

# Chapter 67

## Psychiatric Patients and Forensic Psychiatry

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Psychiatry and Criminal Law  
Psychiatric Malpractice  
Civil Rights

### PSYCHIATRY AND CRIMINAL LAW

The purpose and rationale for the system of criminal justice in the United States are based on four fundamental concepts: isolation, retribution, deterrence, and rehabilitation.

As far back as biblical times, the issue of crime and punishment was premised on the notion of intent. The idea of wrongful or criminal guilt inherently required two elements: (1) that the wrongdoer commit an act or misdeed and, more important, (2) that the act was the product of a willing and rational intent. In other words, a crime is made up of two essential components: (1) voluntary conduct (*actus rea*) and (2) intent or guilty mind (*mens rea*).

An exception to a finding of criminal guilt historically has been reserved for minors and mentally disabled persons. In Babylonian times, for example, Jewish law held that “it is an ill thing to knock against a deaf mute, an imbecile or a minor: he that wounds them is culpable, but if they wound others they are not culpable.”<sup>1</sup> Centuries later, a secular pronouncement was contained in the *Justinian Digest*:

*There are those who are not to be held accountable, such is not a madman and a child who is not capable of malicious intention: these persons are able to suffer a wrong but not to produce one. Since a wrong is only able to exist by the intention of those who have committed it, it follows that these persons, whether they have assaulted by blows or insulted by words, are not considered to have committed a wrong.*<sup>2</sup>

In 1265 Bracton, Chief Justice of England, wrote the first systematic treatise on English law and in it stated that neither child nor “madman” could be liable because both lacked the felonious intent necessary for an act to be considered criminal. He likened the acts of an insane person, lacking in mind and reason, to be not far removed from that of a brutish animal.<sup>3</sup> Other notable jurists, including Lord Hale, Chief Justice Mansfield, and Chief Justice Holmes in the United States, have all recognized the need to excuse from criminal responsibility any person incapable of forming the requisite criminal intent.<sup>4</sup>

### Competency to Stand Trial

Society’s sense of morality dictates that an individual who is unable to comprehend the nature and the object of the proceedings against him or her, to confer with counsel, and to assist in the preparation of his or her own defense may not be subjected to a criminal trial. The oft-quoted legal theorist, Blackstone, in defining this common law rule said:

*If a man in his sound memory commits a capital offense, and before arraignment for it, he becomes mad, he ought not be arraigned for it; because he is not able to plead to it with that advice and caution that he ought. And if, after he has pleaded, the prisoner becomes mad, he shall not be tried; for how can he make his defense?*<sup>5</sup>

Borrowing from this common law principle, one of the fundamental tenets of American jurisprudence is the entitlement of every defendant to be afforded a fair and adequate hearing. For this requirement of fairness to be effectuated, the individual litigant must be capable of meaningful participation in the ongoing events of the legal process. The requirement that a litigant be competent to stand trial is of such moral and philosophical importance to the system of justice that it is considered a fundamental element and recognized as a constitutional right. In *Pate v. Robinson* the Supreme Court held “that the failure to observe a defendant’s right not to be tried or convicted while incompetent to stand trial deprives him of his due process right to a fair trial.”<sup>6</sup>

Despite the constitutional recognition that a defendant must be competent at the time of the trial, the determination and parameters of this fundamental principle have been the source of continued ambiguity. For example, such common mental status criteria as orientation to time and place and the capacity to recollect past events have been found to be insufficient in determining trial competency. Various states have established standards by which to measure a defendant’s competency to stand trial. At a bare minimum, it is sufficient to say that the fundamental fairness of law requires at least a finding of competency consistent with the test developed in *Dusky v. United States*:

## 622 Psychiatric Patients and Forensic Psychiatry

“[T]he test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational as well as factual understanding of the proceedings against him.”<sup>7</sup>

As seen from the general nature of this test, dispute and controversy are not uncommon in a case where a defendant’s capacity is at issue. Although numerous federal and state decisions have sought to devise a more objective test, none has been totally successful. As a rule, any substantial impairment that interferes with a defendant’s capacity to communicate, testify coherently, or follow the proceedings of the trial with a “reasonable degree of rational understanding” leads to a determination of incompetency.

The determination of competency is essentially a three-fold procedural process. The first step can be characterized as the *trigger stage*. Both the prosecution and the defense, as well as the court, may raise or trigger the issue of incompetency whenever there is a suggestion that the defendant may not be competent to stand trial. In fact, the trial court is under constitutional obligation to recognize and respond to any evidence that the defendant may not be mentally fit for trial. Once the issue has been raised, neither the defendant nor counsel can waive the issue and have the case brought to trial. Fundamental fairness of law requires that a defendant be competent throughout a trial.<sup>8</sup>

After the issue of a defendant’s competency is raised, common procedure is for the court to appoint one or more independent experts to conduct a psychiatric examination. Two issues, one procedural and one substantive, are important to note. Although in most jurisdictions a question of competency automatically triggers an impartial psychiatric examination, a defendant has no constitutional right to one. Also, the function of a competency evaluation, as opposed to an insanity defense evaluation, is that the sole issue to be decided is whether the defendant is sufficiently competent “at that time” to proceed in his or her own defense during the trial. Evidence of incompetency, insanity, or other forms of incapacity during the commission of the crime is not germane to the question of competency to stand trial.

After the question of competency is raised, the court then determines whether there is *sufficient evidence* to justify a formal hearing. The importance of competency to participate in one’s own defense is so fundamental to the system of justice that a competency hearing can be held at any time during a trial proceeding. At this second stage the role of a psychiatrist is vital. Often the results of a psychiatrist’s examination are persuasive in the court’s determination of competency. In the federal court system and in some states, if a psychiatric examiner concludes that the defendant is likely to be incompetent, a judicial hearing on the issue is required. Although neither the U.S. Supreme Court nor any state has articulated clearly how much evidence of incompetency is necessary to compel a hearing, as a rule, evidence sufficient to raise a bona fide doubt will suffice the constitutional standards.<sup>9</sup> Once a hearing is offered, the defense must prove incompetency to stand trial by a preponderance of the evidence.<sup>10</sup>

There are several assessment instruments that have been developed to assist the forensic psychiatrist in evaluating a

defendant suffering from a mental disorder in determining his or her competence. Most of these instruments have limited utility because they test the defendant’s factual understanding of the legal process, rather than competence; therefore, assessment is primarily a clinical one by interview and mental status examination of the defendant.<sup>11</sup>

At a separate and distinct legal proceeding, the third stage, the *competency hearing*, takes place. Typically, the psychiatric expert who initially evaluated the defendant is the prime witness at this proceeding. A competency hearing is similar to and different from a normal trial in several respects. It is similar in that it is adversarial in nature. In addition to the findings of the court-ordered psychiatric expert, both the state and the defense may produce their own witnesses (lay and expert) regarding the defendant’s competency, along with any other evidence. Also, the defendant has a right to counsel and is permitted to cross-examine the other side’s witnesses. However, unlike a normal trial, the defendant has no options regarding adjudication before a judge or jury. A competency hearing is typically before a judge. Also, in most states the defendant must prove incompetency by at least a preponderance of the evidence, although in the federal courts the prosecutor must carry the burden. In another important distinction, because of the special circumstances in which a competency hearing is carried out, the defendant’s right to invoke the privilege against self-incrimination is narrowed. The U.S. Supreme Court in *Estelle v. Smith* concluded that a defendant may not claim the privilege against self-incrimination to prevent the examining psychiatrist from testifying about the defendant’s competency.<sup>12</sup> However, the court did rule that the privilege against self-incrimination (Fifth Amendment) may bar the disclosure of statements or any resulting psychiatric conclusions from those statements if they were made during the pretrial competency hearing or a subsequent sentencing proceeding.

Although the involvement of the psychiatric expert in this situation might appear to be curtailed, the contribution that expert findings and testimony make in a competency proceeding is invaluable to a system of fundamental justice.

The disposition of persons found incompetent to stand trial is procedurally uniform in the United States. However, differences in state statutes provide for a variety of rights and limitations. Traditionally, defendants found mentally incompetent to be tried were automatically referred to a state institution until they were found to be competent. In effect, a defendant’s stay in a mental hospital, often an institution for the criminally insane, could drag on indefinitely and often did. Release could be effectuated only if either the defendant was found to be competent, at which time trial proceedings would then be initiated, or the prosecution dropped the charges. In 1972 the landmark case *Jackson v. Indiana* addressed this traditional practice of indefinite commitment of defendants found incompetent to stand trial.<sup>13</sup> First, the court held that although automatic commitment in and of itself is not prohibited, the length of commitment could not exceed a “reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in

the foreseeable future.” Also, the court determined that the state would bear the burden of demonstrating progress in the attainment of competency, so that a defendant whose competency does not appear reasonably foreseeable must be either formally committed pursuant to standard civil commitment procedures or released.

Both the *Harper* and *Riggins* cases indicate that the Constitution permits involuntary antipsychotic medication to be administered to a defendant with mental disorder who is charged with a crime and is incompetent to stand trial, but only if the treatment is medically appropriate, unlikely to have side effects that would undermine the fairness of the trial, taking into consideration less intrusive alternatives, and is necessary to further important governmental interests. Courts, however, must assess these issues on a case-by-case basis and whether or not the medication is necessary to further those government interests while still being in the best interest of the patient defendant.<sup>14</sup>

## Insanity Defense

Probably no single issue in the annals of criminal law has stirred more controversy, debate, and comparison among laypersons, as well as jurists, than the insanity defense. The 1982 jury decision finding John Hinckley not guilty by reason of insanity for the shootings of President Reagan and three other persons stunned the nation, and this decision thrust back into the public consciousness questions regarding the viability and fundamental morality surrounding the defense.

By the mid-eighteenth century a significant attempt was made to apply some form of cognizable formula for determining insanity. Judge Tracy in *Rex v. Arnold* suggested that one of the essential requisites for determining criminal responsibility was whether the accused was able to distinguish “good from evil” at the time of the offense.<sup>15</sup>

Later in the century, Hawkins wrote an important treatise on the subject that revised this moralistic standard to the more cognitively based question of “right and wrong.”<sup>16</sup> Despite what appeared to be an improvement in providing some form of rule for evaluating insanity, the right-wrong test was short-lived.

In 1800 the interpretation of legal insanity broadened significantly with the inclusion of insane delusions as an acceptable ground for the defense. In *Hadfield’s Case* the addition of delusions, or false beliefs that are firmly held despite incontrovertible evidence to the contrary, was first accepted by the common law court.<sup>17</sup> Hadfield, a soldier who had suffered severe head trauma during the French wars, attempted to shoot King George III to attain martyrdom, which he was convinced was his destiny. Despite the lack of a “frenzy or raving madness,” his counsel contended that the delusion was the true character of insanity:

*These are the cases which frequently mock the wisdom of the wisest in judicial trials: because such persons often reason with a subtlety which puts in the shade the ordinary conceptions of mankind; their conclusions are just and frequently profound; but the premises from which they reason, when within the range of the malady, are uniformly*

*false—not false from any defect of knowledge or judgment; but, because a delusive image, the inseparable companion of real insanity, is thrust upon the subjugated understanding, incapable of resistance, because unconscious of the attack.*<sup>18</sup>

Following counsel’s argument, the court practically preempted the proceeding by ordering an acquittal. Some 40 years later a similar attempt was made on the lives of Queen Victoria and Prince Albert by Edward Oxford. Oxford, like Hadfield, suffered from the delusion of martyrdom and was also acquitted.<sup>19</sup> Despite the notoriety of these two cases, the application of the insanity defense based on delusional beliefs was not widely successful.

In 1843 a significant change in the legal rule used to determine insanity was created. In the trial of Daniel M’Naughten<sup>20</sup> the defendant expressed feelings of great persecution by the pope and Tories, the political party in power at that time. To rid himself of this torment, M’Naughten decided to kill Sir Robert Peel, the prime minister. Not knowing Peel by sight, M’Naughten lay in wait at his residence and mistakenly shot his secretary, Henry Drummond, who was leaving the prime minister’s home. In addition to the numerous medical experts who all testified to M’Naughten’s insanity, the court also summoned two physicians who were simply observing the trial. Because neither physician was partisan to the proceedings, both were afforded a special degree of credence. On their unanimous conclusion that the defendant was indeed insane, Chief Justice Tindal halted the proceedings, and the jury promptly found M’Naughten “not guilty by reason of insanity.” Several days after the verdict, Queen Victoria, herself the target of assassination by the insanity acquittee Edward Oxford, summoned the House of Lords to a special session. The Lords were instructed to clarify and more strictly define the standards by which a defendant could be acquitted by reason of insanity. Out of this session the so-called M’Naughten rule was developed.<sup>21</sup> This rule provides the following:

*The jurors ought to be told in all cases that every man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary can be proved to their satisfaction; and that, to establish a defense on the ground of insanity, it must be clearly proved, that, at the time of the committing of the act, the party accused was labouring under such a 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, that he did not know he was doing what was wrong.*<sup>22</sup>

In essence, the M’Naughten rule, often referred to as the “right-wrong” test, has three elements that must be proven to establish insanity. The accused, at the time of the crime, must be suffering from some mental illness that caused a defect of reason such that he lacked the ability to understand the nature and quality of his actions or their wrongfulness.

Thus passed the eighteenth-century “good-evil” standard into the right-wrong test of the nineteenth century. Moreover, the M’Naughten decision marked the advent of the psychiatric expert witness as the key figure in defenses

## 624 Psychiatric Patients and Forensic Psychiatry

based on insanity. Henceforth, psychiatrists would be afforded special latitude in offering retrospective opinions regarding the defendant's state of mind at the time of the offense, whether his or her conduct emanated from some form of mental disorder, and whether the defendant was unable to know that his conduct was wrongful due to mental disorder.

For more than a century the M'Naughten test served as the basic standard by which the insanity defense was judged in the United States and Great Britain. Even today a significant minority of states still apply it in its original form. Despite its extensive utility, it was later criticized. Even with its fairly broad language, the M'Naughten test was often narrowly construed as an evaluation of a defendant's cognitive capacity to distinguish right from wrong. Furthermore, its scope of application was greatly influenced by the perception of many psychiatrists that the concept of disease of the mind encompassed only psychosis, to the exclusion of other pathologies.

As advances in psychiatric theory were made, the M'Naughten rule came under increasing attack as being antiquated. The major argument was that some forms of mental illness affect a person's volition or power to act without impairing cognitive functioning. In other words, although many mentally ill individuals might be able to distinguish between right and wrong, they could not control their wrongful actions. To rectify this perceived deficiency, a number of states broadened the M'Naughten rule to include an additional element known as the "irresistible impulse" test.<sup>23</sup> The irresistible impulse test in essence stated that even though an individual might understand the nature and quality of his or her act and the fact that it is wrong or unlawful, he or she is nonetheless compelled to commit the act because of mental illness. This test basically rests on four assumptions:

*[F]irst . . . there are mental diseases which impair volition or self control, even while cognition remains relatively unimpaired; second. . . the use of M'Naughten rule alone results in findings that persons suffering from such diseases are not insane; third. . . the law should make the insanity defense available to persons who are unable to control their action, just as it does to those who fit M'Naughten; fourth, no matter how broadly M'Naughten is construed there will remain areas of serious disorders which it will not reach.<sup>24</sup>*

Regardless of whether the irresistible impulse test was developed by state statute or case law, it was never used as a sole standard but as a modification of the M'Naughten test.

Despite the addition of the irresistible impulse concept to the determination of insanity, this too was believed to be too narrow in light of contemporary psychiatry. In 1954, Judge Bazelon, writing for the U.S. Court of Appeals for the District of Columbia in the decision on *Durham v. United States*, rejected the M'Naughten rule as too limited and held the following:

*We find as an exclusion criterion the right-wrong test is inadequate in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is*

*based upon one symptom and so cannot validly be applied in all circumstances. We find that the "irresistible impulse" test is also inadequate in that it gives no recognition to mental illness characterized by brooding and reflection and so delegated acts caused by such illness to the application of the inadequate right-wrong test. We conclude that a broader test should be adopted.<sup>25</sup>*

Accordingly, the court articulated a broader standard that provided that "[a]n accused is not criminally responsible if his unlawful act was the product of a mental disease or defect." Apparently, the purpose of the Durham rule,<sup>26</sup> with the description of mental disease or defect deliberately vague, was to afford greater flexibility to psychiatric testimony to circumvent narrow or psychiatrically inapposite legal inquiries.<sup>27,28</sup> As expected, the Durham rule, or New Hampshire rule as it was sometimes called, created considerable controversy because of its ambiguity and semantically indefinite meaning. It was never widely accepted in the legal system and was adopted in only three jurisdictions: New Hampshire, Maine, and the District of Columbia. Ultimately, the same Court of Appeals for the District of Columbia that created it abolished the Durham rule in 1972.

In the early 1960s the American Law Institute (ALI) drafted a model provision intended to reasonably bridge the narrowness of the M'Naughten rule and the expansiveness of the Durham rule. Incorporated in its Model Penal Code, the ALI standard stated the following:

*A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.<sup>29</sup>*

The ALI test differs from the M'Naughten standard in three ways. First, it incorporates a volitional element to insanity, thereby providing an independent criterion, the ability (or inability) to control one's conduct. Second, the ALI substitutes with the phrase, "lacks substantial capacity to appreciate the wrongfulness of conduct," which in effect takes into account a defendant's affective or emotional state instead of simply cognitive comprehension. Finally, the ALI standard does not require a total lack of appreciation of the nature of the defendant's conduct but instead that only "substantial capacity" is lacking. Arguably, the ALI test embraces a broader spectrum of psychiatric disorders sufficient to trigger the insanity defense because it contemplates mental defects as well as diseases.

The ALI test is accepted in a majority of jurisdictions and has been frequently cited as being considerably more applicable than its predecessors. For example, its incorporation of both a cognitive and a volitional element of impairment is viewed as more consistent with the contemporary conceptualization of mental illness in general. Its move away from total (e.g., M'Naughten) to substantial incapacity also appears to be realistic in terms of modern psychiatry. It broadens the role of the psychiatric expert by providing additional questions to be addressed, while leaving the responsibility of the ultimate decision up to the jury.

The ALI standard, despite its improvements in incorporating language indicative of advances in modern psychiatry, leaves the interpretation of “mental disease or defect” wide open. To address this ambiguity, most courts have relied on the definition provided in the case *McDonald v. United States*.<sup>30</sup> In *McDonald* the court defined mental disease or defect as “any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls.”<sup>31</sup> This definition was created to help clarify the Durham standard but turned out to provide guidance for courts using the ALI rule. It is important to keep in mind that the insanity defense under the ALI standard is a two-pronged test. In addition to providing the existence of a mental disease or defect, the defendant then had to show that the disease or defect so impaired judgment that he or she was not able to conform conduct to the requirements of the law (volition element).

In 1984, Congress enacted its first legislation, the Insanity Defense Reform Act of 1984, addressing the insanity defense:

*(a) Affirmative Defense. It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality of the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.*

*(b) Burden of Proof. The defendant has the burden of proving the defense of insanity by clear and convincing evidence.*

## Abolition of the Insanity Defense

Before 1930, Washington, Mississippi, and Louisiana had tried without success to do away with the insanity defense. Even before then, as well as after, numerous commentators had sought to abolish the defense.<sup>32,33</sup>

In 1979, Montana became the first state to constructively limit the use of an insanity plea. It amended its Code of Criminal Procedure to delete the section recognizing the insanity defense, which was substantially consistent with the ALI standard. The legislature substituted a new section that limited the relevancy of mental disease to the determination of *mens rea* of criminal intent. The Montana section stated: “Evidence that defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a state of mind which is an element of the offense.”<sup>34</sup>

Three years later Idaho explicitly abolished the use of insanity as a separate defense to charges of criminal acts. As in Montana, however, the Idaho statute recognized that a defendant’s mental state may be relevant to the issue of criminal intent:<sup>35</sup> “[N]othing herein is intended to prevent the admission of expert evidence on the issue of *mens rea* or any state of mind which is an element of the offense, subject to the rules of evidence.”<sup>36</sup> Alabama and Utah have followed similar courses in either restricting a plea of insanity to the question of criminal intent or abolishing it altogether.

As alluded to earlier, the change in Montana and Utah to a *mens rea* approach in effect is a constructive abolition of the use of insanity as a defense because a person must be found so impaired that he or she is incapable of forming the intent to commit the act. For example, if a defendant purposefully shoots and kills a person, the defendant will not avoid criminal responsibility by claiming that his or her conduct was the result of a hallucination, delusion, or some form of thought disorder. A *mens rea* statute would only relieve persons of responsibility if they were unable to form the requisite intent to commit the crime. To establish the lack of intent, it would be necessary to demonstrate that the defendant was completely unaware of what he or she was doing or did not believe the act being committed (shooting a gun at victim) was actually taking place. A common illustration is that the defendant believed the gun was a banana and that he or she wasn’t trying to kill the victim but instead was only squirting the victim with banana seeds.

This degree of impairment indicates the narrowness of the *mens rea* approach. For any more than a handful of all insanity acquittees each year to be found nonresponsible under this standard is highly doubtful. John Hinckley, Monte Durham, Daniel M’Naughten, Hadfield, and any number of other notable defendants whose insanity trials helped shape the insanity law in this area certainly would not qualify.

Despite this fact, proponents for abolishing the insanity defense argue that there is no constitutional requirement that a defense of mental illness exist at all.<sup>37</sup> Furthermore, allowances for the lack of *mens rea* comport with the historically held tenet that fundamental morality requires exculpation when a person truly does not know what he or she is doing. It is also argued that the *mens rea* standard is much easier to administer, thereby reducing the likelihood of confusion and complications frequently arising from contradictory expert testimony. Similarly, abolitionists and proponents of the *mens rea* test contend that an individual’s mental state at the time of the crime still would be considered with regard to treatment, rather than penal alternatives.

The U.S. Justice Department recommended a comprehensive set of changes affecting a variety of areas in criminal justice. Entitled the Comprehensive Crime Control Act of 1984, several provisions pertaining to the insanity defense were included:<sup>38</sup> (1) limiting the (insanity) defense to those who are unable to appreciate the nature or wrongfulness of their acts, (2) placing the burden (of proof) on the defendant to establish the defense by clear and convincing evidence, (3) preventing expert testimony on the ultimate issue of whether the defendant had a particular mental state or condition, and (4) establishing procedures for federal civil commitment of a person found not guilty by reason of insanity if no state will commit defendant.

## Guilty But Mentally Ill

In 1975 Michigan became the first state to adopt the alternative plea “guilty but mentally ill” (GBMI) or “guilty but

## 626 Psychiatric Patients and Forensic Psychiatry

insane" (GBI). Presumably dissatisfied with the definitional and procedural problems of the insanity defense and the belief that its abolition was not constitutionally sound, Michigan sought a compromise. Also, Michigan sought to decrease the number of successful insanity pleas in its courts, since a 1974 court held that insanity acquittees must be treated the same as civil committees.<sup>39</sup> In effect this 1974 ruling permitted a significant number of insanity acquittees to be released from hospitalization fairly quickly, which raised a concern for public safety. Several other states have enacted similar GBMI legislation, many because of the Hinckley decision.<sup>40</sup>

Because it is at the forefront of this alternative defense plea, Michigan's law has served as a model for other states. Therefore there is sufficient procedural commonality to permit generalization. When an insanity plea is entered, a psychiatric evaluation is required. At the conclusion of the trial, a jury is presented with four possible verdicts: (1) not guilty, (2) guilty, (3) not guilty by reason of insanity, or (4) guilty but mentally ill. The GBMI verdict requires a finding of three factors: the accused was (1) guilty of the crime, (2) mentally ill at the time the offense was committed, and (3) not legally insane at the time of the offense.<sup>41</sup> Most states adopting the GBMI plea require that these factors be proved by a preponderance standard (e.g., 51 out of 100 chances). After a finding of guilty but mentally ill, the court has the discretion to impose any sentence within the statutorily prescribed limits of the crime committed. Typically, sentencing is geared toward psychiatric care within the confines of a prison. If no treatment is available in prison, probation contingent on outpatient treatment is always an option.

Despite the appearance of a novel alternative incorporating both rehabilitative and retributive aspects, the GBMI plea has been heavily criticized, even in its home state.<sup>42</sup> Opponents of the plea state that it is exceedingly difficult to discriminate between a finding of guilty but mentally ill and not guilty by reason of insanity (NGRI) in light of the similarity in definition. A similar concern is that juries will misuse the GBMI plea out of ignorance, thereby finding a defendant guilty when an NGRI finding was more appropriate. Also, the title "guilty but mentally ill" is considered deceptive because it implies some form of mitigation but actually provides no special allowance.

Proponents who tout this alternative on humanitarian grounds because of the treatment element are often confronted by the fact that treatment is not guaranteed, but only part of a criminal sentence.

In effect then, despite a change in name and arguably greater choice of alternatives, a jury's verdict of GBMI is basically no different for a defendant than a verdict of guilty.

## PSYCHIATRIC MALPRACTICE

The development and emergence of malpractice lawsuits against psychiatrists have been very gradual and seemingly of recent occurrence. Before 1970, civil actions for psychiatric-related injuries were relatively rare. As a medical specialty,

psychiatry was considered almost immune from lawsuits because it was a difficult area to build a case against a practitioner.

Malpractice actions against psychiatrists have steadily increased since the early 1970s, but this fact must be seen in context. The incidence of claims against psychiatrists still remains much lower than against other physicians,<sup>43</sup> and most claims do not result in successful verdicts against the psychiatrist.

Along with the incidence of malpractice actions, the variety of claims against psychiatrists has also increased. Some causes of action reflect acts of negligence or substandard care for which any physician may be found liable. These malpractice areas include negligent diagnosis, abandonment from treatment, various intentional and quasi-intentional torts (assault and battery, fraud, defamation, invasion of privacy), failure to obtain informed consent, and breach of contract. Areas of liability specific to psychiatry include harm caused by organic therapies (electroconvulsive therapy [ECT], psychotropic medication, psychosurgery), breach of confidentiality, sexual exploitation of patients, failure to control or supervise a dangerous patient or negligent release, failure to protect third parties from potentially dangerous patients, false imprisonment, and negligent infliction of mental distress. These claims represent the major causes of action that may be brought against a psychiatrist.

Malpractice actions based on a psychiatrist's use of psychotropic drugs have been fairly infrequent considering the widespread use of this form of treatment during the past 20 years. However, a study of claims filed between 1972 and 1983 against psychiatrists showed that 20% of the actions were related to medication.<sup>44</sup> With managed care, more frequent utilization of the psychiatrist as the prescriber of medication with the psychotherapy, and primary care parceled out to psychologists and other non-medical therapists, more actions based on medication can be expected.

Relatives of patients who have committed suicide by taking an overdose of medication often file suit, claiming that the psychiatrist was negligent in prescribing the drugs. In the treatment of suicidal patients a delicate balance exists between providing clinical treatment, which involves certain risks, and applying protective, less therapeutic measures. In recognition of this balance, a psychiatrist will not automatically be found liable if a patient commits suicide with medication provided for treatment. Negligence is likely to be found in high-risk situations in which either the psychiatrist's choice of intervention (e.g., medication) or manner of supervision was unreasonable under the circumstances.

The *Clites v. Iowa* case is one of the first decisions specifically dealing with *tardive dyskinesia* (TD) and aptly illustrates some of the liability considerations inherent in the issue of drug therapy.<sup>45</sup> The plaintiff was a mentally retarded man, who had been institutionalized since age 11 and treated with major tranquilizers from age 18 to 23. TD was diagnosed at age 23, and the plaintiff subsequently sued. He claimed that the defendants had negligently prescribed medication, failed to monitor its effects, and had

not obtained his informed consent. A damage award of \$760,165 was returned and affirmed on appeal. The court ruled that the defendants were negligent because they deviated from the standards of the “industry.” Specifically, the court cited a failure to administer regular physical examinations and tests; failure to intervene at the first sign of TD; the inappropriate use of drugs in combinations, in light of the patient’s particular condition and the drugs used; the use of drugs for the convenience of controlling behavior rather than therapy; and the failure to obtain informed consent.

## Breach of Confidentiality

The duty to safeguard the confidentiality of any communication in the course of psychiatric treatment is the cornerstone of the profession. This obligation of confidentiality is fundamental, but none is more keenly sensitive to its importance than mental health professionals. This point is aptly reflected in the ethical codes of the various mental health organizations. For example, Section 4 of the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* reads in part as follows:

*A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences within the constraints of the law. . . confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. . . . Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about the patient. The welfare of the patient must be a continuing consideration.*<sup>46</sup>

In essence, confidentiality refers to the right of a person (e.g., patient) not to have communications revealed without authorization to outside parties. The issue of confidentiality in a psychiatric perspective embodies two fundamental rationales. First, a patient has a right to privacy that should not be violated except in certain legally prescribed circumstances. Second, physicians have historically been enjoined (on an ethical basis) to maintain the confidences of their patients. In doing so, patients should feel more comfortable revealing information, which would enhance their treatment.

Psychiatrists have always been susceptible to ethical sanctions if they breach patient confidentiality, but liability for monetary damages is a relatively recent development. Several legal theories allow a patient plaintiff recovery for breach of confidentiality. Besides statutory bases, some courts have upheld a cause of action based on breach of confidentiality on a contract theory.<sup>47</sup> Accordingly, a psychiatrist is considered to have implicitly agreed to keep any information received from a patient confidential, and when he or she has failed to do so, there is a breach of that implied contract term by the psychiatrist. In cases based on this theory, damages typically have been restricted to economic

losses flowing directly from the breach, but compensation based on any residual harm (e.g., emotional distress, marital discord, loss of employment) is precluded.<sup>48</sup>

Theories based on invasion of privacy have supported recovery involving breach of confidentiality. The law defines invasion of privacy as an “unwarranted publication of a person’s private affairs with which the public has no legitimate concern, such as to cause outrage, mental suffering, shame, or humiliation to a person of ordinary sensibilities.”<sup>49</sup> This theory has limited appeal to plaintiffs in jurisdictions requiring a public disclosure of personal facts as opposed to disclosure to a single person or a small group.

A minority of courts has upheld claims for breach of confidentiality based on breach of fiduciary duty of the psychiatrist.<sup>50</sup> Similarly, claims based on violations of medical licensing statutes and physician–patient privilege statutes have provided remedies for unconsented disclosures of confidential information,<sup>51</sup> although with limited success. Such actions, when successful, are presumably based on public policy grounds.

In many states the legal duty to maintain patient confidentiality is governed by mental health confidentiality statutes. These statutes outline the legal requirements covering confidentiality. For example, the Illinois Mental Health and Developmental Disabilities Confidentiality Statute contains 17 sections covering the duty of confidentiality, exceptions to it, rules and procedures for authorizing disclosures, patient and third-party access rules, penalties or violations, and provisions for civil actions by parties injured by unauthorized disclosures.<sup>52</sup>

## Failure to Warn or Protect

Confidentiality was considered sacrosanct by the psychiatric profession until the Supreme Court of California heard the case *Tarasoff v. Regents of the University of California* in 1976.<sup>53</sup> *Tarasoff* involved a university student from India who became obsessed with a young woman (Tatiana Tarasoff) he met at a dance. She clearly indicated that she had no interest in the young man. Following this rejection, he began individual therapy at the university counseling center. After several sessions the treating psychologist concluded that his patient might try to harm Ms. Tarasoff. The psychologist enlisted the aid of the campus police to detain the patient to ascertain his eligibility for civil commitment. The police interviewed the patient and concluded that he was rational. Based on his assurances that he had no desire to harm Ms. Tarasoff and would refrain from seeing her, they decided not to detain him. The supervising psychiatrist for the case reviewed the facts to that point and concluded there was no basis for commitment. The patient terminated treatment, and 2 months later killed Tatiana Tarasoff.

Tatiana’s parents filed a wrongful death action against the university, the treating psychologist, the supervising psychiatrist, and the campus police. The plaintiffs asserted that the defendants owed a “duty to warn” Tatiana of the impending danger that the patient posed to her. The California Supreme Court agreed. In affirming but

## 628 Psychiatric Patients and Forensic Psychiatry

modifying their earlier holding (1974) the court held the following:

*[W]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. . . . Thus [the discharge of this duty] may call for [the therapist] to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.*

The reaction to both decisions, referred to as *Tarasoff I* and *Tarasoff II*, was immediate, forceful, and frequently vehement. The majority of the early commentary, especially from the psychiatric profession, was critical of the numerous unanswered questions left by the California court. This new theory of liability imposed questions such as the following: Was a duty owed if the threat of danger was not aimed at anyone in particular? What steps did a psychiatrist or therapist have to take to discharge the duty? Was a duty to warn still owed if the potential victim was already aware of the patient's threat or dangerous propensities? How was a therapist's determination of dangerousness to be judged if the profession itself disclaimed the ability to accurately predict future behavior? In some cases these and other questions have been addressed in piecemeal fashion by the numerous "duty to warn/protect" decisions since *Tarasoff*.

The response by the courts following the 1976 California decision has been inconsistent and, at times, confusing. Several courts have followed the holding of *Tarasoff*, concluding that a therapist was liable for not warning an identifiable victim. For example, courts in Kansas and Michigan have ruled that the duty to warn was restricted only to readily identifiable victims.<sup>54</sup> A slightly broader but analogous limitation has been fashioned by decisions in Maryland and Pennsylvania, where the courts have recognized a duty to warn only when the victim is "foreseeable."<sup>55</sup>

The second case to apply the *Tarasoff* ruling, *McIntosh v. Milano*, added a slightly broader twist to the duty-to-warn theory.<sup>56</sup> In *McIntosh* a 17-year-old patient fatally shot a young neighborhood woman. Evidence revealed that the patient had disclosed to the defendant psychiatrist feelings of inadequacy, fantasies of being a hero or important villain, and using a knife (which he brought to therapy one session) to intimidate people. The patient also shared that he had once fired a BB gun at a car in which he thought the victim was riding with her boyfriend. However, the psychiatrist denied that the patient had ever expressed any feelings of violence or made any threats to harm the victim. The parents of the victim claimed that the psychiatrist knew the patient was dangerous and owed a duty to protect the victim. The New Jersey court, in denying a motion for summary judgment, agreed and held that *Tarasoff* applied, based on the therapist-patient relationship. The court found a more general duty to protect society that was analogous to a physician's duty to warn others (in the general public) of persons carrying contagious disease.

Representing the broadest expansion of the *Tarasoff* duty-to-warn theory was a Nebraska decision of *Lipari v. Sears, Roebuck and Co.*<sup>57</sup> A patient, who recently had dropped out of the Veterans Administration (VA) day treatment program, purchased a shotgun from Sears. He resumed treatment, only to drop out against medical advice approximately 3 weeks later. A month after the second termination he walked into a crowded nightclub and randomly discharged the shotgun, injuring the plaintiff and killing her husband. The plaintiff claimed that the VA should have known the patient was dangerous and that the VA was negligent for not committing him. The court held that Nebraska law recognized a duty to protect society, following the holdings of *Tarasoff II* and *McIntosh*. More significantly, they held that foreseeable violence was not limited to identified, specific victims but may involve a class of victims (e.g., the general public at large).

Two other cases, one in Washington State<sup>58</sup> and another in California, have expanded the duty to warn to include victims who were not specified or readily identifiable. In *Hedlund v. Orange County* the victim was a woman in couples therapy with a man with whom she lived.<sup>59</sup> During a session when she was not present, the man told the therapist that he planned to harm her. While in a car with her son next to her, the man shot at her. The woman sought damages for herself and her son, who, she claimed, suffered emotional harm. Rejecting the defendant's argument that they owed no duty of care to the young boy, the California court extended the duty to warn to foreseeable persons in close relationship to the specifically threatened victim.

Fifteen days before the *Hedlund* decision, the U.S. District Court in Colorado decided the case *Brady v. Hopper*.<sup>60</sup> The plaintiffs were all men who had been shot by John Hinckley during his attempted assassination of President Reagan. The plaintiffs alleged that the defendant's psychiatrist, John Hopper, knew or should have known that Hinckley was dangerous. Relying heavily on the *Lipari* decision, the plaintiffs claimed that the defendant should have known that the president was Hinckley's intended victim and that they were a class of people reasonably foreseeable to be at risk because of this danger. The court focused its decision on the issue of foreseeability of the risk to the specific plaintiffs involved. While affirming the duty of therapists to protect third parties, the court's conclusion was prefaced with the admission: "[T]he existence of a special relationship does not necessarily mean that the duties created by that relationship are owed to the world at large." In rejecting the plaintiffs' claims that the defendant was liable to them, the court concluded: "In my opinion, the specific threats to specific victims rule states a workable, reasonable, and fair boundary upon the sphere of a therapist's liability to third persons for the acts of their patients." Therefore, under *Brady*, a determination of dangerousness, in general, will not create a duty to protect without a specific threat to a specific victim. In December 1984 the Court of Appeals for the Tenth Circuit, in a three-page opinion, affirmed the district court's opinion in *Brady*.<sup>61</sup> In essence, it deferred to the discretion of the lower court, stating reversal only could be found if a gross error in the application of the law had occurred.

Cases to date involving some form of the duty-to-warn theory can be viewed as falling somewhere on a continuum based on two common factors: (1) a threat (or potential for harm) and (2) a potential victim. At one end is the *Brady* decision with its “specific threat specific victim” rule, and at the other end is *Lipari*, which held that “foreseeable violence” created a duty to protect “others,” regardless of whether the victim was identified or specified. In addition, decisions in Maryland, California, Pennsylvania, and Iowa have refused to apply the theory by either rejecting it outright or finding no liability based on the facts of the case.<sup>62</sup>

At present, most courts have held that in the absence of a foreseeable victim, no duty to warn or protect will be found. Reviewing the cases, a few facts stand out. Most notable is the relative absence of litigation that most commentators thought would occur after the *Tarasoff* decision in 1974.<sup>63</sup>

Whatever the extent of the duty imposed by the *Tarasoff* decision and its progeny, a psychiatrist or therapist cannot be held liable for a patient’s violent acts unless it is found that (1) the psychiatrist determined (or by professional standards reasonably should have determined) that the patient posed a danger to a third party (identified or unidentified) and that (2) the psychiatrist failed to take reasonable steps to prevent the violence.

The liability considerations that underlie the treatment and care of the dangerous patient generally differ according to the amount of control a psychiatrist, therapist, or institution has over the patient. As a general rule, psychiatrists who treat dangerous or potentially dangerous patients have a duty of care, which includes controlling that individual from harming other persons inside and outside the facility as well as himself or herself. On the other hand, the outpatient who presents a possible risk of danger to others creates a duty of care, which may include warning or somehow protecting potential third-party victims. Although some facts may require an expansion of the duty of care in one or the other setting (inpatient, outpatient), this general distinction is important to more clearly understand the legal issues and preventive considerations that the dangerous patient presents.

The duty of care owed to dangerous or potentially dangerous patients in an inpatient setting is very similar in principle to those duties governing the treatment of suicidal patients. Causes of action alleged by third parties injured by the dangerous or violent acts of an inpatient generally involve one of two situations. In one situation the inpatient is discharged and shortly thereafter harms a third party. The plaintiff sues whoever made the decision to discharge the patient, claiming that he or she was negligently released. In the second general situation an inpatient escapes from the hospital and then harms someone. The claim in this scenario is typically that the physician or facility in charge of the patient’s care was negligent in either supervision or control of the patient.

In both general scenarios the analysis for determining liability is similar. As in cases involving suicide, a treating psychiatrist or other practitioner cannot be held liable for harms committed after a patient’s discharge (e.g., negligent

release) unless the court determines (1) that the psychiatrist knew or should have known that the patient was likely to commit a dangerous or violent act and (2) that in light of this knowledge, the psychiatrist failed to take adequate steps to evaluate the patient when considering discharge. Similarly, in cases involving third parties injured by a dangerous patient who has escaped, the court evaluates (1) whether the psychiatrist knew or should have known that the patient presented a risk of elopement and (2) in light of that knowledge, whether the psychiatrist took reasonable steps to supervise or control the patient. Although the *Tarasoff* doctrine has been extended further than anticipated, the actions of a psychiatrist in a negligent discharge or negligent control or supervision claim are scrutinized based on the reasonableness of the actions and the standards of the profession.

## Sexual Exploitation

From a legal standpoint, the courts have consistently held that a physician or therapist who engages in sexual activity with a patient is subject to civil liability and in some cases to criminal sanctions. The reason for this overwhelming condemnation rests in the exploitative and often deceptive practice that sex between a health care professional (e.g., psychiatrist, physician, therapist) and patient represents. The fundamental basis of the psychiatrist–patient relationship is the unconditional trust and confidence patients have in the therapist. This trust permits patients to share their most intimate secrets, thoughts, and feelings. As therapy progresses, unconscious feelings of conflict, fears, and desires originating from important relations in the patient’s past are said to be “transferred” to the therapist in the present. This *transference phenomenon* is a common occurrence in psychotherapy and often provides a therapist valuable information to analyze and interpret. The transference phenomenon makes a patient vulnerable to the emotions being experienced, such as feelings of love. Therefore the therapist must conduct the treatment with sensitivity and care. A similar phenomenon, *countertransference*, occurs when a therapist experiences unconscious conflicts and feelings toward a patient. As with patient transferences, countertransference feelings should be recognized as important therapeutic information and analyzed to gain insight into how to better understand the patient.

In addition to civil sanctions, a practitioner may face criminal liability if there is evidence that some form of coercion, usually in the form of tranquilizing medication, was used to induce compliance or reduce resistance to the initiation of the sexual activity. A psychiatrist or other practitioner may be charged criminally if the sexual activity involves a child or adolescent patient. In a situation involving a minor, no evidence of force or coercion needs to be demonstrated to support a finding of criminal liability.

In the landmark case *Roy v. Hartogs*, expert testimony concluded that “there are absolutely no circumstances which permit a psychiatrist to engage in sex with his patient.”<sup>64</sup> However, some therapists do attempt to rationalize their actions. Some of the most common

## 630 Psychiatric Patients and Forensic Psychiatry

defenses, all of which to date have been rejected by the courts, include that the patient consented to having sex, that the sexual relation was not a part of treatment, or that the treatment ended before the sexual relations began.<sup>65</sup>

### Abandonment

Once an agreement (explicit or implicit) to provide medical services has been established, the physician is legally and ethically bound to render those services until the relationship has been appropriately terminated. If a physician terminates treatment prematurely and the patient is harmed by the termination, a cause of action based on "abandonment of treatment" may be brought. Generally, in the absence of an emergency or crisis situation, treatment can be concluded safely if a patient is provided reasonable notice of the termination and is assisted in transferring the care to a new physician. Proper transfer of care typically implies that the original psychiatrist or physician prepares and makes available the patient's records as needed by the new physician. It is also prudent for the original care provider to give the patient written and verbal notice to avoid any possible questions regarding the nature, timing, or extent of the announcement of termination. This is particularly important when treating psychiatric patients or persons who are psychologically vulnerable because there may be a tendency to misconstrue or deny a verbal notice.

The issue of abandonment frequently arises when either no notice of termination has been given or the extent of this notice has been insufficient in some way. Although there are no rules or guidelines per se regarding sufficiency of the notice, a therapist who decides to terminate treatment is expected to act reasonably. For example, if few therapists are available in the area to accept transfer of the patient's case, the treating therapist should afford the patient a longer notice period to locate a replacement. If a patient refuses or is unable to locate another therapist, however, the treating psychiatrist or therapist has no obligation to treat the patient indefinitely. The reasonableness of a therapist's notice therefore is judged on the totality of the relevant circumstances.

Patients who are experiencing some sort of crisis or emergency situation require special consideration. For example, a therapist who is treating a patient who is suicidal or presents a possible danger to some third party is not likely to be considered to be acting reasonably if he or she terminates treatment. From a clinical perspective, such a move may exacerbate a patient's already vulnerable feelings and prompt the patient to do something that he or she might not have otherwise done. Legally, the courts are not likely to consider a therapist's decision to terminate treatment reasonable during a time when care is required. Therefore a therapist should be wary of ending therapy during a period of emergency and instead should hold off termination until a more appropriate time.

### Patient Control and Supervision

The treatment of patients who pose a risk of danger to themselves or others presents a unique clinical and legal challenge to the mental health profession.

A lawsuit for patient suicide or attempted suicide is often brought by a patient's family or relatives claiming that the attending psychiatrist, therapist, or facility was negligent in some aspect of the treatment process. Specifically, there are three broad categories of claims that encompass actions stemming from patient suicide. The first is when an outpatient commits suicide or is injured in a suicide attempt. Plaintiffs in this situation claim that the psychiatrist or therapist was negligent in failing to diagnose the patient's suicidal condition and provide adequate treatment, which is typically hospitalization. The second situation is when an inpatient is given inadequate treatment and commits or attempts suicide. Typically, the essence of a negligence claim involving inadequate treatment is that the patient was suicidal and the psychiatrist failed to provide adequate supervision. The last general situation is when a patient is discharged from the hospital and shortly thereafter attempts or commits suicide. Family members, or the injured patient, frequently claim that the decision to release the patient was negligent.

The treatment of suicidal or potentially suicidal patients inherently requires a psychiatrist or other practitioner to make predictions regarding future behavior. The mental health profession has frequently disclaimed ability to predict future behavior with any degree of accuracy. As a result, the law has tempered its expectation of clinicians in identifying future dangerous behavior. Instead of a strict standard requiring 100% accuracy, the law requires professionals to exercise reasonable care in their diagnosis and treatment of patients at risk.<sup>66</sup> Accordingly, a court will not hold a practitioner liable for a patient's death or injury resulting from suicide if the treatment or discharge decision was reasonably based on the information available.

In an attempt to enhance the recovery of patients at risk of suicide, some hospitals use what is known as an *open ward policy*. This policy permits a patient considerable freedom of movement within the hospital and minimizes procedures that are constraining, such as seclusion, physical and chemical restraints, and constant observation. In some cases the courts have recognized the therapeutic value of this procedure and concluded that the professional is in the best position to balance the risks and benefits of increased patient freedom. In doing so, the courts have basically deferred to the judgment of the professional, even though the professional's decision may later prove to be wrong. This deferment to professional judgment is as much an acknowledgment of the difficulties psychiatrists face in attempting to predict future behavior as it is an acceptance of certain practices and procedures of modern psychiatry. A 1981 federal district court decision sums up its conclusion as follows:

*[M]odern psychiatry has recognized the importance of making every effort to return a patient to an active and productive life. Thus the patient is encouraged to develop her self-confidence by adjusting to the demands of everyday existence. Particularly because the prediction of danger is difficult, undue reliance on hospitalization might lead to prolonged incarceration of potentially useful members of society.<sup>67</sup>*

A few courts have refused to make such a deferment and instead have kept to the more traditional evaluation of the reasonableness of the precautions provided.<sup>68</sup> The issue of reasonableness, whether involving the diagnosis, supervision, or discharge of a patient, is usually measured in terms of the accepted standards of the profession. Expert testimony is needed to establish or disprove that the defendant psychiatrist failed to exercise the reasonable care other psychiatrists would have used in that or similar circumstances. The risk of liability is greatly enhanced when it can be demonstrated that a practitioner or institution failed to follow its own usual practices and procedures for treating a patient at risk for suicide.

## CIVIL RIGHTS

### Voluntary Hospitalization

Mentally ill persons can be admitted to a psychiatric hospital or institution in essentially two ways. The first is to be involuntarily committed. The other and more common means is for the individual to sign in voluntarily, which is similar to a patient entering a general medical facility. In other words, admission is effected through what is legally and clinically presumed to be a free and voluntary action on the part of the patient.

Voluntary or consensual hospitalization of the mentally ill person is a relatively new idea. Massachusetts enacted the first voluntary admission statute in 1881, but other states were slow to follow. By 1949, only 10% of all mental patients were voluntary admissions. For about the next 20 years, states struggled to amend and revise their commitment laws to define and establish realistic procedures for voluntary admission. By 1972 most psychiatric admissions were voluntary.

The purpose of voluntary hospitalization for mentally ill persons is to dispel the coercion, trauma, and stigma normally associated with involuntary hospitalization and to afford the same opportunity for treatment to mentally ill patients that is available to those with physical illness.

One issue of increasing importance in relation to the idea of voluntary hospitalization of the mentally ill person is the question of competency to consent. Presumably, the act of voluntarily entering a psychiatric hospital requires the patient to be legally competent to make such a decision. Many of the first statutes authorizing voluntary commitment made the requirement of competency a specific element. The rationale for such a strict requirement was, at least in part, to prevent clearly incompetent patients from being improperly manipulated by psychiatrists and mental hospitals.

More recent laws, however, designed to encourage voluntary admission and based on a theory that it ensures needed treatment, omit such requirements in most states. The dilemma regarding the issue of a patient's competency to be hospitalized voluntarily remains unresolved. To date, the question of whether a patient by voluntary admission must be competent to exercise an informed consent has not been authoritatively addressed by any court. This lack

of judicial scrutiny is largely a consequence of present-day voluntary admission procedures. A person who has been coerced into voluntarily signing in or lacks the capacity to fully comprehend the consequences of the application for admission is unlikely to have any grounds on which to raise either issue since, at any time, a request for discharge can be made. Such an individual would then be either released pursuant to that request or committed pursuant to state involuntary commitment statutes. In either event, at least in theory, the issue of invalid or improper voluntary admission would have been negated, thereby preventing any court from hearing the significant issues surrounding this aspect of the voluntary admission process.

## Involuntary Hospitalization

### Basis and Rationale

Involuntary hospitalization or civil commitment refers to state-imposed involuntary detention or restrictions of personal freedom based on a determination that a person is mentally ill and dangerous to self or others or is gravely disabled.

The institution of the civil commitment process is based on two fundamental common law principles. The first relates to the right of the government, provided by the U.S. Constitution to the individual states, to take whatever actions are necessary to ensure the safety of its citizens. Referred to as the *police power*, this authority is limited by the states' constitutions and by the Fourteenth Amendment of the U.S. Constitution.

The other rationale used to justify the involuntary commitment of mentally ill persons is the *parens patriae* doctrine. This concept, which denotes that the state is acting in place of the parent, prescribes that the "sovereign has both the right and the duty to protect the person and the property of those who are unable to care [for] themselves because of minority or mental illness."<sup>69</sup> From a practical perspective, numerous state statutes and case law, in an attempt to cut back the broadness of certain state commitment provisions, have either abolished the *parens patriae* rationale or made it contingent on a finding of dangerousness (e.g., thereby invoking the salient purpose of the police power).

### Commitment Standards

The civil commitment process can be viewed in terms of (1) the criteria or standards governing whether someone is committable and (2) the procedural rules regulating the process.

In most jurisdictions the basic criteria for involuntary civil commitment are the product of a statute. The wording and interpretation of the various commitment laws differ from state to state, but the standards for commitment are similar.

Typically, all states require an individual to demonstrate clear and convincing evidence of at least two separate and distinct elements. The first pertains to the individual's mental condition. Nearly every state requires a threshold finding that a person suffers from some mental illness,

## 632 Psychiatric Patients and Forensic Psychiatry

disorder, or disease. The second and often more critical requirement is a determination that some “specific adverse consequence” will ensue, as a result of the mental illness, if the person is not confined. Commonly couched in language such as “likely to harm self or others,” “poses a real and present threat of substantial harm to self or others,” or “dangerous to himself or others,” this element is frequently referred to in references as simply the “danger to self or others” requirement. In some states, such as Delaware and Hawaii, this element is extended to harm to property as well as persons.

Closely related to both the mental illness and dangerousness requirements is the standard of “gravely disabled.” This standard is somewhat similar to the mental condition requirement in that it typically applies to a person’s ability to provide self-care. This is not a uniform standard as are the other two criteria but represents an attempt by a minority of states to provide a broader description of the kind of manifest behavior that may prompt commitment. An example of a state statute applying the gravely disabled standard is the following:

*Gravely disabled means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital care is necessary and available and that such person is mentally incapable of determining whether or not to accept treatment because his judgment is impaired by his mental illness.<sup>70</sup>*

### Least Restrictive Alternative

Up to the late 1960s, a patient civilly committed to a state institution could expect to remain there for a major portion, if not the duration, of his or her life. Often criticized as mere human warehousing, the majority of mental institutions in America failed at achieving anything remotely therapeutic. Usually, the best that a civilly committed patient could hope for was bare-minimum custodial care. The thought of ever leaving the institution was a fleeting fantasy for many patients, and those who were discharged were rarely any better off than when they were admitted.

Patients legitimately committed due to mental illness and posing risk of danger might remain hospitalized long after the time when one or both of these conditions no longer existed. Because states rarely required the periodic evaluation of those civilly committed, however, a patient could literally waste away in the hospital despite no longer qualifying for detention. This situation represented a serious abridgment of the civil liberties of patients with mental illness and spurred considerable concern by libertarians, scholars, and civil rights activists.

In 1966 the case *Lake v. Cameron* (applying D.C. law) signaled a significant advancement in the recognition of civil rights of mentally disabled persons.<sup>71</sup> *Lake* involved the involuntary commitment of a 60-year-old woman diagnosed as senile but not considered a danger to herself or others. Writing for the majority, Chief Judge Bazelon held that a person could not be involuntarily committed to a psychiatric hospital if alternative placements could be

found that were less restrictive on a patient’s constitutional right to liberty. From this opinion the doctrine of the “least restrictive alternative” (LRA) was developed which, at least in theory, recognized and sought to protect the rights to liberty of patients who were so routinely ignored in the past.

After the *Lake* decision, numerous states adopted legislation requiring courts to consider less restrictive alternatives whenever appropriate. In the absence of statutory authority, several lower federal courts upheld the validity of the LRA doctrine based on implied constitutional grounds. This implied reasoning was addressed in the seminal case *Lessard v. Schmidt*:

*Even if the standards for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort. A basic concept in American justice is the principle that “even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in light of less drastic means for achieving the same basic purpose.”<sup>72</sup>*

The LRA doctrine has been applied to numerous other forms of restraining a patient’s liberty within the hospitalization process (e.g., the use of physical restraints and seclusion rooms). In extending the scope of the doctrine to other treatment procedures, respect for a patient’s civil rights is acknowledged, the hospitalization experience becomes less stigmatizing, and positive patient–staff relations are fostered.

Despite the social, therapeutic, and psychological value of the LRA doctrine, its application is subject to severe limitations. As Chief Judge Bazelon held in *Lake*, a less restrictive alternative must actually exist in order for the doctrine to apply.

From a practical standpoint this requirement presents a major setback in most cases because such less restrictive alternatives rarely are available. The practical value of the LRA doctrine therefore is limited unless the courts take the initiative to create, or order, alternative placements. In the absence of legislative authority, this development is unlikely.

### Rights of the Civilly Committed Patient

The right to treatment and habilitation, to the basic necessities of life, to refusal of treatment, and to treatment in the least restrictive environment have all been litigated and afforded varying degrees of protection.

The concept of a right to treatment was first articulated in 1960 when Dr. Morton Birnbaum proposed that:

*The courts, under their traditional powers to protect the constitutional rights of our citizens begin to consider the problem of whether or not a person who has been institutionalized solely because he is sufficiently mentally ill to require institutionalization for care and treatment actually does receive adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible; that the courts do this by means of recognizing and enforcing the right to treatment; and, that the courts do this, independent of any action by any legislature, as a nec-*

essary and overdue development of our present concept of due process of law.<sup>73</sup> [emphasis in original]

A constitutional right to treatment, or to “habilitation,” was held to apply to mentally disabled individuals in the landmark case *Wyatt v. Stickney*.<sup>74</sup> The court held that in the absence of the opportunity to receive treatment, mentally disabled individuals in institutions were not patients but were residents with indefinite sentences. Further, the court stated that basic custodial care or punishment was not the purpose of involuntary hospitalization. The purpose, they concluded, was treatment. In its subsequent opinions the court developed an extensive remedial plan that was intended to establish minimum constitutional standards for adequate treatment and habilitation of mentally disabled persons.

A second basic constitutional right, the right to liberty, was addressed in the Supreme Court decision *O'Connor v. Donaldson*.<sup>75</sup> Donaldson had been involuntarily confined in a state mental institution for almost 15 years and was suing the state for depriving him of his constitutional right to liberty. In the first award granted to a mentally ill patient based on a violation of constitutional rights, Donaldson received \$20,000 in damages. In addressing the deprivation of liberty that involuntary confinement imposed, the court concluded that three conditions had to be met to justify release: (1) the institution was not offering proper treatment; (2) the patient did not present a danger to self or others; and (3) the person was capable of living in the community with the assistance of family or friends. Although these narrow conditions were illuminated in later litigation, *Donaldson* laid the foundation for future constitutional litigation regarding the rights of the mentally ill.

The U.S. Supreme Court has not yet squarely addressed the issue of the right to refuse treatment. The issue of whether an involuntarily committed patient has a constitutional right to refuse treatment (antipsychotic medication) was before the high court in 1982 in *Mills v. Rogers*,<sup>76</sup> but it was sidestepped and sent back to a lower federal court for reconsideration.

Despite the Supreme Court's refusal to decide *Mills*, several lower federal courts have sought to resolve the issue of right to refuse treatment. In one of the most noted cases, *Rennie v. Klein*, the Court of Appeals for the Third Circuit affirmed the finding that a constitutional right to refuse treatment existed.<sup>77</sup> However, the appeals court differed from the lower court when it adopted a “least intrusive means analysis.” Under this analysis, antipsychotic drugs could be forcibly administered in a nonemergency situation to patients who had never been adjudicated incompetent, only if such treatment was the least restrictive mode of treatment available.

A year after *Rennie* the U.S. Supreme Court held in the landmark case of *Youngberg v. Romeo* that mentally retarded residents of state institutions had a constitutional right to the basic necessities of life, reasonably safe living conditions, freedom from undue restraints, and the minimally adequate training needed to enhance or further their

abilities to exercise other constitutional rights.<sup>78</sup> Of significant importance to future civil rights cases involving mentally disabled persons was the court's deference to the judgment of qualified professionals to establish minimal adequate training and to safeguard a patient's liberty interests. In seeking to minimize judicial interference in the daily administration of institutions, the court held that “liability may be imposed only when the decision is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”<sup>79</sup>

The full impact of *Youngberg* has yet to be determined, but at least one significant civil rights case, *Rennie v. Klein*, has been redefined because of it. In 1983 the Third Circuit Court of Appeals rejected the “least intrusive means analysis” and adopted the standard of “whether the patient constitutes a danger to himself or others” in determining whether medication can be forcibly administered.<sup>80</sup>

## Endnotes

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3. S. Grey, *The Insanity Defense: Historical Development and Contemporary Relevance*, 10 Am. Crim. Law Rev. 555 (1972).
4. *Id.*
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## 634 Psychiatric Patients and Forensic Psychiatry

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