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MENTAL HEALTH AND CRIMINAL JUSTICE

Linda A. Teplin
Editor

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To my parents,
Joseph and Shirley Teplin,
who I thought could do (almost) anything

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FOREWORD

The interface between the mental health and criminal justice systems must be seen within the historical context of mental health law. Persons with mental illness have always been plagued by myths surrounding their illness, and have suffered from prejudice and stigma. Within this context, two sets of laws formulated during the nineteenth century became legion in that they were the first to establish policies for treating the mentally ill: the so-called "Regimen for the Alienated" was adopted by French law in 1838, and later the English introduced "the Lunatic Act of 1890." Although enacted by two different judicial systems, these laws had the same objective: to regulate internment of the mentally ill with a view toward protecting society, while simultaneously favoring treatment and curtailing abuses concerning individual liberty. Compared to the arbitrary treatment of the mentally ill in preceding centuries, legislation in the nineteenth century provided significant gains. More recently, the principle of adequate treatment in mental hospitals has been confirmed as the legal right of the involuntarily confined mental patient. The direct order issued under Wyatt v. Stickney (1972) regarding minimal standards of adequate treatment was crucial in that it was the most noteworthy attempt to date to guarantee the individual rights of persons treated within mental health and mental retardation facilities.

The linkage between the mental health and criminal justice systems is a far from recent phenomenon. The insanity defense is deeply rooted in Anglo-American legal tradition and dates back over 800 years. It is based on the concept known as *mens rea;* i.e., a person must have a "criminal mind" at the time that an offense was committed in order to be guilty of a crime. The so-called M'Naghten rule, established in the trial of Daniel M'Naghten, confirmed that a person suffering from a mental illness could be found not guilty by reason of insanity. This was confirmed in the trial of Monte Durham in 1954,

where the bench set forth a rule that a defendant is not guilty if his or her act was a product of mental disease or defect (Durham v. United States, 1954).

Until relatively recently, persons not guilty by reason of insanity could be incarcerated almost indefinitely. This practice was abolished by the court in Rouse v. Cameron (1966). In this case, Charles Rouse was committed to St. Elizabeth's Hospital in Washington after being found not guilty by reason of insanity. He was charged with carrying a dangerous weapon, a misdemeanor with a one-year maximum sentence. After three years of confinement, he petitioned for release by a writ of habeas corpus, alleging that he had not received psychiatric treatment during his confinement. On review by the Circuit Court of Appeals, Justice Bazelon ruled that the purpose of involuntary hospitalization is treatment, not punishment. Without treatment, the hospital is transformed into a penitentiary where one could be held indefinitely, without being convicted for an offense. The judge's decision strongly implies that a constitutional right to treatment exists under due process, equal protection, and cruel and unusual punishment clauses.

Although the concept of mental disorder as an extenuating circumstance in criminal culpability is perhaps the most publicized link between the mental health and criminal justice systems, it is by no means the only one. Moreover, recent "progressive" policy changes in both the mental health and criminal justice systems have served both to increase the possibility of intersystem diversion, as well as to complicate the process. As mentioned above, the right to treatment has been confirmed. In addition, the courts have ruled that individuals have the right to refuse treatment; i.e., they may choose to accept some types of treatment and reject others. This ruling pertains both to those patients who have been committed to hospitals, as well as to those treated as voluntary patients. However, while such legislation enhances the rights of the mentally ill, it is a source of difficulty for mental health professionals. The right to refuse treatment may produce a conflict between the treating physician or staff and the patient who may have inaccurate perceptions and judgment about his or her illness. The right to refuse treatment has other potentially negative consequences as well. If an outpatient has the right to refuse treatment, the untreated illness may cause that person to act in such a way as to exceed the tolerance for deviance within a given community. The result may be arrest, a disposition likely to be more harmful than the refused psychiatric treatment.

Given the longstanding stigma of mental disorder, any judicial and legislative progress can only be considered within the sociopolitical context. Unfortunately, society's fears of the mentally ill have

restricted the implementation of truly innovative treatment policies and, indeed, seem to color much of the discussion vis-à-vis alternative sets of legislation and regulations. These prejudices may have served to reduce the benefits of the civil rights legislation pertinent to mental illness. Thus, although the means for humane treatment of the mentally ill are in place, it is questionable whether these public policy changes have actually improved the lot of the mentally ill. What is frequently obscured in the public debates about legislative remedies for the treatment of the mentally ill are the historical moral standards that confirm that mentally disordered persons may not be accountable for their actions. Seemingly normal people may be stricken with illnesses that distort their reason at times and limit their ability to control their actions. While we are ready to leap at legislative reforms that may restrict our ability to aid the sick, we ignore the legislative reforms that might help many of these individuals to lead healthier lives. In a sense, we are guilty of increasing the stigma of mental illness for the nonviolent mentally ill when we charge recklessly into reforms designed solely to allay these fears of society.

This book examines some of the critical issues relevant to the relationship between the mental health and criminal justice systems. The authors attempt to clarify the problem confronting a society that prides itself on its sense of fair play and justice. In so doing, this volume provides some needed insights into balancing the needs of society with the rights of the mentally ill.

—Harold M. Visotsky, M.D.

CASES

DURHAM v. UNITED STATES (1954) 214 F.2d 862 (D.C. Cir.)
ROUSE v. CAMERON (1966) 373 F.2d 451 (D.C. Cir.)
WYATT v. STICKNEY (1972) 344 F.Supp. 373 (MD Ala.)

PREFACE

The link between criminal justice and mental health issues dates back to common law and has long been a somewhat problematic relationship. As a result of recent case law, statutory modifications, and public policy reformulations, this association has become increasingly complex. This book examines the interface between mental health and criminal justice from a social science perspective. What this means is that the book will not merely present a passive review of the legal context vis-à-vis the mentally ill. Rather, the focus will be to discover the modus operandi of the system. As such, this volume is designed to be of interest to both researchers and public policy makers. In addition, the organization of the volume lends itself to classroom use in criminal justice, psychology of law, and sociology courses.

Section I presents important background information pertaining to the laws and statutes governing treatment of the mentally disordered offender. The chapter by Norval Morris is a provocative piece of fiction that examines the age-old issue of the extent to which the mentally incompetent can be held responsible for their actions. Section II contains four chapters that look at the dynamics of intersystem processing. The focus of this section is to ascertain how changes in one component may have unintended consequences for the system as a whole. The third section examines the way in which police manage the deinstitutionalized mentally ill on the streets. Section IV contains two chapters, both of which present important data on the way in which deviant behavior is defined and processed. Finally, Section V contains three chapters, all of which focus on one point in the processing of the mentally disordered offender. The contribution by Bruce Sales and Thomas Hafemeister takes a fresh look at the insanity defense. The chapters written by Eliot Hartstone et al. and by John Carroll and Arthur Lurigio examine aspects of the incarceration experience and probation and parole. In sum, the book provides an encompassing

view of the relationship between the mental health and criminal justice systems at their myriad points of interface.

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I would like to thank Judith Wray for her editorial assistance.

—Linda A. Teplin

EDITOR'S INTRODUCTION

This book will examine the interface between the mental health and criminal justice systems from a social science perspective. The rationale underlying this approach is twofold:

(1) Law makes action possible, but it cannot prescribe particular responses for every contingency. Of necessity, discretion is used to make decisions as to the most "appropriate" disposition, be it a competency hearing or a decision to transfer an offender from a prison to a mental hospital. In order to understand the ways in which the legal structure is implemented, it is necessary to observe the law in action. In this way, the behavioral or social scientist discovers the informal normative codes that determine how the laws are actually implemented and utilized. Using this approach, we may then make recommendations for public policy change based on observable problems with current praxis.

(2) As a result of the increasing points of contact in mental health and criminal justice processing, the systems have become quite interdependent. The result of this is that any change in one system can affect the entire process. As a consequence, we can no longer make modifications in one system without incurring changes in other social institutions. The social science approach permits an in-depth examination of this phenomenon which, in turn, will facilitate a more thoughtful approach vis-à-vis the development of public policy.

Thus this book will examine the law in action, with particular emphasis on the ways in which recent changes in case law, statutes, and public policy have interacted to produce the current mental health and criminal justice process.

BACKGROUND

A number of recent developments in mental health law and public policy have complicated the always delicate relationship between the

mental health and criminal justice systems. Six major changes underlie the increasing intricacies of this interface: (1) changes in commitment laws and procedures; (2) the community mental health movement; (3) the "psychiatrization of the criminal"; (4) the changing characteristics of public hospital patients; (5) decreased financial support for mental health programs; and (6) public perception of the use of the insanity defense.

(1) Changes in Commitment Laws and Procedures. More rigorous criteria and procedural safeguards have made civil commitment of the mentally ill increasingly difficult (Dickey, 1980; Halleck, 1980). It has been speculated that, as a consequence of these changes, the criminal justice system is being used as a way to obtain treatment for persons who do not meet the criteria for commitment (Teplin, 1983). Once a person is arrested, evaluations for incompetency are invoked. The arrest charges are then dropped after the initial evaluation period expires (Steadman and Hartstone, 1983). In this way, mental health care is assured for persons who are thought to require treatment but who do not meet the legal requirements for commitment (Winick, 1983). The enormous number of persons found incompetent to stand trial provides some support for this thesis; defendants found incompetent to stand trial make up approximately 32% of all admissions of mentally disordered offenders (Steadman et al., 1982).

(2) The Community Mental Health Movement. As a result of the Community Mental Health Movement, large numbers of persons have been released into the community who formerly would have been given custodial care in a state or county facility (NIMH, 1983). Moreover, the right of the mentally ill person to live within the community without treatment has been confirmed (see O'Connor v. Donaldson, 1976; Rennie v. Klein, 1981; Rogers v. Okin, 1982). These changes have resulted in an unknown number of deinstitutionalized persons now residing within the community, many of whom choose to function without the assistance of psychological support programs. Unfortunately, many communities may not tolerate the presence of the mentally ill, particularly given the stereotype of the mentally ill as being "dangerous" (Shah, 1975; Fracchia et al., 1976; Steadman and Cocozza, 1978). As a consequence, citizens may invoke the criminal justice system to handle situations involving the mentally ill, particularly in instances where persons publicly exhibit the more bizarre and disruptive symptoms of mental disorder. Unfortunately, once law enforcement officials are involved, their dispositional options are limited, both by the "protections" afforded the mentally ill, as well as by the limited number of psychiatric placements available (Teplin, 1984, Ch. 7, this volume). As a

consequence, arrest may become one of the few remaining ways to handle the situation (Teplin, 1984).

(3) The "Psychiatrization of the Criminal." The right to psychological treatment for prisoners has been confirmed in a number of cases (see Rouse v. Cameron, 1966; Millard v. Cameron, 1966; State v. Harvey, 1978, 1979). Although the constitutional right to treatment is somewhat questionable, such a right will often be recognized as a matter of statutory interpretation (Dix, 1983). This may result in an increasing number of transfers from prisons to mental health facilities.

(4) The Changing Characteristics of Public Hospital Patients. Over the last forty years, the characteristics of patients in public hospitals have drastically changed. One study found that the proportion of inpatients with arrest records increased from 15% in 1947 to 40% in 1975 (Cocozza et al., 1978). By 1978, the proportion of patients with arrest records was over one-half (Monahan and Steadman, 1983a). Steadman et al. (1982) feel that this increase is a result, at least in part, of overcrowding within the prisons. They postulate that as prisons have become overcrowded, other alternatives for detention have been sought with the state mental hospitals (Steadman et al., 1982). This movement results in what Warren and Guttridge (Chapter 5, this volume) have aptly termed "transinstitutionalization."

(5) Decreased Financial Support. When inflation is taken into account, federal support for mental health treatment has actually declined since 1975, resulting in a lack of available treatment programs for the deinstitutionalized person (NIMH, 1983; Kiesler et al., 1983). If sufficient treatment is not available, the mentally ill have no choice but to live within the community without the benefit of treatment. As a result, their symptoms go untreated and unabated. This may result in their being arrested for minor offenses that are merely symptoms of their mental illness, such as trespassing or disorderly conduct (Teplin, 1984). In a sense, the unavailability of funding for treatment results in the mentally ill being arrested for the symptoms of their disorder.

(6) Public Perceptions of the Use of the Insanity Defense. Both legislators and the general public erroneously presume that the insanity defense is frequently pleaded and often successful (Morris, 1983). In reality, successful use of the defense is rare, and the proportion of persons who have been found not guilty by reason of insanity (NGRI) is only 8.1% of those admitted to facilities for mentally disordered offenders (Steadman et al., 1982). However, as a result of their comparatively longer length of stay, they comprise a fairly high percentage (22.4%) of residents in those facilities (Steadman et al.,

1982). As a consequence, from the standpoint of institutional administration and programming, NGRIs are a very significant problem (Steadman and Braff, 1983). More important, the controversy regarding the successful NGRI defense of John Hinckley, Jr. has already resulted in a number of public policy reformulations regarding both the utilization of the NGRI defense, as well as the treatment of persons acquitted as NGRI (see American Bar Association, 1983; American Medical Association, 1983; American Psychiatric Association, 1983). An exploration of the vast array of issues surrounding the insanity defense is thus both timely and provocative.

These changes in the legal and sociopolitical context have resulted in a unique permeability between the mental health and criminal justice systems. Moreover, the inherent complexity of this relationship means that modification of one point in either the mental health or criminal justice process has an enormous impact on the system as a whole. This book presents a study of the myriad points of interface between mental health and criminal justice. In so doing, the goal is to generate a gestalt of the way in which persons are defined and processed as being "mentally disordered" and/or "criminal," and in so doing to gain an increased understanding of the treatment of the mentally disordered offender.

CASES

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