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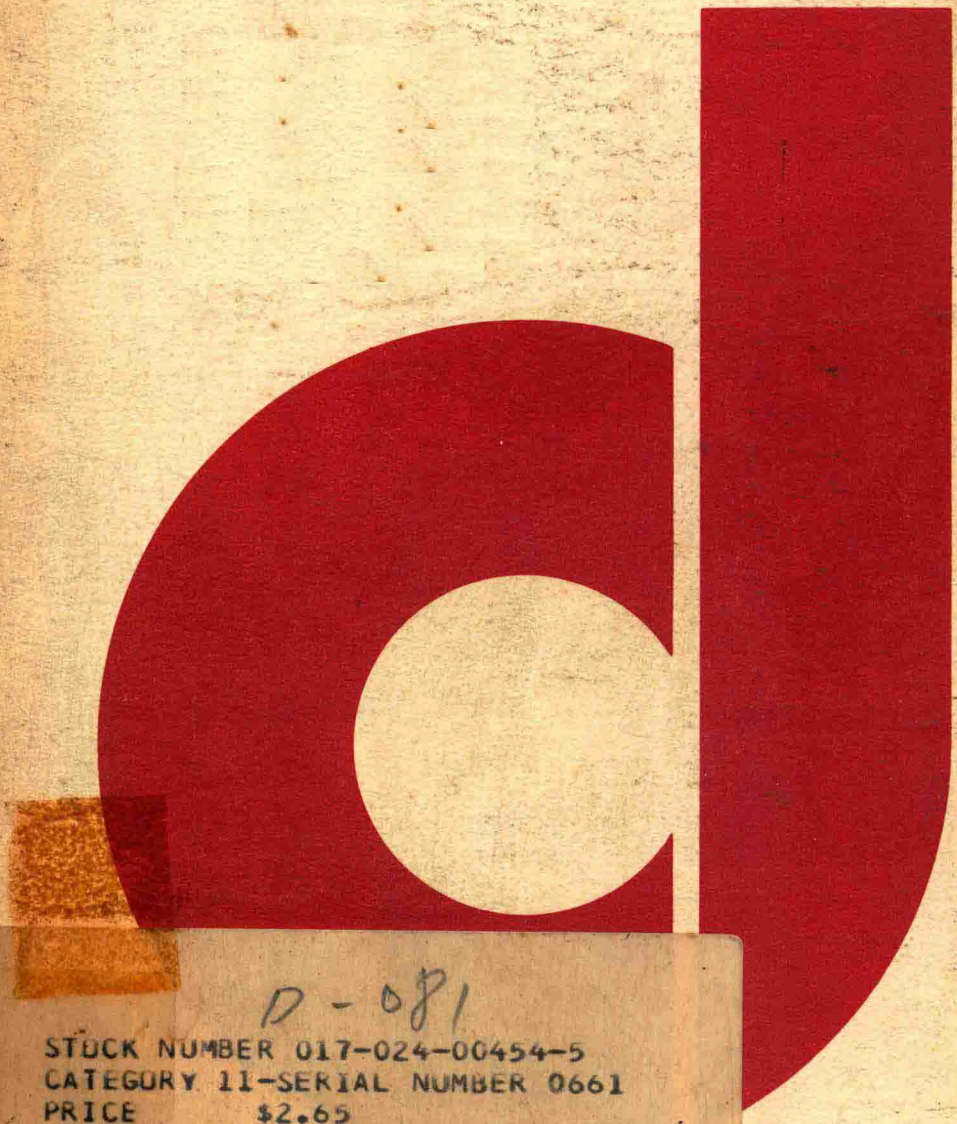
MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION



Crime and Delinquency Issues

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

CRIME AND DELINQUENCY ISSUES:
A Monograph Series

MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Rockville, Maryland 20852

This monograph is one of a series on current issues and directions in the area of crime and delinquency. The series is being sponsored by the Center for Studies of Crime and Delinquency, National Institute of Mental Health, to encourage the exchange of views on issues and to promote indepth analyses and development of insights and recommendations pertaining to them.

This monograph was written by a recognized authority in the subject matter field under contract number HSM-42-73-249 from the National Institute of Mental Health. The opinions expressed herein are the views of the author and do not necessarily reflect the official position of the National Institute of Mental Health or the Department of Health, Education, and Welfare.

Library of Congress Card Number: 74-600185

DHEW Publication No. (ADM) 76-176
Printed 1975 - Reprinted 1976

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

FOREWORD

We are pleased to make available to a wide audience of legal and mental health professionals and administrators, social scientists, as well as interested lay persons, this comprehensive and scholarly monograph by Dr. Alan Stone. It addresses many complex topics encompassed within the interactions of the legal and mental health systems. Several of these topics are of priority concern to this Center and also to the National Institute of Mental Health.

The relationships between the legal and mental health systems have a fairly long history, and they cover a wide range of topics and problems. In recent years the various topics addressed in this monograph have been the focus of markedly increased legal, mental health, and general societal attention. Especially noteworthy has been the significantly greater judicial attention these issues have received during the past few years and the increasing number of truly landmark appellate and Supreme Court decisions.

This monograph provides an outstanding review and discussion of the most salient issues pertaining to the aforementioned topics. The author, a psychiatrist, is professor of law and psychiatry in the faculties of Law and Medicine at the Harvard University, and his range of expertise covers both the psychiatric and the legal aspects of the topics he addresses. Most of the issues discussed here have been the subject of considerable debate. To this debate Dr. Stone brings his particular perspectives and proposals. He brings also a style that is lively, unique, and often quite provocative. Readers will find themselves informed, stimulated, and challenged; they will not be bored.

In this monograph Dr. Stone proffers his knowledgeable perspectives and proposals for greater attention to the proper and truly therapeutic uses of the medical model and provides some excellent suggestions for lawyers who become involved with the mental health system.

The interactions between the legal and mental health systems give rise to a number of very fundamental questions such as: Who can be morally convicted of a crime? Who can involuntarily be committed to a mental hospital or similar facility for compulsory treatment, for how long, and with what judically required standards of care and treatment? What kinds of treatment may be imposed without the consent of the patients, even if this is supposed to be for their own benefit? To what extent should involuntary interventions

in the lives of individuals be closely governed by due process and other constitutional safeguards—even when such interventions are premised on the individual's need for care and treatment?

Clearly, these issues engage the fundamental and overriding question of the balance of power between the State and the individual. Therefore, these questions go well beyond the usual legal, medical, and mental health concerns. Rather, they relate to issues of basic societal values and broad public policies; moreover, they have profound moral and ethical implications. As such, these questions are much too important to be left simply to lawyers and mental health professionals.

It has frequently been noted that our society displays an amazing discrepancy between its idealized statements of remedial and therepeutic objectives with certain social deviants (e.g., juvenile delinquents and the mentally ill), and the resources that it actually is willing to provide to attain these objectives. For example, the recent report of the Group for the Advancement of Psychiatry[1] (1974) makes the following comment:

> As one surveys the demeaning and degrading conditions which exist in hospitals for the criminally insane, the awful hypocrisy of our society and its system of criminal justice stands revealed in the harsh light of reality. American psychiatry, if for no other reason than its passive complicity in this situation, must share the burden of social responsibility for it. These defendants who are presumed innocent until proved guilty, are forced to live in circumstances far worse than those imposed on convicted murderers (page 861).

Certainly, the burden of social responsibility previously mentioned must also be shared by the other mental health and related professions, by our legal colleagues, and indeed by the society which allows such conditions to exist.

There has also been considerable writing about the many ways in which the mentally disabled have been and continue to be denied protection of their civil rights and their right to adequate and proper care and treatment. Much concern has also been expressed about the serious and even shocking abuses which often occur with regard to both procedures and practices pertaining to the handling and care of such persons (see, e.g., Ennis and Friedman[2], 1973).

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[1] Group for the Advancement of Psychiatry. *Misuse of Psychiatry in the Criminal Courts: Competency to Stand Trial.* Formulated by the Committee on Psychiatry and Law. 8:853-922, (report 89), February 1974.

[2] Ennis, B.J., and Friedman, P.R., eds. *Legal Rights of the Mentally Handicapped.* Three volumes. New York: Practising Law Institute, 1973.

In view of the aforementioned complexities and problems involving the interactions of the legal and mental health systems, it is especially important to inform and also to sensitize mental health professionals concerning their roles and responsibilities in various interactions with the legal system. Hence, I considered it desirable to add a few brief comments and suggestions to further emphasize three major and interrelated topics. Of course, the comments in this Foreword reflect my own views and not necessarily those of Dr. Stone.

The three topics are: (a) the necessity for mental health professionals to be properly informed about the particular legal issues, questions, and criteria of relevance to their work; (b) the role of the mental health professional when interacting with the legal system; and (c) the issue of confidentiality and privilege.

(a) Psychiatrists and other mental health professionals who work in forensic or legal settings, or those who choose to function in situations requiring involvement with the legal system, have a clear and definite responsibility to become properly informed about the relevant legal issues, questions, and criteria pertaining to their roles and functions. It is quite presumptuous, to put it mildly, for mental health and medical professionals to render opinions and recommendations on issues of pretrial competency, criminal responsibility, involuntary civil commitment, sexual psychopathy, and the like, when the relevant legal issues and criteria are not properly understood. Acquiring a sound and accurate understanding of the relevant legal issues must be viewed as a *professional and ethical requirement* (Shah[3] 1969).

The ethical guidelines provided by the various professions appear to cover the foregoing point quite clearly. For example, the Principles of Medical Ethics[4] with annotations especially applicable to psychiatry (1973) provide some comments under section 4 which include the following:

> A psychiatrist who regularly practices outside his area of professional competence should be considered unethical (page. 1061).

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[3] Shah, S.A. Crime and mental illness: some problems in defining and labeling deviant behavior. *Mental Hygiene*, 53:21-33, 1969.

[4] Official Actions. The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry. *American Journal of Psychiatry*, 130:1057-1064, 1973.

Similarly, "Principle 2, Competence," of the Ethical Standards of Psychologists[5] (1973) also appears to provide relevant guidance:

> (c) The psychologist recognizes the boundaries of his own competence and the limitations of his techniques and does not offer service or use techniques that fail to meet professional standards established in particular fields (page xix).

(b) In the usual diagnostic, therapeutic, and consultative relationships, mental health professionals typically function as agents of the clients or patients and are concerned primarily with the welfare of these clients. However, when these professionals are asked by courts or other public agencies to conduct various assessments and examinations in reference to the aforementioned areas of legal decision-making, the above role relationship with the patient does *not* normally exist. For example, when a person is facing criminal prosecution, is being considered for involuntary civil commitment, or is being evaluated for special handling as a sexual psychopath or defective delinquent, or is the subject of presentence and preparole evaluations in the usual criminal process, such information typically is requested by a court or related criminal justice agency. The information thus obtained is used by the particular agency for decisions and dispositions about which the patient or client may typically have little choice.

In situations where mental health professionals are serving the court or some other public agency, they typically are *not* functioning as agents of the client or patient. Thus, very clear and forthright statements should be made to the person being examined as to the nature, limits, and constraints the examination situation and/or related communications. In all such situations, the mental health professionals should make certain that an examinee receives this information *prior* to initiating an examination. The information provided should indicate who requested or ordered the examination, the nature and purpose of the examination, who is to receive the report of the examination, and how the requested information is likely to be used, i.e., the particular decisions which are to be made concerning the patient. The essential point is simply this: the person being examined should *not* be under the impression that his communications are within the context of the usual "doctor-patient" relationship when this is not the case.

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[5] Ethical Standards of Psychologists. In: Lazo, J.A., ed. *Biographical Directory of the American Psychological Association.* 1973 ed. Washington, D.C.: American Psychological Association, 1974, pp. xix-xxiv.

Here, again, professional ethical principles provide relevant guidance. For example, the annotations for psychiatrists under section 9 of the Principles of Medical Ethics (1973) include the following:

> The continuing duty of the psychiatrist to protect the patient includes fully apprising him of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action (page 1063).

Likewise, the Ethical Standards of Psychologists (1973) provides the following guidelines under "Principle 7, Client Welfare":

> (a) The psychologist in industry, education, and other situations in which conflicts of interest may arise among various parties, as between management and labor, or between the client and the employer of the psychologist, defines for himself the nature and direction of his loyalties and responsibilities and keeps all parties concerned informed of these commitments.
>
> (b) When there is a conflict among professional workers, the psychologist is concerned primarily with the welfare of any client involved and only secondarily with the interest of his own professional group (page xx).

And, under "Principle 8, Client Relationship," it is further stated:

> The psychologist informs his prospective client of the important aspects of the potential relationship that might affect the client's decision to enter the relationship.
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> • • • • • • •
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> (b) When the client is not competent to evaluate the situation (as in the case of a child), the person responsible for the client is informed of the circumstances which may influence the relationship (page xxi).

(c) Closely related to the foregoing point is the issue of confidentiality and privilege. (This topic has been discussed in some depth by Dr. Stone in the chapters on civil commitment and quasi-criminal confinement.) It is possible that some patients may

tend to assume that their conversations with the "doctor" will be protected by the usual and expected professional confidentiality; they may also assume the existence of a privilege protecting such conversations from unauthorized disclosures in a court of law. However, in various court ordered and related examination situations, viz., those in which the mental health professional is *not* functioning solely or even primarily as the agent of the patient, the examiner must very explicitly and carefully explain—prior to the examination—the extent to which confidentiality and privilege do not apply.

Relevant sections from professional ethical guidelines again indicate the obligations and responsibilities of psychiatrists and psychologists on the issue of confidentiality. Section 9 of the Principles of Medical Ethics provides the following annotation for psychiatrists:

> Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinees at the beginning of the examination (page 1063).

The Ethical Standards of Psychologists provide the following relevant guidelines:

> **Principle 6, Confidentiality**
>
> (d) The confidentiality of professional communications about individuals is maintained. Only when the originator and other persons involved give their express permission is the confidential communication shown to the individual concerned. The psychologist is responsible for informing the client of the limits of the confidentiality (page xx).
>
> **Principle 7, Client Welfare**
>
> (d) The psychologist who asks that an individual reveal personal information in the course of interviewing, testing, or evaluation, or who allows such information to be divulged to him, does so only after making certain that the responsible person is fully aware of the purpose of the interview, testing, or evaluation and of the ways in which the information may be used (page xx).

Considerable literature is available to which mental health professionals can turn for more detailed information concerning their appropriate roles, functions, and responsibilities in various types of interactions with the legal system. Dr. Stone's monograph provides a wealth of information in this regard, and he also cites numerous important references. For example, the legal as well as mental health professional working in these fields should certainly familiarize himself with the wealth of information provided by Brakel and Rock [6] in the Mentally Disabled and the Law (1971).

The manuscript for this publication was submitted by the author in April 1974. Since a number of important cases have been decided in the intervening months, Dr. Stone has added an appendix (January 1975) in which the major legal cases are discussed.

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[6] Brakel, S.J., and Rock, R.S. *The Mentally Disabled and the Law.* (Rev. ed.) Chicago: University of Chicago Press, 1971. 487 pp.

ACKNOWLEDGMENTS

This monograph is in part the result of intense and sometimes heated dialogue with my colleague and co-teacher at Harvard, Professor Alan M. Dershowitz. That dialogue has for the past 7 years been carried on in the Harvard Law School classroom and thus my thoughts have been exposed to the crucible of the socratic method. As a result, many of my ideas have been influenced by a generation of fractious but thoughtful students, primarily from the Law School, but also from the Medical School, the School of Public Health, the various residency training programs in psychiatry; even an occasional business, divinity, and undergraduate student. During one summer, with support from the Grant Foundation, Professor Dershowitz and I attempted to find a compromise between our views on civil commitment but failed. Those discussions were particularly helpful however in clarifying my own position which appears in chapter 4.

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Chapter 1

Introduction

During the decade of the sixties it became apparent that the legal status of the mentally ill had taken on a new and political dimension. It had been transformed into a civil rights and civil liberties issue of the first order (*1*).

Liberal progressives over the past century had urged that the courts treat the mentally ill as patients rather than criminals. That overriding principle translated into law led to an expansion of medical power over decisionmaking affecting the lives of more and more categories of persons designated mentally ill. A complex system of civil confinement arose which purported to treat the mentally ill and relegated the courts to a supervisory role. Often statutory authority clearly remained in the courts, but under the prevailing ideology the decisions of psychiatrists were decisive and the court's imprimatur was a rubber stamp, abdicating authority.

The flaws in this medically dominated system were largely ignored for several generations. Involuntary confinement in various mental institutions grew to unprecedented proportions. The mentally ill, the aged, the young, the sexually dangerous, and the mentally retarded were literally warehoused in "megainstitutions" where living conditions were, and in many cases still are, execrable. Massive Federal programs aimed at aiding the States to remedy these conditions were conceived, but implementation fell far short of the mark.

Critics began to suggest that the entire mental health enterprise was ideologically corrupt (*2*). Mental illness was a myth, the mental health professions were the new inquisition, and the mentally ill were the scapegoats of society (*3*). Ironically this criticism took hold during a decade when the biological aspects of mental illness were being convincingly demonstrated and when psychotropic drugs were revolutionizing the treatment of the seriously mentally ill. Whatever the value of these developments may prove to be, three things are now obvious:

First, the megainstitutions presided over by the mental health professions are an acknowledged disaster. Second, the panacea of community mental health centers has not yet achieved what zealous proponents had promised. They may never be able to, because

community mental health services, as now defined, are an infinitely expansible market. Third, there is growing distrust of the coercive uses of psychiatry in what I shall call the law-mental health system.

Litigation recognizing the unmet needs, attacking the megainstitutions, and raising the ideological questions has begun to mount. Five years into the decade of the seventies there is enough evidence to suggest that the United States is engaged in an all out legal war over the fate of the mentally ill.

That war has changed the basic nature of forensic psychiatry, transforming it from an esoteric specialty into a pragmatic concern for all mental health professionals and the growing number of lawyers practicing in the mental health field. How will this litigation affect the provision of mental health care? How will institutional treatment be changed? What will be the nature of the new relationship between the courts and the decisionmaking process in the mental health care system? What new mental health policies and planning should be initiated to meet the emerging requirements of legal criteria set up in rejection of the medical model? That is the broad range of questions which confront the law-mental health system and which stimulated the work which follows.

The Role of the Judiciary

The future development of laws regulating mental health ultimately rests in the hands of the lawgivers: the judiciary and the legislatures. During the recent past, a judicial trend has begun to emerge which portends the policies and principles which will dominate mental health law in the decade of the seventies. The reformist trend of the courts has an antecedent historic sequence in the area of criminal law. During the last few decades a series of procedural safeguards for criminal defendants has been authored by the highest courts: right to counsel, protection against self-incrimination, etc. (*4*). Transcending the various narrower legal arguments in each instance is the principle that loss of liberty is the most grievous penalty in a democratic society, and therefore every procedural protection must be given to citizens at risk, even if their economic status (*5*) requires the State to pay the costs involved.

Once these precedents were established, the courts were asked to examine loss of liberty in other contexts. The most important of these are the many forms of involuntary civil confinement. Although, as we shall see, the statistics are misleading and difficult to interpret, it is safe to conclude that civil confinement during the past two decades may have affected more citizens than did criminal confinement. (This is true only if we include juveniles, the retarded,