout the whole criminal procedure. He should participate in the discussion and evaluation of his criminal behavior, and the harm he has caused—not only material but also psychological—through not having acted in consonance with the expectations of society as regards respect for human rights and fundamental freedom. He should also participate in the discussion of the consequences of his deeds and what he could do to alleviate them. Last, but not least, he should be involved in consideration of how to prevent recidivism and what he could do now towards a reconciliation with the victim or his family or other person affected. He should then have the opportunity to make himself as worthy as possible of that reconciliation.

M. Prison Grendon Underwood (Parker, 1970) was opened in 1962 in England under the direction of a full-time psychiatrist, W. J. Gray, as the long-delayed outcome of The 1939 East-Hubert Report, *The Psychological Treatment of Crime.* Housing 200 males, one half of whom are juveniles, it provides for a therapeutic community with intense and frequent large and small group meetings. The staff of approximately sixty-five (including guards) is responsible for treatment, with a staff-prisoner ratio of 1:3.5. Stays last approximately eighteen months. For political reasons the prison, although recommended to be built in London, is a long trip of one and a half hours away. This poor location makes prison industries poor and graduated release difficult.

None of these three prisons has any clinically controlled evaluation.

There are no base-expectancy failure rates to support belief that felons, as a result of these prison experiences, live better and less criminal lives in which less harm is done to themselves and others. Yet certain facts are inescapable. These prisons allow difficult prisoners to live in a humane setting in which less harm is done to themselves and others and in which an opportunity for change is available. Many do seem to change. Compared to institutions with similar purposes in the United States, they seem to be philosophically, politically, and practically far ahead of us.

The Patuxent Institution was established in 1955 in Maryland as an institution to treat, under indeterminate sentence, convicted offenders designated as “defective delinquents” under a 1951 Maryland law. The defective delinquent was defined as “an individual who by the demonstration of persistent aggravated antisocial or criminal behavior evidences a propensity toward criminal activity and is found to have either some intellectual deficiency or emotional imbalance or both as to clearly demonstrate an actual danger to society” (The Annotated Code of the Public Generals Laws of Maryland, 1951). The institution, built to hold 600, has a prisoner population of approximately 500. Besides the director, a psychiatrist, there are approximately thirty-five mental health professionals (psychiatrists, psychologists, and social workers). Inmates remain an average of four and a half years. Treatment consists of small groups and a “graded tier” system that uses the behavioral hypothesis of operant conditioning.

Although broad categories of offenders are eligible for examination at Patuxent, the trend over time has been toward the referral of predominantly violent offenders (from 41 percent in 1955 to 71 percent in 1972). Controversy (Hodges, 1971) has increased regarding the usefulness of indeterminate sentencing and the methods and efficacy of treatment at Patuxent. In a report (Department of Public Safety and Corrective Services) dated January 9, 1973, recidivism rates were reported of a sample of prisoners who passed through the institution. It should be added that this report of the Department of Public Safety and Correctional Services of Maryland resulted in the withdrawal of a Maryland House Bill that called for the abolishment of Patuxent Institution. The report discusses recidivism rates of 577 patients referred for diagnosis (see Table 44-1). If these statistics are correct, it is clear there is a direct relationship between the amount of treatment a patient receives at Patuxent and his recidivism rate on release. One problem in assessing the statistics is that the recidivism rates for each category include convictions for all sorts of crimes. When compared with the careful study by Kozol (1972, p. 392), in which a general recidivism of 32 percent was reported, the 7 percent rate at Patuxent is remarkable. In examining the data, however, the patient who receives full treatment receives in-care for an average of four years and parole delinquency status for another three years. Only then is he finally released. If a patient commits a crime at any time during his parole status, he does not appear on the recidivism

statistics of the fourth category. After three years of unviolated parole, when the patient is released from delinquency status, the odds that he will enter the last category as a success rather than a recidivist are greatly increased. This is supported by the statistics for the period 1959-1969, which show that 45 percent of the parolees violated their parole—26 percent by committing a new crime. If we add the 26 percent to the 7 percent rate shown, we arrive at 33 percent, a figure approximately that of the Bridgewater Study by Kozol. Lastly, it has been reported in support of indeterminate sentencing that only 3 percent of the first 638 patients have not experienced some form of release. Actually, Schreiber (1970) reports that of 348 inmates presently committed, 151 are beyond their original terms. Because the effects of treatment are not as broad or clear-cut as represented in the report, serious questions arise as to the propriety of indefinitely sentencing an offender, given the limited predictive ability of the psychiatrist and the questionable success of the treatment.

In addition to the above questions, a federal and a Maryland state court challenged the institution’s theoretical justification on practical grounds. First, a federal court22 ruled that a prisoner who was convicted of assault and sentenced to five years imprisonment, but who was sent instead to Patuxent indeterminately, refused psychiatric examination, and remained beyond his original sentence, *had* to be released, because: (1) continued confinement was unlawful in that the petitioner was no longer in the class eligible for

commitment; and (2) his refusal to submit to a psychiatric examination did not justify his continued confinement. Supreme Court Justice Douglas made much of the second point, supporting the petitioner's claim to a Fifth Amendment right against self-incrimination. Second, a lower two-judge court (McCray v. Maryland, 1971) ruled in favor of inmates concerning the terrible conditions of solitary confinement—in fact, some of the conditions were worse than those proscribed by the American Correctional Association for Prisons—the lack of rules governing conduct of prisoners and staff, the diet, the censorship of mail, and the number and training of the staff. The court concluded that the "maintenance of prisoners in cells in a prison-like setting with the offering of group therapy and limited rehabilitative vocation training is not a total rehabilitative effort" (McCray v. Maryland, 1971). This may account for the mostly poor response of the press (Stanford, 1972) to this prison.

*Table 44-1. Recidivism Rates—Comparing Four Groups of Patuxent Patients and the National Recidivism Rate**

	NUMBER	RECIDIVISM RATE, PERCENT
Patients recommended for commitment but not committed by the courts (not treated, subjected to regular correctional system programs)	156	81
Patients released at rehearing against staff advice, in-house treatment only	186	46
Patients released at rehearing against staff advice, in-house treatment, plus conditional release experience	100	39

Patients released at recommendation of staff of Institutional Board of Review, in-house and continued treatment for three years on parole	135	7

**Statistics are for 1955-1964 (Department of Public Safety and Corrective Services, 1973, p. 3).*

The Center for the Care and Treatment of Dangerous Persons at Bridgewater, Massachusetts, was established in 1959 to implement a 1958 state law providing for the indefinite detention and treatment of dangerous offenders. Dangerousness is narrowly defined as a potential for inflicting serious bodily harm on another person. A prerequisite for such a finding is a past history of violent acts. Those offenders remanded to the Center are given a most extensive and meticulous examination made independently by at least two psychiatrists, two psychologists, and a social worker. Each diagnostic study includes a clinical examination, psychological testing, and a reconstruction of the life history, elicited from many sources. Table 44-2 gives a statistical examination of a sample of offenders processed by the Center, for serious assaultive crimes committed by the total of 435 patients released (Kozol, 1972, p. 390). The mean age of all 435 patients released was 35.6 years, unlike the Baxstrom population, which was middle-aged at the time of transfer to civil hospitals. It then seems unlikely that the recidivism rate was affected by the aging process.

As the Table 44-2 indicates, the Center's success in predicting dangerousness was good as to offenders recommended for release both

before treatment and after commitment for treatment. Of 386 patients released upon the Center's recommendations, only thirty-one (8 percent) committed crimes. Since the number of patients (forty-nine) released against the Center's recommendations is rather small, the recidivism rate may not be generalizable to larger samples. Nevertheless, this group had a combined recidivism rate of 34.7 percent. Although this figure exceeds the rate of the group of patients recommended for release, what is striking is that the Center was only 34.7 percent successful in predicting dangerousness in this group. That is, 65.3 percent proved to be false positives, that is, found to be not dangerous after release, in spite of predictions to the contrary. What is distressing is that even with a very narrow definition of dangerousness, the Center massively over predicted dangerousness in the group it recommended against releasing.

Table 44-2. Recidivism: A Comprehensive Study of All Patients Released

		RECIDIVISTS	
	NUMBER	NUMBER	PERCENT
Recommended for Release			
At time of initial diagnostic study	304	26	8.6
After commitment and treatment	82	5	6.1
Total	386	31	8.0
Not Recommended for Release			

At time of initial diagnostic study	31	12	38.7
After commitment and treatment	18	5	27.8
Total	49	17	34.7
Total of all patients released	435	48	11.0

There are a few other American institutions that try to treat the disturbed offender. Among these are Vacaville (California) and Springfield (Missouri) in the federal system. For the most part, they are said (Goldfarb, 1973) to range from a cheap version of Patuxent to just plain awful.

The role of the psychiatrist in the “treatment” of the chronic and/or dangerous offender is still being defined, as are the determinants of criminal behavior. As with the mentally ill, labeling of the offender (mentally ill or not) without some kind of resources for treatment or rehabilitation is a mockery at best and pernicious at worst. Certainly the psychiatrist has a role to play in the areas of prediction of dangerousness and the testing of the efficacy of various modes of intervention, if only to determine the narrowness of that role. The relationship between frustration and aggression, the genesis of violent behavior, the interaction between biological, psychological, and social variables in criminality with or without violence, and the role of prisons and extramural services in treatment and resocialization are still being developed. The psychological areas of poor self-image, genesis of aggression, and narcissistic rage show some promise of delineating certain motivational

factors that interdigitate with social situations in triggering violence toward other persons.

Most of the evidence points toward the necessity of developing small, specialized prisons for only the narrowest segment of convicted offenders. Such concepts as the use of space for developing optimal closeness and distance; stepwise increases of perimeter, stimulation, and responsibility; and the use of group supports and therapy can be tested there. It may well be that in such a setting the negative response to dangerous offenders can be minimized and less harm done to them (Goldfarb, 1973; Halleck, 1971; Lion, 1973). Ways of doing this can be gleaned from the methods used by the three European treatment prisons described above. Some of these methods are the prisons' small size, the importance of the first four to six weeks of a prisoner's stay, the use of intense group experiences (Jew, 1972), the sharing of responsibility by prisoners and staff with prisoners voluntarily (Barr, 1967) involved to a larger degree, and the use of graduated release. All of the prisons (Morris, 1965) that successfully treat offenders have these characteristics, and they also have an average stay of eighteen months. The failure of American experiments along the same line may result from not using those criteria noted, as well as from attempting to care for our entire class of offenders, once defined, rather than an optimal number. Thus the programs have been overwhelmed.

If, in addition, we can begin to predict dangerousness so that the truly dangerous can be segregated and given an opportunity to change, then the fear as well as the danger of harm to the ordinary citizen may be substantially reduced. The dangerous felon can return to the open community to live a better and less criminal life.

Psychiatric Reports and Testimony

In order to collect data effectively, make recommendations, and be of help to the client, patient, offender, prisoner, or parolee, or to the lawyer, court, or treatment staff, the following are areas that should generally be understood.

1. A psychiatric expert should be qualified and experienced in the diagnosis and treatment of persons with various mental disorders. He should have some knowledge of offender and normal populations. He should know the law pertaining to the area of difficulty being discussed and should confer with the lawyer, the court, or other persons asking for his expertise, to determine if he can play a role, and if so what kind.

2. The psychiatrist must clarify his role (as previously defined) with the person being examined, explaining such issues as confidentiality or the lack of it, possible consequences of the revelation of information, and how data will be used by the lawyer, court, or any agency involved.

3.A clinical examination should be carried out, usually in two to six hours in one half hour segments divided over days or weeks. An anamnestic history should be taken, with careful attention paid to facts and attitudes about alleged crimes and violence, attitudes about self and others, feelings about relationships to others (family and community), and prospects for the future. Unlike an examination of a person who seeks psychiatric help, these examinations should seek to establish facts as well as fantasy, which must be carefully differentiated.

4.Special tests should be run, including: (a) other medical examinations, e.g., neurological, endocrine, and so forth; (b) electroencephalograms; and (c) psychological tests to corroborate clinical findings, including organicity, and to reveal any less apparent psychopathology.

5.Data from other sources should be included. Information from family, friends, employers, police, witnesses, arrest records, and hospital or correctional records should be used, when available, to produce a composite picture of the individual's personality, alleged offense(s), and possible responses to punishment and treatment.

The data are then summarized and used to answer questions concerning illness, dangerousness, competence, accountability, and treatability in the form of correspondence, reports, depositions, or testimony.

In 1967 the Federal Appeals Court, District of Columbia, in attempting to help psychiatrists understand their role there, developed instructions40 to

ensure the collection of adequate information in cases involving insanity defenses. As stated below, these instructions provide an excellent description of what is expected of a psychiatrist in court:

> *Court's Instruction to Expert Witness in Case Involving the "Insanity Defense"*
>
> Dr. _______, this instruction is being given to you in advance of your testimony as an expert witness, in order to avoid confusion or misunderstanding. The instruction is not only for your guidance, but also for the guidance of counsel and the jury.
>
> Because you have qualified as an expert witness your testimony is governed by special rules. Under ordinary rules, witnesses are allowed to testify about what they have seen or heard, but are not always allowed to express opinions and conclusions based on these observations. Due to your training and experience, you are allowed to draw conclusions and give opinions in the area of your special qualifications. However, you may not state conclusions or opinions as an expert unless you also tell the jury what investigations, observations, reasoning, and medical theory led to your opinion.
>
> As an expert witness you may, if you wish and if you feel you can, give your opinion about whether the defendant suffered from a mental disease or defect. You may then explain how defendant's disease or defect relates to his alleged offense, that is, how the development, adaptation and functioning of defendant's behavioral processes may have influenced his conduct. This explanation should be so complete that the jury will have a basis for an informed judgment on whether the alleged crime was a "product" of his mental disease or defect. But it will not be necessary for you to express an opinion on whether the alleged crime was a "product" of a mental disease or defect and you will not be asked to do so.
>
> It must be emphasized that you are to give your expert diagnosis of the defendant's mental condition. This word of caution is especially important if you given an opinion as to whether or not the defendant suffered from a

“mental disease or defect” because the clinical diagnostic meaning of this term may be different from its legal meaning. You should not be concerned with its legal meaning. Neither should you consider whether you think this defendant should be found guilty or responsible for the alleged crime. These are questions for the court and jury. Further, there are considerations which may be relevant in other proceedings or in other contexts which are not relevant here; for example, how the defendant’s condition might change, or whether there are adequate hospital facilities, or whether commitment in the courtroom is the kind of opinion you would give to a family which brought one of its members to your clinic and asked for your diagnosis of his mental condition and a description of how his condition would be likely to influence his conduct. Insofar as counsel’s questions permit, you should testify in this manner.

When you are asked questions which fall within the scope of your special training and experience, you may answer them if you feel competent to do so; otherwise you should not answer them. If the answer depends upon knowledge and experience generally possessed by ordinary citizens, for example questions of morality as distinguished from medical knowledge, you should not answer. You should try to separate expert medical judgments from what we may call “lay judgments.” If you cannot make a separation and if you do answer the question nonetheless, you should state clearly that your answer is not based solely upon your special knowledge. It would be misleading for the jury to think that your testimony is based on your special knowledge concerning the nature and diagnosis of mental conditions if in fact it is not.

In order that the jury may understand exactly what you mean, you should try to explain things in simple language. Avoid technical terms whenever possible. Where medical terms are useful or unavoidable, make sure you explain these terms clearly. If possible, the explanation should not be merely general or abstract but should be related to this defendant, his behavior, and his condition. Where words or phrases used by counsel are unclear, or may have more than one meaning, you should ask for clarification before answering. You should then explain your answer so that your understanding of the question is clear. You need not give “yes or no” answers. In this way any confusion may be cleared up before the

questioning goes on.

> Some final words of caution. Because we have an adversary system, counsel may deem it is his duty to attack your testimony. You should not construe this as an attack upon your integrity. More specifically, counsel may try to undermine your opinions as lacking certainty or adequate basis. We recognize that an opinion may be merely a balance of probabilities and that we cannot demand absolute certainty. Thus you may testify to opinions that are within the zone of reasonable medical certainty. The crucial point is that the jury should know how your opinion may be affected by limitations of time or facilities in the examination of this defendant or by limitations in present psychiatric knowledge. The underlying facts you have obtained may be so scanty or the state of professional knowledge so unsure that you cannot fairly venture any opinion. If so, you should not hesitate to say so. And again, if you do give an opinion, you should explain what these facts are, how they led to the opinion, and what if any, are the uncertainties in the opinion.

In an earlier report on psychiatric testimony, the Group for the Advancement of Psychiatry (1954) noted the limitations of the psychiatrist as expert witness:

1. He cannot fit any scientifically validated entity of psychopathology into present legal formulae of insanity. He cannot determine by scientific method the existence of “knowledge” as explained in legal tests, excepting in cases of disturbed consciousness or profound mental deficit.

2. He cannot testify in any manner in terms of moral judgment.

3. He cannot within the framework of present court requirements determine degree of legal responsibility calibrated to medical degrees of psychopathology.

As for competence, it was stated (1954):

1. He can predict behavior of the mass statistically and determine with fair accuracy the classes of undeterrable persons. He can predict the tendency of behavior in the individual and with fair accuracy determine his deterrability.

2. He can with fair accuracy determine the degree of disorder of the accused relating to: (a) the present mental state of the accused as it is relevant to his capacity to appreciate the significance of the charge and to cooperate in the preparation of his defense; and (b) the causal connection of the mental state and the act charged.

3. He can make advisory recommendations for suitable disposition of the convicted.

Twenty years later it would appear that the competence of the psychiatrist was exaggerated. Only now are the problems beginning to be understood, as the legal and psychiatric professions examine the questions together.

Rights of Patients

During the Age of Reason, two principles were articulated that expressed the sentiments of society regarding the treatment of persons designated as patients. The first, the right to be treated humanely, was applicable to the physically as well as the mentally ill and, in psychiatry, was

expressed in the work of a group of men known as “moral” psychiatrists: Pinel, Tuke, and Chiarugi. Since “moral psychiatry” argued that the location of the problem and its possible correction lay in the higher (moral) faculties, the second principle supported the right of a patient to participate—that is, share responsibility—in the treatment.

These two rights slowly evolved into the patient’s right to be treated as responsible and, as circumstances permitted, free. Public health laws, including mental health codes, shifted from concern for the protection of society to concern for the rights of individuals. This resulted in a gradual lessening of the doctor’s power over a patient’s body and mind. The rights of patients have been increasingly broadened and clarified, while the rights of physicians have been narrowed to agreements for specified interventions at agreed-upon times. Civil and criminal charges relating to breach of contract, false imprisonment, invasion of privacy, assault and battery, and negligence, can be brought against the psychiatrist. Freud (1964) emphasized that the psychoanalyst must not take advantage of the transference. Undue influence and advantage taken by the psychiatrist in relation to the patient’s transference has been perceived in two cases (Hammer v. Rosen, 1960; Landau v. Werner, 1961), with findings for the plaintiff in both. Prudence is required to be certain that suggestions are suggestions and prescriptions only prescriptions.

Lastly, the patient's conduct outside of the physician's office, if criminal, should raise questions concerning the physician's involvement. Certainly, should the patient indicate the possibility of future dangerous behavior, (and if he is not certifiable as legally mentally ill), then serious questions of the doctor's posture vis-a-vis privilege and public policy, can be raised. This allocation of a greater share of responsibility to the individual for his destiny in regard to behavior, illness, and death has put a larger burden on the physician in terms of accountability. It has also demanded of the physician a greater concern with ethics and public policy as regards the nature and extent of his interventions with other citizens. As developing technology allows attempts to be made to prolong life and to modify and control behavior, serious discussions of the implications for the limiting of liberty and choice ought to be continuing. And psychiatrists, lawyers, and jurists should be leading the way.

Privilege

Four criteria are universally accepted for judging any privilege's appropriateness:

1. The communication must originate in a confidence that they will not be disclosed.

2. The element of confidentiality must be essential to the full and satisfactory maintenance of the relationship to the parties.

3. The relation must be one which, in the opinion of the community, ought to be sedulously fostered; and

4. The injury that would inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of the litigation (Wigmore, 1961, Sect. 2285).

Such privilege has been granted the attorney-client, physician-patient, and clergyman-penitent relationships. But all professional-client privileges contain exceptions, usually in relation to criminal rather than civil laws. The exceptions usually relate to the fourth item above—that is, when the “benefit gained for the correct disposal of the litigation” outweighs the “injury that would inure to the relationship by the disclosure.” The attorney-client privilege covers all civil actions and criminal actions *except* where the attorney has knowledge (or ground to believe) that his client (1) was contemplating the commission of a crime (future crime exception) or (2) was attempting to suppress the discovery of a crime already committed (Wigmore, 1961, Sect. 2298).

The physician-patient privilege is only applicable to civil actions. However, the clergy-penitent covers all communications in all kinds of actions. The nature of the psychiatrist-patient relationship—because of the intense, probing character of the communication, the desirability of expressing things not acceptable to society at large, and the concern for

feelings and fantasy as well as facts—seems to make it closer to the clergy-penitent relationship, which alone remains unhampered. Historically, however, psychiatrists, as physicians, have used the physician-patient privileges when available. Only California (People v. Scheer, 1969) has sought to distinguish between physician-patient and psychiatrist-patient. A probable mistake was the proposal (1960) of a model statute by the Group for the Advancement of Psychiatry, which in 1960 stated, "The confidential relationship and communication between psychiatrist and patient shall be placed on the same basis as regards privilege as provided by law between attorney and client." Neither the physician-patient nor lawyer-client privilege can provide the protection needed for a full psychotherapeutic relationship. An Illinois trial court recognized that a psychotherapist-patient relationship was worthy of more extensive privilege than a physician-patient relationship. The reasons are worth noting (Binder v. Ruvell, 1952):

1. A thorough examination for mental illness and more important, a thorough cure, cannot take place unless the patient reveal his thoughts. A therapist cannot ferret out secrets of the mind in the way a physician can ferret out secrets of the body.

2. Whereas an organic illness can be treated without trust between a physician and patient, a mental illness cannot.

3. If the patient feels betrayed by one analyst, chances are that he will mistrust the whole profession—and thus negate his chances for future treatment. On the other hand, patients frequently seek out

new doctors.

In criminal actions, the conflict between injury and benefit is more of concern to the accused and to society as a whole. It is not helpful to say that psychiatrists do not treat criminals, as they may, and it cannot be ignored in relation to the entire area of the treatment of offenders, dangerous or not. Such persons are more in need of privilege—to talk without fear that their therapist will testify against them in court—than is the civil litigant (MacCormick, 1959; Slovenko, 1960; Slovenko, 1966).

Informed Consent

The physician's duty to inform his patients is derived from his duty to obtain the patient's consent to the proposed treatment. Consent consists of awareness and assent. Battery was the older theory of recovery in relation to this concept, but since the late 1950s a second ground—negligence—has been developing. The classic case where consent is not required is an emergency situation where the life and health of the person is in immediate danger. Consent is held to be implied.

Consent can be imposed by the law—for example, inoculations. Upon application of a physician or hospital, a few courts have ordered medical treatment for a nonconsenting adult on the grounds that the state, as *parens patriae,* has an interest in protecting the patient's life. This is especially true if

the patient has children who would become wards of the state on his incapacity or death.2 A few cases appear to condone the withholding of information when a disclosure of collateral risks to a treatment may unduly alarm an already apprehensive patient. Arguments tend to be paternalistic, usually based neither on law nor logic. The problem of innovative treatment, the results of which are not fully known or explored, is informing the patient and getting his consent. In response to this, Waltz (1970) states:

> If a physician acted improperly by going ahead with an innovative technique as to which there were too many unplumbed questions involving its potential risks, liability will flow from the physician's unreasonable consent. If, on the other hand, lie acted reasonably in going forward on the basis of existing knowledge, the patient's consent even to the possibility of unanticipated risks is again irrelevant, since the physician had no legal duty to disclose risks about which he neither knew nor should have known, and for that reason alone he is immune from liability.

This leaves the position of consent intact, and does not thwart the development of new ideas for medicine. Three court decisions in California (Cobbs v. Grant, 1972), the District of Columbia (Cantebury v. Spence, 1972), and Rhode Island (Wilkenson v. Vesey, 1972) in the 1970s together more clearly define the legal position in relation to informed consent in medical malpractice. That position is (Breckler, 1973):

> Respect for the patient's rights of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves. Unlimited discretion of the physician is irreconcilable with the basic right of the patient to make

> the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected.

In Cobbs versus Grant (1972), the court indicated that the patient had an abject dependence upon and trust in his physician for education in regard to his condition. That is, the relationship between physician and patient was a fiduciary one. It was further stated that “adults of sound mind have a right to determine whether to submit to lawful medical treatment.” And in Cantebury versus Spence (1972), it was emphasized that “. . . the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.” There were no exceptions except for emergency or incompetency. The most important element in obtaining informed consent is discussion of death, bodily harm, recovery and recuperation, and the possible complications. The patient should know all his options.

In the area of mental illness, how may consent be properly obtained when the mental illness of the patient is severe enough to render the patient incapable of consent? The standard used by the courts is the same as that for competency to stand trial—that is, to be able to understand the seriousness of the information that the doctor is required to give him and to make a decision based on that knowledge. If a patient is not competent to give consent, it can be given by the person *legally* responsible for the patient (Faber v. Olkon, 1953). In a pair of decisions the U.S. district court in Alabama held as unconstitutional a statute which allowed sterilization of mentally retarded

inmates at the behest of the superintendent and assistant superintendent of the institution, and set down guidelines for informed consent in such a situation, and for the review of that consent.[10]

Medicine, Psychiatry, and Liberty

Progress in the physical sciences and medicine has resulted in increased freedom, due to technological innovations, that make the quality of life less harmful and more enjoyable with the decline in sickness and premature death. Equally serious dangers have become more apparent in recent years, with resulting concern about overpopulation, pollution, surveillance, and behavior control.

Participation in Medical Research

Such studies fall into two categories: (1) therapeutic experiments conducted in the context of the traditional doctor-patient relationship; and (2) experiments that are aimed at acquiring knowledge of potential value to others but of no benefit to the research subjects themselves. The first category is covered by malpractice and contract law, as noted above. The second category of research, carried out to serve the scientific interests of the investigator, raises more difficult problems, with many uncertain ethical and legal questions. In 1971 the Public Health Service produced new guidelines (Department of Health, Education, and Welfare, 1971), including a

sophisticated discussion of the types of risk that may occur (such as physical, psychological, and social dangers), and it lucidly defined the differences between therapy and experimentation. Detailed criteria for informed consent were provided and exculpatory clauses were expressly prohibited.

Yet a number of problems about research remain unresolved. One is that of research on civil prisoners. Inmates often are enthusiastic about participation because they get paid, it relieves monotony, and it implies earlier release. It is doubtful whether truly noncoerced consent can be obtained from prisoners. A prisoner in Michigan, diagnosed as dangerous and chosen as a subject for psychosurgery, was *not* allowed to be a subject although he himself was strongly in favor of it. In this case, a panel of experts and the state agreed that there could be no true consent to this procedure for this prisoner (Rawls, 1971). One argument for research on prisoners is that society needs to understand and control dangerous and/or repetitive criminal behavior. Many and at times extreme approaches have been suggested, including lithium therapy (Sheard, 1971), in-depth electrode placement, and ablation of parts of the brain (Maletsky, 1973; Mark, 1970; Rawls, 1971). This is all being proposed on the basis of a behavioral complex characterized by episodic “violent” behavior (Maletsky, 1973; Mark, 1970; Monroe, 1970). As discussed above, it remains theoretically possible and practically valid to have therapeutic experiments aimed at controlling violent behavior so that offenders might lead more free and satisfying lives.

Nevertheless, there should be absolute freedom from coercion. Methods by which acceptable research can be carried out in this area are still being devised.

More subtle are the ethical questions (Medical Tribune, 1973) raised concerning the use of long-acting medications or electrode implantation in the control of psychosis, epilepsy, and other behavior. Such medication, once injected, can affect the individuals for weeks and possibly months. How, and when and to what extent such medications should be used experimentally or therapeutically requires continuing discussions of public policy.

Another set of unresolved problems concerns research on subjects who are incapable of giving informed consent. This includes children and the mentally incompetent. Should any hazardous research be carried out on these groups? If so, who should provide consent and under what limitations? What standards should govern nonhazardous but painful studies? Still further, to what extent has the burden of research participation been lifted from the indigent hospitalized? What about mass testing of drugs by American companies in countries other than the United States?

Lastly, what threats to civil liberties are inherent in the medical process of organ transplantation? Serious questions regarding the definition of death, the choice of subjects, and the equitable distribution of scarce biological

resources are raised. The newest development in medicine is the possibility of producing human beings through a type of asexual reproduction known as "cloning." If it becomes feasible to produce such individuals, what are the consequences for them as well as for the rest of us?

Freedom to Be Wrong, Freedom to Die

As medical science progresses and its technological assets increase, there is an increasing illusion that the power of the physician over illness and death is absolute. Because of this the physician, when confronted with not knowing what to do, usually responds with a massive use of technological supports as a means of handling his own anxiety. This often results in a maintenance of metabolism but of little else that resembles life as we ordinarily experience it. Patients who do not wish to be treated or saved should have the right to make that decision. Each person should be able, when possible, to die in his own way and in his own place, as long as he brings no harm to others (Lerner, 1970). As populations live longer, physicians have an increasing proximity to death as a part of life (Barton, 173).

To insure a dignified death, the patient should have the right to know the truth, to experience human company and caring, to share in the decisions, and to be unmolested if that is his wish. Should the patient be incapable of communication, comatose, senile, or mute, it is suggested that the physician

act in a way that he believes would be consistent with the patient's wishes (Kass, 1972). Since euthanasia (Furlow, 1973), in relation to the hopeless and terminal patient, has become more of an issue as the number of such individuals increases, there have been renewed discussions of its ethical and moral implications. The more we know, the more difficult the questions become. In attempting to determine the possible limits of human behavior, concern with maintaining optimal freedom should be central. In that regard, the words of Supreme Court Justice Louis Brandeis are instructive (Olmstead v. United States):

> Experience should teach us to be most on guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberties by evil-minded rulers. The greatest danger to liberty lurks in insidious encroachment by men of zeal, well-meaning hut without understanding.

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Notes

1 This Mental Health code has been modified since 1963. For comparison see 111. Rev. Stat. Chap. 91 1/2, Sects. 1-17, 1952.

2 See The Narcotics and Drug Abuse Task Force Report, in which civil commitment is tentatively recommended (President’s Commission on Law Enforcement, 1967, p. 17).

3 Donaldson v. O'Conner, 493 F2d 507, (5th circuit), 1974

4 Wyatt v. Aderholt, 493 F2d 712, (5th circuit), 1974

5 See also "APA Favors ALI Test of Criminal Responsibility," Psychiatr. News, 6 (1971).

6 See also "APA Favors ALI Test of Criminal Responsibility," Psychiatr. News, 6 (19 7 1) .

7 See references 82 [pp. 347- 351], 129, 143 [pp. 84-88, 2 18], 154 [pp. 778-798], and 183 [p. 151].

8 As of early 1975: S 1-1975, Report by Committee on the Judiciary of the United States Senate. Federal Criminal Code, Chapt. 23, Sect. 2302 (b).

9 Murder, second degree; arson; forcible rape; robbery while armed with a deadly weapon; mayhem; bombing of an airplane, vehicle, vessel, or other structure.

10 Wyatt v. Aderholt, 368 F Supp. 1382, 1973 Wyatt v. Aderholt, 368 F Supp. 1383, 1974.