

**NATIONAL SYMPOSIUM ON  
JUSTICE AND MENTAL HEALTH  
SYSTEMS INTERACTIONS:**

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**NOVEMBER 7-9, 1990  
RAMADA HOTEL, BALLSTON METRO CENTER  
ARLINGTON, VIRGINIA**

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# **NATIONAL SYMPOSIUM ON JUSTICE AND MENTAL HEALTH SYSTEMS INTERACTIONS**

## **GOALS AND OBJECTIVES**

THE GOALS OF THE SYMPOSIUM ARE THREEFOLD:

A. To Educate

- To inform judicial and mental health professionals of the nature and consequences of current approaches to the organization, administration and fiscal management of mental health services for individuals served by both the mental health and justice systems

B. To Establish Relationships

- To establish relations between the justice and mental health systems in order to better manage the provision of mental health services to judicial/mental health clients
- To establish a network of individuals who have expertise and experience in the interaction of the justice and mental health systems, including judges, court administrators, mental health administrators, psychologists and other scholars in the field

C. To Guide Action

- To develop an agenda for research and the development of responsible public policy on the structure, organization, and administration of the provision of mental health services to judicial/mental health clients

## SIX OBJECTIVES FOLLOW FROM THESE GOALS:

### A. Education Objectives

- Describe the major components of a conceptual framework, including the beliefs, goals, methods, techniques and so forth (viz., paradigm) for analyzing the organization and administration of mental health services provided to judicial/mental health clients
- Describe some of the specific and common problems associated with the organization, administration and fiscal management of mental health services provided to populations served by both the mental health and justice systems

### B. Relationships Objectives

- List possible approaches for forming linkages (individual, organizational, administrative and so forth) between the justice and mental health systems
- Create a specific network of individuals in the field who can provide and disseminate information on justice and mental health systems interactions

### C. Action Objectives

- List several areas in which empirical data will help researchers and practitioners in both systems better manage the organization, administration and funding of mental health services provided to judicial/mental health clients
- List several areas in which the development of public policy and improved management practices will enhance the interactions between the justice and mental health systems





**NATIONAL SYMPOSIUM ON  
JUSTICE AND MENTAL HEALTH SYSTEMS INTERACTIONS**

**AGENDA**

WEDNESDAY, NOVEMBER 7, 1990

9:30 am - 9:45 am	Welcome and Introductions (Gallery II)  Richard Van Duizend Deputy Director, State Justice Institute
9:45 am - 10:30 am	In Search of a New Paradigm for Understanding Mental Health and Justice Systems Interactions (Gallery II)  Ingo Keilitz Director, Institute on Mental Disability and the Law, National Center for State Courts
10:30 am - 12:00 pm	Small Group Session 1: Problem Identification  See attached list of facilitators for each group.  Group A (Rembrandt Board Room) Group B (Renoir Suite) Group C (Matisse Suite) Group D (Gallery II) Group E (TBA Suite)
12:00 pm - 1:10 pm	Box Lunch (Mezzanine Level Foyer)
1:10 pm - 2:10 pm	Report of Group Session 1 (Gallery II)  Moderator: Michael Perlin Professor New York Law School
2:10 pm - 3:00 pm	Invited Address: Boundary - Spanners: A Key Component for the Effective Interaction of the Justice and Mental Health Systems (Gallery II)  Speaker: Henry J. Steadman President Policy Research Associates, Inc.  Chair: Joel Dvoskin Associate Commissioner New York State Office of Mental Health
3:00 pm - 3:10 pm	Break
3:10 pm - 4:00 pm	Invited Address: Civil Commitment from a Systems Perspective (Gallery II)  Speaker: Paul S. Appelbaum A. F. Zeleznik Professor of Psychiatry University of Massachusetts Medical Center  Chair: Jonas R. Rapoport Chief Medical Officer Circuit Court of Baltimore City
4:00 pm - 5:00 pm	Discussion and Integration (Gallery II)  Moderators: Joel Dvoskin Michael Perlin

DINNER ON OWN

NATIONAL SYMPOSIUM AGENDA (continued)

THURSDAY, NOVEMBER 8, 1990 (revised 11/5/90)

9:00 am - 10:05 am

Invited Address: Promoting Justice in Child and Family Services  
(Gallery II)

Speaker: Gary B. Melton  
Carl Adolph Happold Professor of Psychology and  
Law, University of Nebraska-Lincoln

Chair: Thomas L. Hafemeister  
Staff Attorney  
National Center for State Courts

10:05 am - 10:15 pm

Introduction to Small Group Session 2 (Gallery II)

Thomas Hafemeister

10:15 am - 12:15 pm

Small Group Session 2: Goals for Mental Health and Justice Systems  
Interactions

See attached list of facilitators for each group.

Group A (Rembrandt Board Room)

Group B (Renoir Suite)

Group C (Matisse Suite)

Group D (Gallery II)

Group E (TBA Suite)

12:15 pm - 1:30 pm

Box Lunch (Mezzanine Level Foyer)

1:30 pm - 2:30 pm

Report of Group Session 2 (Gallery II)

Moderator: Joel Dvoskin

2:30 pm - 2:40 pm

Break

2:40 pm - 4:00 pm

Discussion and Integration (Gallery II)

Moderators: Joel Dvoskin  
Michael Perlin

DINNER ON OWN.

## NATIONAL SYMPOSIUM AGENDA (continued)

### FRIDAY, NOVEMBER 9, 1990

9:00 am - 10:05 am

Invited Address: Putting Mental Health Into Mental Health Law:  
Therapeutic Jurisprudence (Gallery II)

Speaker: David B. Wexler  
Law College Association Professor of Law and Professor  
of Psychology, University of Arizona

Chair: Sandra A. Garcia  
Professor, Department of Psychology  
University of South Florida

10:05 am - 10:15 pm

Introduction to Small Group Session 3 (Gallery II)

Ingo Keilitz

10:15 am - 12:00 pm

Small Group Session 3: Strategies for Improving Justice and Mental  
Health Systems Interactions

See attached list of facilitators for each group.

Group A (Rembrandt Board Room)  
Group B (Renoir Suite)  
Group C (Matisse Suite)  
Group D (Gallery II)  
Group E (TBA Suite)

12:00 pm - 1:15 pm

Box Lunch (Mezzanine Level Foyer)

1:15 pm - 2:15 pm

Report of Group Session 3 (Gallery II)

Moderator: Michael Perlin

2:15 pm - 3:15 pm

Discussion: Agenda for the Future (Gallery II)

Discussants: Michael Perlin  
John Petrila\*  
Ingo Keilitz

Moderator: Joel Dvoskin

\*Affiliation listed on next page.

3:15 pm

ADJOURNMENT

NATIONAL SYMPOSIUM AGENDA (continued)

FACILITATORS FOR SMALL GROUP SESSIONS

Group A:

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## ORGANIZATION OF THE SYMPOSIUM

### Overview

The symposium will consist of several small group and plenary sessions as well as six substantive presentations. Three small group sessions will focus on (a) the problems associated with justice and mental health systems interactions, (b) the goals of those interactions, and (c) strategies for improving the interactions. Specifically, the questions that the small groups will be asked to address are:

- At what points do the needs of the justice system and the needs of the mental health system conflict with regard to the provision of mental health services? Please give some examples of fiscal, structural, attitudinal, administrative, taxonomic or other problems that occur.
- What goals would you like to see drive the interactions of the two systems (i.e., how do we know if we are doing a good job)? In answering the question, think about who the client is (i.e., who is serving whom).
- What specific public policies, management strategies and research agenda should be pursued to improve mental health and justice systems interactions?

To guide participants' thinking in answering these questions, we will hear presentations from six speakers. Each will help us formulate a new perspective on justice and mental health systems interactions. The outlines of each presentation and background materials are included in this notebook. The six presenters and their respective topics, in the order of their presentations, are:

- |                        |   |
|------------------------|---|
| • Ingo Keilitz:        | In Search of a New Paradigm for Understanding Mental Health and Justice Systems Interactions                |
| • Henry J. Steadman:   | Boundary - Spanners: A Key Component for the Effective Interaction of the Justice and Mental Health Systems |
| • Paul S. Appelbaum:   | Civil Commitment from a Systems Perspective   |
| • Gary B. Melton:      | Promoting Justice in Child and Family Services  |
| • Clarence J. Sundram: | Justice and Mental Health Systems Interactions: A Search for the Holy Grail?                                |
| • David B. Wexler:     | Putting Mental Health Into Mental Health Law: Therapeutic Jurisprudence                                     |

Each day will end with a plenary discussion to help integrate the information from the small group sessions with the ideas presented by the speakers. In this way, the symposium will build from one session to the next and from one day to the next.

### Small Group Sessions

One small group session will take place each day. For these sessions, the symposium participants will break into five groups of ten to twelve individuals each. The composition of the groups will remain the same across all three days. The group you are assigned to will be noted on the back of your name tag which will be given to you at the start of the symposium.

The small group sessions will utilize the Nominal Group Technique (NGT). NGT is a structured "brainstorming" activity that is particularly helpful for groups consisting of people who have not worked together. During the small group sessions, we want to make sure that as many ideas are identified as possible. In order to accomplish this, it is important not to get bogged down discussing one particular idea. The symposium is bringing together professionals with varying backgrounds and experiences with regard to justice and mental health systems interactions. It is important that we hear from each participant and get as many ideas expressed as possible.

The NGT consists of four basic steps: (a) silent, individual generation of ideas in writing, (b) round-robin recording of ideas, (c) serial discussion of the list of ideas, and (d) voting on the ideas (Moore, 1987, pp. 26-32). In brief, the steps in the process are as follows:

- Step 1: Silent Generation of Ideas in Writing. Your group facilitator will read the group question and ask you to respond in writing. (The question will also be written on a flip chart in the front of the room.) You will have approximately five minutes to respond. List as many ideas as you like, and try to write them in short phrases or brief sentences. During this step, you should work silently and independently.
- Step 2: Round-Robin Recording of Ideas. During this step, your group's facilitator will ask each individual in the group to present one idea orally and without any discussion, elaboration, or justification. Each idea will be recorded on a flip chart sheet. The facilitator will "go around the table" several times; therefore, each group member will have an opportunity to present several different ideas. When it is your turn to present an idea, try to state it in a brief phrase or sentence. If you do not have an idea or all of your ideas have already been recorded, you may pass. If you think of another idea, you can add it the next time the facilitator comes around to you. The facilitator will continue to solicit ideas until the group members have exhausted their lists or until the group thinks it has generated a sufficient number. If time is short, the facilitator may decide

to go around the table one more time and ask group members to state the most important idea remaining on their individual lists.

- Step 3: Serial Discussion of the Listed Ideas. The purpose of this step is to clarify the ideas presented. The purpose is not to argue an idea's accuracy, validity or worth. Participants are asked to resist getting into lengthy discussions about any one item. Participants will have an opportunity to comment on various ideas at several points during the plenary sessions.

The facilitator will read each item aloud in sequence and invite comments. Many of the items will be self-explanatory and, therefore, will not require any discussion. Others may need some clarification before all of the members understand what is meant by a particular item. At this stage, any member can clarify or comment on any of the ideas.

Within reason, new items can be added and small editorial changes made. Duplicate items may also be combined. However, resist attempts to combine many items into broader categories. We do not want to lose the precision of the original items.

- Step 4: Voting. During this step, you will be asked to select the five most important items from the group's list and write them down on a piece of paper. Then you will be asked to rank the ideas from 1 (least important) to 5 (most important). You will have approximately five minutes for this task.

After five minutes, the facilitator will ask each group member to indicate what items were selected and how the items were ranked. At the end of this process, the group will be able to review the voting pattern across items. In general, the number of votes an item gets is a good indication of its relative importance. Do not add the rankings together to come up with a composite score. A composite score would obscure the different patterns of voting. For example, a composite score of "5" could be the result of five people rating it a "1" or one person rating it a "5".

At the end of the group session, the facilitator will prepare a summary sheet of the group's voting. This summary sheet will be the basis of a short presentation of the group's deliberations during the plenary session.

#### Reference

Moore, C. M. (1987). Group techniques for idea building. Applied social research methods series: Vol. 9. Newbury Park, CA: Sage.





# National Symposium on Justice and Mental Health Systems Interactions

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# **In Search of a New Paradigm For Understanding Mental Health and Justice Systems Interactions**

Ingo Keilitz  
Director  
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National Center for State Courts

## Outline of Presentation

Wednesday, 9:45 - 10:30 am, November 7, 1990

### **I. We Define First and Only Then See**

- A. The story of a pig
- B. Walter Lippman

### **II. The Role of Paradigms**

- A. Constellations of beliefs, values, and techniques
- B. Advantages
- C. Disadvantages

### **III. Mental Health Law (Mostly) Governed by Single Paradigm**

- A. Success of "doctrinal analysis paradigm" until the 1980s
- B. Search for replacement
- C. Paradigm switch

### **IV. In Search of a New Paradigm**

- A. Levels of inquiry
  - 1. Legal doctrine and substantive law
  - 2. Courtroom
  - 3. Trial courts as organizations
  - 4. Justice and mental health systems

- 5. Community
- B. Focus on the systems and their interactions
  - 1. Mission, goals, objectives
  - 2. Court services and functions
  - 3. Mental health service units/components
  - 4. Inter-system arrangements

#### **IV. Conclusions**

- A. Reorientation
- B. Change in the presentation and analysis of familiar data
- C. Development of new paradigm

## RETHINKING JUSTICE AND MENTAL HEALTH INTERACTIONS: A SYSTEMS APPROACH\*

Ingo Keilitz

We study the insanity defense, competency to stand trial, involuntary civil commitment, guardianship, informed consent, the right to refuse treatment, and other mental health law issues not only to understand them but also to make the administration of justice in cases involving them more just and efficient. This Article is based on the belief that understanding and improvement of the interactions of the justice and mental health systems will be enhanced if policymakers, social scientists, administrators and others concerned with mental health law give greater attention than in the past to the structural aspects of justice and mental health systems interactions and the interorganizational relations of their various components.

Social scientists have for many years "tinkered" with legal doctrine (e.g., insanity, competence, involuntary civil commitment) but have had relatively little impact on the operation of the justice system as a whole (Haney, 1980). Such tinkering typically is done within the confines of established abstract, legal categories that traditionally are resistant to change, especially when the impetus for change comes from outside the legal profession. It seldom extends beyond the individual case or type of case, how that case is presented, and the basis upon which the case may be determined. Roesch and Corrado (1983) noted that "social scientists would perhaps accomplish a good deal more by directing their attention to examining and understanding the complex system-level context in which interventions take place." Underlining the importance of historically and politically evolved functions and relationships, they contend that such factors as "individual and organizational self-interest, differing ideological perspectives, and political pressures and constraints can

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\* This article was prepared for the National Symposium on Justice and Mental Health Systems Interactions, November 7-9, 1990, Washington, DC: National Center for State Courts (NCSC). The author is the Director of the Institute on Mental Disability and the Law of the NCSC.



effect the way in which an intervention develops (p. 405)." Saleem Shah made a similar observation when he noted the wide gap between the "law on the books" and the "law in practice" (1981:255).

Responding to the court-related problems and needs of mentally disordered persons is likely to become increasingly difficult as the gap between the "law on the books" and the "law in practice" widens and as our nation becomes grounded in seemingly intractable problems which foreshadow a virtual breakdown of the public mental health system: a dramatic decline in the number of patients residing in large public hospitals and a burgeoning population of homeless persons with mental illness; the failure of the public policy of "deinstitutionalization" whereby decent community care replaces hospitalization in large "mega-institutions"; trends toward the "rationing" of mental health care favoring involuntary treatment; simultaneous litigations that advocate the right to services and the right to refuse services, without effectively distinguishing the two; the "transinstitutionalization" of mentally ill patients from public hospitals to other institutions include nursing homes, jails, and temporary shelters; political and fiscal shortsightedness that encourages us to spend unlimited amounts of money on today's crises rather than reasonable amounts to prevent the crisis from occurring in the first place; and the continuing prejudice and fear of mentally disordered persons (Parry, 1986; Keilitz, 1989).

Understanding and improvement of justice and mental health systems interactions--their structure, organization, and day-to-day administration--seem critical to assuring the court-related problems and needs of mentally disordered persons are addressed in this inhospitable environment. These interactions are important to understand because they represent a critical point of contact between the chronically mentally ill and the justice system, thus having significance for the identification of mentally ill defendants in criminal cases and respondents in civil cases who are in need of mental health services. They also have significance for the quality of justice

afforded a disadvantaged and vulnerable segment of the population. An analysis of the structure, organization, and administration of justice and mental health interactions may be necessary to ensure that the quality of mental health expert assistance provided to the courts of the nation is high, that forensic services are delivered in a manner consistent with performance standards relevant to the justice and mental health systems, that litigants' rights are protected, that the integrity of the legal and mental health professions is protected, and that a framework for developing mental health expert services to the courts is designed (Melton, Weithorn, and Slobogin, 1985).

Although the necessity of expert mental health services to facilitate efficient and fair performance of a court's adjudicative, investigatory, supervisory, and administrative responsibilities is widely acknowledged (American Bar Association Criminal Justice Standards Committee, 1989; American Bar Association Commission on Standards of Judicial Administration, 1976 Shuman, 1986), relatively little is known about the structural aspects of the justice and mental health systems interactions and the interorganizational relations of their various components. The purpose of this Article is to highlight the importance of the structural, organizational and administrative aspects of the interactions of the justice and mental health systems to the delivery of justice in cases--criminal, civil, juvenile, and domestic relations--involving claims of mental disorder. The mission of a court clinic, the specific services it performs, its organizational and administrative relations with the judiciary, the local bar, and the local mental health system, for example, are considered to be factors as important to the operation of the insanity defense as the "test" of insanity defined by statute, the use of conclusory statements by mental health experts in live testimony or reports, and any divergence of opinions by opposing experts.

Illustrating the ad hoc evolution of justice and mental health systems interactions, the Article begins with an account of the origins and development of the

Medical Service of the Circuit Court of Baltimore City. This account is followed by an overview of historical developments and past research. It underscores the point that while there has been attention paid to the structure and organization of the mental health and justice systems separately, relatively little has focused on their interaction. The Article concludes with a number of considerations believed to be important for the understanding and improvement of justice and mental health system interactions, including the beliefs, values, and goals governing those interactions, the importance of the trial courts as a focus of future inquiry, and the need for a conceptual framework and taxonomy.

### **John Rathbone Oliver**

Responsibilities for expert mental health services to the courts are distributed in various ways between a court and other agencies and officials, more often than not on the basis of historically and politically evolved functions and relationships, as well as individual and organizational self-interests such as those that led to the development of one of the nation's first court clinics in Baltimore beginning in 1917. In that year, John Rathbone Oliver was a young psychiatrist at the Henry Phipps Psychiatric Clinic of Baltimore's John Hopkins Hospital (Oliver, 1930; Keilitz, 1989). The magistrate of the police court a few blocks away would occasionally visit Oliver to discuss cases that the magistrate referred to the clinic for diagnoses. Oliver soon was spending his free afternoons in the court sitting beside the magistrate on the bench helping him to identify juvenile defendants who showed signs of mental disorder. As the word of what Oliver was doing spread, he was invited to visit other courts in Baltimore.

In 1918, Oliver left John Hopkins Hospital and began his own private practice, though his interest in delinquency and "legal medicine" continued. An associate judge of the Supreme Bench of Baltimore City, a former classmate of Oliver's at Harvard, introduced him to the Superior (felony) Court, and Oliver was soon helping the courts without compensation as he had done earlier for the magistrate court. Because the

courts did not have a formal position for a consulting psychiatrist, Oliver was appointed as a bailiff (a court officer with authority, care, or jurisdiction over some aspect of non-judicial court operation, typically keeping order in the court, custody of the jury, or prisoner security) of the Supreme Bench of Baltimore City. Oliver thus became one of the first mental health professionals to become an official of a court helping the court with its adjudicative, investigatory, supervisory, and administrative functions in cases involving mental disorder.

For several years, Oliver drew a bailiff's modest salary while he served as a consulting psychiatrist to the court. He had no office, no secretary, and no funds for purchasing equipment and materials. After some time and with the help of Oliver's friend, the associate judge (who by this time had become a chief judge), the Maryland State Legislature passed a bill creating the Medical Service of the Supreme Bench of Baltimore City. This new service of the court was headed by Oliver. Oliver's mission for the Medical Service foreshadowed the type of forensic mental health services considered routine today (Casey and Keilitz, 1989):

[O]ur ideal, was in a sense, a social one. Our service was to give the destitute offender as well as the delinquent of moderate means the same opportunities before the court that had hitherto been the privileges of the rich. The accused who has money can pay a physician to examine him and to come into court to testify to his mental or physical condition. The poor man cannot afford this, and so his real condition often remains unknown to the court. We intended that in Baltimore, so far as in us lay, the poor offender should have the same chances as the rich to make his physical or mental handicaps known to his judges. (Oliver, 1930:18)

Oliver served as the chief medical officer of the Supreme Bench until 1930. He achieved prominence as a forensic psychiatrist, author, lecturer, and criminalist. He was succeeded by Manfred Guttmacher, a psychiatrist who headed the court clinic (today known as the Medical Service of the Circuit Court of Baltimore City) from 1930 to 1966, and who expanded its operation from mental deficiency and "bastardy" to issues of criminal responsibility and competency. Guttmacher, like his predecessor,

achieved international eminence as a forensic psychiatrist. After Guttmacher's death in 1966, this tradition of leadership by the head of the Baltimore court clinic in the field of forensic psychiatry continued with the appointment psychiatrist Jonas R. Rappeport, who has held the position from 1967 to the present.

### **Justice and Mental Health Systems Interactions**

A number of historical developments over the last twenty years, including the expansion of the civil rights movement, the proliferation of the state and federal statutes related to the treatment and care of mentally disabled persons, and a growing national awareness of the rights, obligations, and entitlement of citizens with mental disorder, has lead to an "explosion" of litigation, legislation, and literature in all aspects of mental disability law. The presence of mental health experts in the nation's courtrooms is today a common occurrence. Psychiatrists, psychologists, social workers and psychiatric nurses have become increasingly involved in preparing, evaluating, and presenting evidence in judicial proceedings. The annual number of mental health evaluations performed for the courts alone may exceed two million (Shah and McGarry, 1980). One commentator has suggested that medical reports or testimony is required in 50% to 85% of all trials (Resnick, 1986).

Justice and mental health systems interactions--the overlap of judicial administration and mental health services--can reasonably be described as a growth industry (K. Miller, 1990; Melton, Petrila, Poythress, and Slobogin, 1987; R. Miller, 1988). Agencies and organizations providing mental health services increased from 3,005 to 4,302 between 1970 and 1982, an increase of 43% (National Institute of Mental Health, 1985). One-quarter of all hospital days in the United States in 1981 were accounted for by mental disorder (Kiesler and Sibulkin, 1987). The direct and the indirect costs of mental illness were estimated in 1983 to be almost \$73 billion (Hardwood, Napolitano, and Kristiansen, 1983). The number of mental health professionals (e.g., psychiatrists, psychologists, social workers, and psychiatric nurses)

increased from 23,000 in 1947 to 121,000 in 1977, a greater than 5-fold increase in 30 years (Mechanic, 1980). The number of psychiatrists and licensed psychologists per 1,000 members of the population increased by a factor of 10 over a 30-year period (Cummings and Duhl, 1987). The decisionmaking role and power that has been assigned to mental health professional goes far beyond what anyone would have predicted 30 years ago (K. Miller, 1980; Robitscher, 1980).

While, there has been a considerable amount of attention paid to the structural and administrative aspects of the judicial system (American Bar Association, 1974; Henderson, Kerwin, and Saizow, 1984; Lawson, 1982; Berkson and Carbon, 1978) and the mental health system (Okin and Dolnick, 1985; Goodrick, 1989), inquiry on the structure, organization, and administration of services where the systems interact is scarce. In contrast, the improvement of relations between organizations in the private sector has long been a concern of organizational behavior researchers (Whetten, 1981).

As the number of interactions between the justice and mental health systems increases, the alliances between the two systems will need to become more clearly defined. Improvements of the interorganizational relations will need to be made. Unfortunately, there exists today no generalized framework--even in its broadest form--for understanding such relations. Policymakers, social scientists, administrators and practitioners affected by justice and mental health interactions are left adrift among increased caseloads, service demands, and service providers. The development of mental health assistance programs for courts dealing with each of these casetypes has been idiosyncratic, segmented, and ad hoc (Keilitz, 1989b). Guidance is clearly needed to develop improved mental health services in criminal, civil, and juvenile cases involving claims of mental disorder. What are the systemic problems--theoretical, conceptual, taxonomic, structural, fiscal, administrative and attitudinal--in the interactions of the justice and mental health systems including fragmentation, ad hoc policymaking, "no one in charge," and so forth? What are the special considerations in

the interactions of these two systems with regard to improved organizational relations?

## **Past Research**

The literature on justice and mental health interactions can be grouped in five major areas of inquiry: (1) the articulation and development of universal jurisprudential concerns (e.g., individual rights and liberties of mentally disordered persons and the limitations upon state powers); (2) the identification and characterization of those who are both mentally ill and proper subjects for the justice system (e.g., persons who are insane, who are incompetent to stand trial, or those who are suitable for involuntary civil commitment); (3) the permissible scope of mental health experts' involvement in the justice system; (4) the "ordinary administration of justice" in cases involving claims of mental disorder (e.g., caseflow management of cases involving claims of mental disorder); and (5) the formal structure and organization (the system) of forensic mental health services (i.e., any provision of services by mental health professionals to the justice system).

To date most of this literature is focused in the first three of these areas. Morris and Hawkins (1970) noted that "[r]ivers of ink, mountains of printers' lead, and forests of paper" have been expended on a single issue--insanity and criminal responsibility (viz., whether there should be a defense of insanity and, if so, what the "test" for insanity should be). With a few notable exceptions, the ordinary administration of justice in cases involving mental disorder and its organization as part of the broader systems of justice, mental health, and social service have been largely ignored by researchers and policy analysts. Research and development of responsible public policy on particular forensic mental health services (e.g., expert assistance to indigent criminal defendants in insanity cases) and on the broader systems of services in judicial administration and mental health are meager. Inquiries on court organization and performance (e.g., studies of the pace of litigation and court delay) routinely ignore cases involving claims of mental disorder.

Six efforts have been made to study the system of forensic mental health services and its relationship to the courts. Three focus on the effectiveness of community-based forensic mental health services (Beran and Toomey, 1979; Labin and Spencer, 1976; Melton, Whitehorn, and Slobogin, 1985). The three of the studies are attempts to validate the effectiveness of community-based forensic services in Ohio, Tennessee, and Virginia. Until the late 1970s, most state systems of forensic services fit one basic model, often called a "centralized" approach (Grisso, 1988; Keilitz, 1981). Under this approach, most forensic mental health services are provided in one or two of a state's forensic hospitals or units. More recently, some states have converted to "decentralized" systems whereby services are based in regional or community centers. A number of rationales have been advanced for shifting the bulk of forensic mental health services from centralized institutions to outpatient facilities: (1) saving public monies; (2) minimizing restrictions on the rights of accused persons; (3) minimizing abuses of the criminal justice system; and 4) improving the quality of forensic mental health services (Kapp, 1987).

Three of the studies were conducted by the National Center for State Courts' Institute on Mental Disability and the Law. One was a descriptive study of the organization, administration, and program evaluation of mental health screening and examinations in criminal justice settings throughout the country (Keilitz, 1981; Keilitz and Holmstrup, 1984; Keilitz, 1984). The other is a recently completed evaluation of mental health expert assistance provided to indigent criminal defendants (Casey and Keilitz, 1989). It was prompted by the United States Supreme Court's decision in Ake v. Oklahoma, 470 U.S. 68 (1985), which expanded the rights of indigent criminal defendants to include access to mental health expert assistance if insanity is likely to be a significant issue at trial. The final study, undertaken by an Illinois task force, addressed the broad issues of justice and community mental health systems



interactions involved when an adult who is mentally retarded or mentally ill becomes involved in the state's criminal justice system (Hafemeister 1989a, 1989b).

Although these six studies may have raised more questions than answers--for example, whether decentralization of forensic mental health services is incompatible with the call for coordination and consolidation--they have broken important ground. Keilitz' 1981 work, for example, provides an initial categorization of forensic mental health facilities that has proven useful to others (Grisso, 1988). The studies articulate the hypothetical benefits and disadvantages of various types of systems and suggest that deficiencies in forensic mental health services may be caused or perpetuated by the structural and organizational systems in which they are provided. Together, the studies begin to focus needed attention on the systemic and interorganizational issues related to the structure, organization, and administration of services in legal proceedings involving claims of mental disorder. Although limited, the results address the need for basic information about court and mental health system interactions, for conceptual models to guide system development, and for creative ideas with which to better integrate the work of the courts and forensic mental health professionals.

### **Beliefs, Values, and Goals**

Organizations are cultures with shared beliefs, values, goals and schemes by which organizational members make sense of events and actions. What beliefs, values or goals govern the interactions of the mental health and justice systems? Should they be governed by fundamental purposes of trial courts, such as doing and appearing to do individual justice in individual cases; resolving disputes; upholding federal and state constitutions; working independently of, but in cooperation with, other branches of government; promoting the rule of law; protecting individuals from arbitrary use of government power; due process; public protection; making a formal record of proceedings; and encouraging behavior in accordance with societal norms as expressed

in statutes, ordinances, and regulations (Commission on Trial Court Performance Standards, 1990)? Or should they be governed by the values and goals of the mental health professions, such as reduction of suffering, treatment needs of individuals treatment in the least restrictive environment, and doing no harm (Hippocrates' Oath)? Are there compromises--"therapeutic jurisprudence," the study of the use of the law to achieve therapeutic objectives (Wexler, 1989)--that incorporate the beliefs, values and goals of both the mental health and the justice system? With regard to such "compromises," Wexler (in press) has described how psychological principles governing compliance with medically-prescribed treatment regimes might be used by the judiciary and the legal system to increase the compliance with medication and treatment of conditionally released insanity acquittees.

Questions about beliefs, values, and goals are of more than theoretical interest. How they are addressed can have profound effects on policy and practice. Indeed, what is generally recognized in the private sector is beginning to be acknowledged in the public sector: clear direction, good strategy, and effective implementation of organizational action plans are critical to the success of any organization (Goodrick, 1989). The scope, nature, and consequence of most any interaction of the mental health and justice systems will be determined by the direction-setting question, "What is our function and what will it be?" Addressing it compels thinking about the scope and mix of functions performed by mental health personnel to facilitate courts' adjudicative, investigatory, supervisory, and administrative responsibilities and to reflect on what kinds of interactions and interorganizational relations of the justice and mental health systems should be established and for what reasons. Should a court clinic, for example, provide counseling and treatment of civil and criminal litigants in addition to its more traditional functions of court evaluation and consultation? Is the judicial branch's independence threatened if a court clinic provides treatment to probationers, an action traditionally considered an executive function? Does it matter if a court clinic is aligned structurally and administratively,

with the court as opposed to a community mental health center? Such practical questions will be much easier to answer if the beliefs, values, and goals governing the interactions of the justice and mental health systems are clearly articulated in statements of strategic mission (Thompson and Strickland, 1987).

It would be unfair to imply that mental health law scholars have paid no attention to the beliefs, values, and goals that underlie justice and mental health interactions. Indeed, many commentators have explored the permissible limits of the state's coercive powers stemming from its paternalistic or parens patriae function (the traditional authority to care for those incapable of caring for themselves) and its police power (the mandate to protect the public safety). Their focus of inquiry on legal doctrine and their aim of reform of substantive law (i.e., the "law on the books"), however, are quite different than the emphasis on systemic aspects of the interactions of the justice and mental health systems.

### **Focus on the Trial Courts**

With few exceptions, most matters coming before the courts are initiated and finally determined in the trial courts. The trial court is the "most important and the most complex element of the judicial system" (American Bar Association, 1976:1). The tasks of determining the issues of fact and law, receiving evidence and resolving conflicts in civil, criminal, and juvenile cases involving claims of mental disorder or mental disability are performed largely in the trial courts. A general jurisdiction trial court may provide the following types of forensic mental health services or functions: (a) bail risk determinations focusing on the mental health of the defendant; (b) indigent defense evaluation; (c) other pre-trial mental health "screening" (e.g., competency to confess or waive counsel); (d) determinations of competency to stand trial; (e) insanity at the time of the alleged crime; and (f) presentence or post-conviction mental health evaluations to assist the court in sentencing. Special courts of limited jurisdiction (probate, family, juvenile, and mental health) may provide the

following types of services: (a) involuntary civil commitment determinations; (b) guardianship investigations or evaluations; (c) determinations of civil competency; and (d) mental health evaluations in juvenile proceedings.

The trial court has two important functions. First, it is required to decide disputed issues of fact and law, and formulate sanctions and remedial orders in individual cases according to uniformly applied principles and rules of procedure. Second, it must manage its overall caseload and itself as an organization according to sound administrative policies and practices. The basic aim of the first function is a fair and just determination of individual cases. The aim of the second is to achieve a proper allocation of the court's time and resources among the cases and administrative duties for which the court is responsible. The fair, effective, and efficient administration of justice requires continuous attention to both functions (American Bar Association Commission on Standards of Judicial Administration, 1976).

This view of trial courts depicts them as organizations that must be managed. Just as hospital administration is much more than the sum total of surgeries performed, babies delivered, and pills dispensed, judicial administration of trial courts encompasses much more than the trial of individual cases. It focuses, for example, on the allocation of the court's resources among all its functions. In larger terms, it concerns itself with whether the court allocates its resources in proportion to the legal, moral, and social importance of the problems addressed.

For the most part, mental health law scholars have concentrated their attention on the first function, and then only as an aspect of the decisionmaking context of appeals courts--an approach that has been labelled "appellate psychology" (Haney, 1980, p. 176) and that may be an example of what Professor Jerome Frank described as the "upper court myth," viz., that trial courts are unimportant relative to appellate courts (Frank, 1973). To a large degree, this focus ignores the trial courts' ordinary

administration of justice and their day-to-day business of interacting with the various components of the mental health system.

### **A Conceptual Framework**

This section suggests a conceptual framework for the understanding and the improvement of justice and mental health systems interactions developed as part of a systems analysis of court mental health interactions in Baltimore, Dayton, Detroit, Phoenix, and Tucson (Keilitz, 1989c). Because one of the most enduring concerns in the administration of mental health law is the need for better coordination of a state's mental health system and the justice system, the analysis explored, in particular, the problem of service fragmentation and its solutions by means of collaboration, coordination and consolidation. It outlined a conceptual framework for organizing the various approaches followed by trial courts in securing mental health services, including the collaborative agreements or interorganizational linkages between the courts and the various components to the mental health system. It provides a modest beginning of a taxonomy of courts and mental health systems interactions based upon the perceived degree to which the justice system is integrated with a community's public and private mental health services.

An initial problem encountered in the analysis was the absence of even a rudimentary taxonomy of systemic approaches trial courts have taken in delivering forensic mental health expert assistance in criminal, civil, and juvenile cases involving mental disorder. Table 1 provides the elements of a conceptual framework for such a taxonomy. The framework is based on three "elements" of court-mental health interactions: (1) the services and functions requiring the interaction of courts and various components of the mental health system; (2) the organizational component or unit providing that service or function; and (3) the nature of the interorganizational arrangement. Figure 1 schematically depicts this last element in terms of four types of arrangements for justice and mental health systems interactions: integrated,

coordinated and overlapping, formal and independent, and ad hoc. An additional element that could be added to this conceptual framework is the mission of the organizational component or unit as expressed in terms of the beliefs, values, and goals governing its interactions with the justice or mental health systems.

**TABLE 1**  
**ELEMENTS OF COURT AND MENTAL HEALTH SYSTEM INTERACTIONS**

Court Services/Functions	Mental Health Service Units/Components	Inter-System Arrangements
<ul style="list-style-type: none"> <li>• Criminal, Pretrial Bail Risk Determinations Competency and Insanity</li> <li>• Criminal, Posttrial Presentence Evaluations Post-conviction Evaluation Probation Case Management</li> <li>• Civil Involuntary Civil Commitment Guardianship Investigations and Evaluations Case Monitoring and Management</li> <li>• Juvenile</li> <li>• Domestic Relations</li> </ul>	<ul style="list-style-type: none"> <li>• Court Mental Health Unit</li> <li>• Court Clinic</li> <li>• Community Mental Health Center</li> <li>• Centralized Hospital</li> <li>• Jail Mental Health Unit</li> <li>• Private Providers</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated</li> <li>• Coordinated, Overlapping</li> <li>• Formal, Independent</li> <li>• Ad Hoc</li> </ul>

An integrated arrangement can be characterized as one in which the forensic mental health services are subsumed within the justice system. As depicted in Figure 1, the component or unit providing the services crosses the "boundary" separating the jurisdiction of the mental health system and the justice system. Some types of court clinics and mental health units of probation departments are examples of integrated arrangements. In an integrated arrangement, mental health professionals typically are employees of the court.

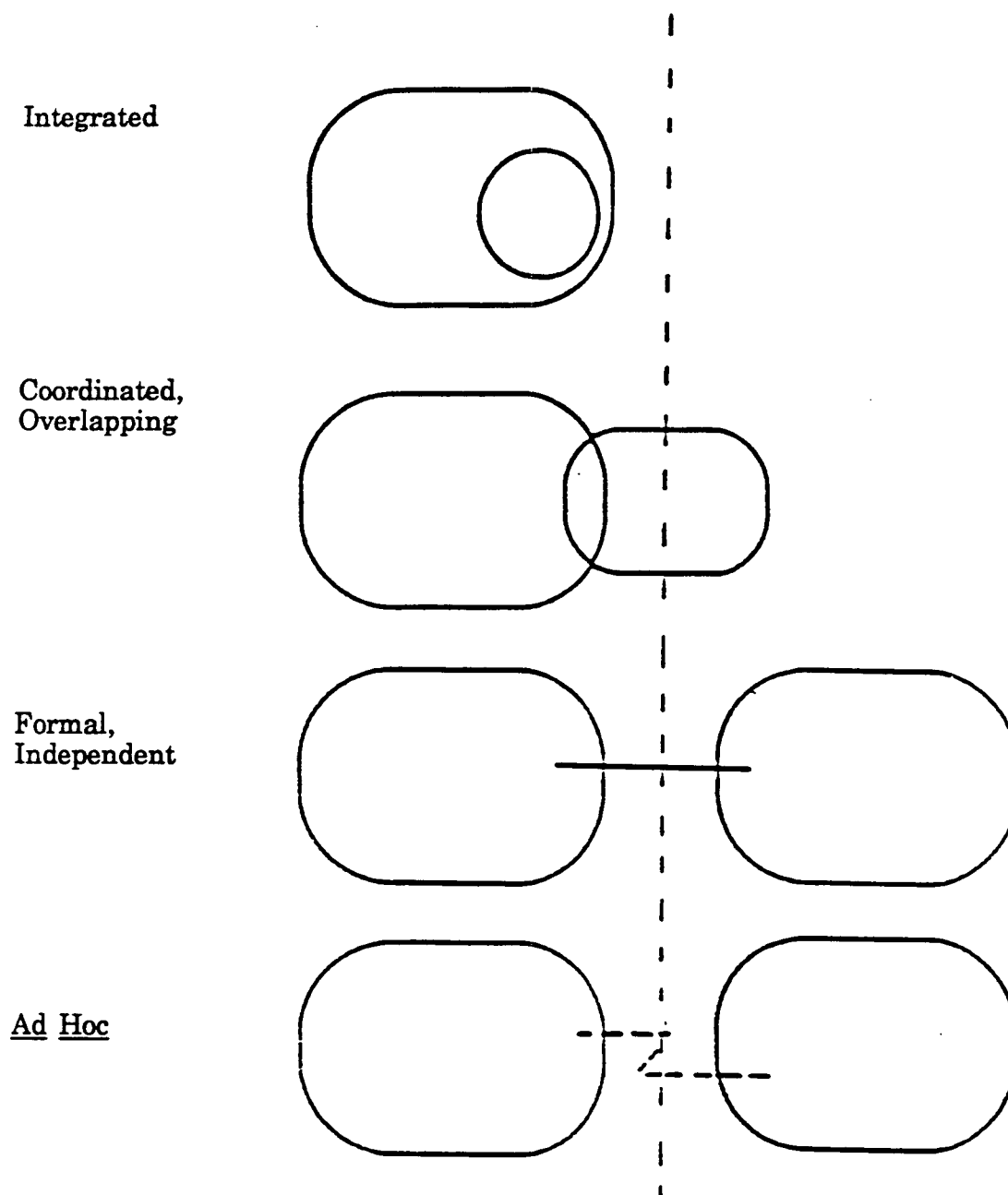


Figure 1. Schematic representation of four types of justice and mental health systems interactions

Coordinated and overlapping arrangements are those in which the justice system and mental health systems maintain their independence but are coordinated and overlap for the purposes of performing a particular court service or function (e.g., determinations of sanity or criminal responsibility at the time of an alleged crime). Under such arrangements, the mental health service component or unit crosses jurisdictional boundaries and overlaps with a component or unit of the justice system. Whereas in integrated arrangements, mental health professionals are employees of the court, in a coordinated and overlapping arrangement they may work in and on behalf of the courts, but yet maintain formal employment with the mental health system.

A formal and independent arrangement is one in which complete system independence is maintained and the court services or functions are performed in accordance with a formal contract or service agreement. Finally, an ad hoc arrangement has none of the structural, organizational, or administrative formality of the other three arrangements. It is characterized by an absence of formal rules and procedures applicable over time. Arrangements between individual judges or attorneys and individual mental health professionals in the private sector are examples of ad hoc arrangements.

These characterizations of interorganizational arrangements should be viewed as constructs or concepts that have opened-ended characteristics. That is, they are not necessarily descriptive of any particular arrangement, nor can they be completely reduced to a set of operational definitions.



## **Taxonomy of Interactions**

If one is ever to develop and improve a social program or set of programs, one must have the means to describe them and the assurance that the description comports with reality. Calling a program of intensive probation supervision a program, for example, does not make it so. The development of court and mental health systems interactions is likely to have been hampered by the absence of a rational means to describe them, to distinguish them from what they are not, and to classify them in some orderly fashion. A rudimentary taxonomy for court and mental health interactions is suggested by the conceptual framework described in the previous section. The further development and refinement of this taxonomy and its actual use in describing and classifying court and mental health interactions throughout the country is a promising area for future research and policy development. In addition, or as an alternative, to the services/functions (e.g., evaluation of criminal competency to stand trial), the unit/component (e.g., court clinic), and the interorganizational collaborative agreements or arrangements between the justice and mental health systems (e.g., formal interorganizational agreements), what other elements should be included in a taxonomy for discussion of interactions of the justice and mental health systems?

The taxonomy of court and mental health interactions suggested may be based upon the perceived degree with which the justice system is integrated with a community's public and private mental health system. Integration is, of course, not the only dimension upon which a taxonomy can be built. Expanding upon Keilitz' 1981 work, Grisso (1988) suggested a number of other dimensions for describing pretrial forensic evaluation agents and systems: (1) comprehensiveness -- the degree to which each pretrial evaluation agent within the system offers diverse forensic services; (2) restrictiveness -- the degree to which the evaluation processes possess the potential for restriction on liberties of criminal defendants; (3) accessibility -- the degree to which pretrial evaluation services are in proximity to courts and jails served;

and (4) due process -- the degree to which law controlling the system are designed to mitigate discretionary abuse of pretrial evaluation services. These dimensions and others should be considered for classifying the considerable functional organizational variability among court and mental health interactions.

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# CRIMINAL COURT CONSULTATION

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# Mental Health Services to the Courts

## A System Isolated from Judicial Administration

INGO KEILITZ

### INTRODUCTION

In 1917, John Rathbone Oliver was a young psychiatrist at the Henry Phipps Psychiatric clinic of Baltimore's Johns Hopkins Hospital.<sup>1</sup> A few blocks away was a small police court. Occasionally, the magistrate of the court would drop by the clinic to discuss cases that he referred to the clinic for diagnoses. Striking up a friendship with the magistrate, Oliver began visiting the court, frequently sitting beside the magistrate on the bench as cases were being heard by the court.

Soon Oliver was spending free afternoons in the police court and in the stationhouse, helping to identify defendants who showed signs of mental disorder. As the word of what he was doing in the police court spread, Oliver was invited to visit other magistrate courts in Baltimore. The next year, Oliver left Johns Hopkins Hospital and began his own private practice, though his interest in delinquency and "legal medicine"

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did not wane. An associate judge of the Supreme Bench of Baltimore City, a former classmate of Oliver's at Harvard, introduced him to the superior (felony) courts, and Oliver was soon helping the courts without compensation as he had done earlier for the magistrate courts. After two years, Oliver was appointed a bailiff—a court officer who has authority, care, or jurisdiction over some aspect of nonjudicial court operation, typically keeping order in the court, custody of the jury, or prisoner security—of the Supreme Bench of Baltimore City. He thus became one of the first psychiatrists to become an official of a court.

For several years, Oliver drew a bailiff's modest salary while he served as a consulting psychiatrist to the court. He had no office, no secretary, and no funds for purchasing equipment and materials. However, after some time and with the help of Oliver's friend, the associate judge who by this time had become chief judge and had visions of creating in Baltimore the type of mental health clinics then attached to the juvenile court in Boston and the criminal court in Chicago,<sup>2-4</sup> the Maryland state legislature passed a bill creating the Medical Service of the Supreme Bench of Baltimore City. This new service of the court was headed by Oliver.

Unlike the courts in Boston and Chicago, which were devoted to providing only mental examinations of cases referred to them by the courts, the Medical Service served the Supreme Bench in the whole area of forensic medicine, performing physical examinations, blood analysis, and examinations of footprints and other physical evidence. Oliver's mission for Baltimore's Medical Service foreshadowed the constitutional right of indigent criminal defendants to free mental health expert assistance articulated by the U.S. Supreme Court almost 70 years later in the case of *Ake v. Oklahoma*, 470 U.S. 68 (1985):

[O]ur ideal, was in a sense, a social one. Our service was to give the destitute offender as well as the delinquent of moderate means the same opportunities before the court that had hitherto been the privileges of the rich. The accused who has money can pay a physician to examine him and to come into court to testify to his mental or physical condition. The poor man cannot afford this, and so his real condition often remains unknown to the court. We intended that in Baltimore, so far as in us lay, the poor offender should have the same chance as the rich to make his physical or mental handicaps known to his judges.<sup>1</sup> (p. 18)

Oliver served as the chief medical officer of the Supreme Bench until 1930 and achieved prominence as a forensic psychiatrist, prolific author, lecturer, and criminologist. He was succeeded by Manfred Guttmacher, a psychiatrist who headed the Baltimore court clinic (today known as the Medical Service of the Circuit Court for Baltimore City) from 1930 to 1966, and who expanded its operation from mental deficiency and "bastardy" to issues of criminal responsibility and competen-

cy.<sup>5</sup> Guttmacher achieved international eminence as a forensic psychiatrist.<sup>6-8</sup> After Guttmacher's death in 1966, this tradition of leadership by the head of the Baltimore Court Clinic in the field of forensic psychiatry continued with psychiatrist Jonas R. Rapoport, who has held the position from 1967 to the present.<sup>5</sup>

The structure and organization of mental health clinics serving the courts throughout the United States are by no means uniform.<sup>2-8</sup> Their variety is typified by the unique origins and idiosyncratic development of the Medical Services of the Supreme Bench of Baltimore City. Unfortunately, though quite a bit is known about *what* court clinics do (e.g., determination of criminal responsibility, assessment of competency to stand trial, and assistance to sentencing judges) and *how* they do it (i.e., the delineation, acquisition, and provision of mental health information to the courts),<sup>2-10</sup> what is known about how the services of court clinics are structured and organized as part of the overall administration of justice is very limited.

The purpose of this chapter is to draw attention to the structure, organization, and administration of mental health expert assistance provided to the courts, especially their integration with court management and the overall administration of justice that exist to enable the courts to resolve disputes brought to them in a just, expeditious, and economical manner.<sup>11</sup> The chapter is based in large part on the work of my colleagues and me at the National Center for State Courts' Institute on Mental Disability and the Law.<sup>5,9,10</sup>

After a brief discussion of court clinics—the most prominent, though certainly not the only structural arrangement for providing mental health expert consultation to the courts—I outline the main premise of this chapter that court clinics are isolated from both the mental health system and the judicial administration. To end this isolation and to enable courts to dispose of the disputes involving claims of mental disorder brought to them for resolution justly, expeditiously, and economically, I suggest that the structure, organization, and administration of mental health expert services for the courts become integrated with the judicial administration of the courts. After a discussion of a recent U.S. Supreme Court decision supportive of this suggestion, several proposals are made to achieve this integration. Although the focus of the chapter is on court clinics, the issues raised pertain in varying degrees to other arrangements for the provision of mental health expert assistance to the courts, including centralized state institutions (security hospitals), community and regional forensic mental health programs, state and regional correctional institutions, community corrections programs,<sup>3,5</sup> as well as private practitioners working for the courts on a fee-for-service basis.

### COURT CLINICS TODAY

Unfortunately, only rough estimates of the number of court clinics in the United States exist. A few commentators, however, have attempted to estimate the frequency of mental health evaluations or consultations performed on behalf of the judicial system. In 1968, Pollack estimated that the total number of "psychiatric-legal consultations" in the United States exceeds one million.<sup>12</sup> More recently, Shah and McGarry estimated that the annual number of forensic mental health evaluations of all types approaches or even exceeds two million.<sup>3</sup> Assuming that these estimates are credible approximations, that is, that as many as two million mental health evaluations and consultations are performed each year for the nation's 18,000 courts of general, limited, and special jurisdiction,<sup>13</sup> it is indeed surprising that so little has been written about how these "peripheral" court services are structured, organized, and administered within the courts.

In 1981, I described forensic mental health programs in five types of facilities: (1) court clinics, (2) centralized state institutions, (3) community and regional forensic mental health programs, (4) state and local correctional institutions, and (5) community corrections programs.<sup>5</sup> Although each provides, in varying degrees, direct or indirect mental health expert assistance to the courts (the Department of Correctional Health Services in Phoenix, Arizona, for example, conducts mental health screening of defendants who raise the issue of competency to stand trial in the Maricopa County Superior Court<sup>14</sup>), court clinics represent the most prevalent mechanism by which courts avail themselves of the assistance of mental health professionals. Generally speaking, court clinics are outpatient mental health clinics located in or near courthouses that are designed exclusively to serve the courts and other components of the justice system (e.g., probation departments, public defender offices, and such pretrial programs as bail release services). They may be aligned with one or more of the divisions of general or limited jurisdiction courts—civil, criminal, probate, family, or appellate. Court clinics can be different: ordered on the basis of the size and nature of their case-loads, the sources of referrals (e.g., the various divisions of courts, probation departments, and law enforcement agencies), the stages in the court proceedings when referrals are made to them (e.g., pretrial, sentencing, or after conviction), staff, budget, type of reporting mechanism (i.e., written reports or testimony), treatment provisions, data collection methods, and many other factors.<sup>5</sup>

Typically, the staff of a court clinic consists of a group of mental health professionals (mostly psychiatrists, psychologists, and social workers), administrators, support personnel, and any number of part-time

consultants. Some clinics have large, full-time staff who are well coordinated as a team, while others rely heavily on consultants who function relatively independently.<sup>5</sup> Some court clinics provide a relatively wide range of services to the courts, including screenings, evaluations, and consultations related to criminal matters (e.g., competency to stand trial, bail release, insanity, and sentencing considerations), civil matters (e.g., involuntary commitment, guardianship, and competency to refuse medical treatment), juvenile proceedings (e.g., delinquency status), and family disputes (e.g., child custody, neglect, and divorce actions), as well as treatment and training services. Other clinics are designed to provide only advisory opinions on specific mental health questions for judges and other court personnel.

A serious difficulty in determining the number of court clinics stems from the variety of structures in which they operate. Many court clinics in larger cities are physically located in courthouses and are administratively associated with felony courts. Others operate under the aegis of the state mental health system or, alternatively, public or private community mental health programs; they may be located in a centralized or regional hospital or a community mental health center.<sup>5</sup> Some court clinics are funded totally by the court system they serve. Others may be "annexed" by the courts or operated under a contractual agreement with the court. Still other clinics are allied with the courts but receive only a portion of their funds (e.g., for capital expenditures but not staff) from the courts. Most court clinics are specialized according to the requirements of a particular division of a general or limited jurisdiction court (e.g., competency to stand trial evaluations for a felony court) and units of the legal system (e.g., assessments of amenability to treatment for a probation department). To make matters more complicated and potentially more confusing for those wishing to identify and classify court clinics, some court-related services operating under the rubric of "court clinic," such as mediation services in divorce or child custody matters, do not deal with mental health issues directly.

How many court clinics provide mental health expert assistance to the approximately 18,000 courts in the United States? In 1966, Guttmacher identified 30 psychiatric clinics of varying descriptions serving adult criminal courts throughout the country.<sup>6</sup> The responses to a 1970 survey identified 53 court clinics in 10 states and the District of Columbia.<sup>15</sup> As of July, 1983, 31 court clinics were offering a full range of services in Massachusetts alone, with an additional 28 more offering limited or partial services.<sup>3</sup> Ohio has close to 20 court clinics, though they are not named as such.<sup>5</sup> Shah and McGarry recently estimated that the number of court clinics most probably exceeds 100 today.<sup>3</sup> Although no recent survey of court clinics exists to confirm or refute these esti-

mates, it seems reasonable to suggest that the number of organizational entities that function as court clinics is probably higher than 100 and closer to 250—the approximate number of major metropolitan areas in the United States.

The establishment of a reliable estimate of the number of court clinics may give impetus to answering important questions about the structure, organization, and administration of mental health expert assistance and other “peripheral services” of the courts (e.g., forensic investigations) not *directly* involved with the courts’ fundamental dispute resolution functions. For example, are court clinics (should they be) structured and organized as an integral part or as an annexation of the judicial system, as part of state, regional, or community mental health systems, correctional system, the private sector, or some combination of these? How do such organizational structures relate to the various components and units of the judicial systems (e.g., criminal courts, civil courts, family courts, municipal courts, probation departments, public defenders offices, prosecutors offices, pretrial services, and so forth)? How does the organizational structure of court clinics relate to the legal issues and questions that clinics are asked to address by the courts? To what ends are the various structural arrangements applied? By what standards should their overall accomplishments be evaluated. Meaningful answers to such questions will depend, to a large extent, on whether court clinics and other peripheral services of the courts are viewed as integral to or outside of the purview of judicial administration.

#### **AKE VERSUS OKLAHOMA**

As noted earlier, John Rathbone Oliver intended that the court clinic he founded in Baltimore in 1918 serve indigent defendants so that, in Oliver’s words, the “poor offender should have the same chance as the rich to make his physical or mental handicaps known to his judges.”<sup>11</sup> (p 18) He was expressing a fundamental concern for equality and fundamental fairness by suggesting that legal resources, in particular mental health expert assistance, should not be dependent on a defendant’s ability to pay for those resources. The court should manifest a like concern for poor and wealthy litigants.<sup>16</sup> This same concern was voiced by the U.S. Supreme Court in 1985 in the form of a constitutional entitlement in the case of *Ake v. Oklahoma*, 470 US 68 (1985). The Court ruled that an indigent criminal defendant is entitled to state-funded psychiatric assistance to help in the evaluation, preparation, and presentation of a defense if a defendant’s sanity is likely to be a significant issue at trial.

The events that gave rise to the decision in *Ake* began in October of 1979, when Glen Burton Ake and an accomplice broke into the home of an Oklahoma couple, killing them both and wounding their two children. After a month of criminal activity, Ake and his accomplice were apprehended in Colorado. Ake was extradited to Oklahoma and tried in the District Court of Canadian County, Oklahoma, in November of 1979. At his arraignment, the Oklahoma trial judge found Ake's behavior to be so disruptive and "bizarre" that he ordered a psychiatric examination of Ake to determine his competency to stand trial. The psychiatrist who examined Ake found him to be delusional and diagnosed his condition as paranoid schizophrenia. He recommended that Ake undergo observation and evaluation in a mental hospital. Based on psychiatric testimony during the ensuing hearing on his competency to stand trial, Ake was determined to be unfit to stand trial and committed to a state mental hospital to regain his competency. Six weeks later, Ake was found legally competent to stand trial, provided that he continue to take antipsychotic medication three times a day to help him keep stable.

At a pretrial hearing, Ake's court-appointed attorney made known to the court his client's intention to rely on an insanity defense. He requested a psychiatric examination of Ake's sanity at state expense because Ake could not afford to pay for such assistance. The court denied the request, and the case proceeded without the benefit of a mental examination of Ake's sanity. Since Ake was therefore unable to present expert testimony in support of his insanity defense, his sole defense at trial was that he was legally insane at the time of the offense. Although testimony was presented by a court-appointed psychiatrist that Ake was dangerous to society, no mental health testimony was presented regarding his sanity at the time of the offense. A jury found Ake guilty on all counts. At a capital sentencing hearing held before the same jury, the prosecutor asked that Ake be given the death penalty. Ake presented no mitigating evidence or testimony to rebut the psychiatrist who testified about his dangerousness. The jury imposed the death sentence. Ake appealed to the Oklahoma Court of Criminal Appeals. The court rejected Ake's claims that he had been denied access to psychiatric assistance in violation of the Fourteenth Amendment to the Constitution and affirmed the guilty verdict and the death sentence. Ake sought review of the decision by the U.S. Supreme Court.

The Supreme Court reversed and remanded the case. Justice Thurgood Marshall's majority opinion held that without the assistance of an independent psychiatrist Ake would not have had a fair opportunity to present his insanity defense and thus he was denied his constitutional right to due process. When sanity is a significant factor in a criminal defense, he wrote, the state must provide a criminal defendant with a "competent psychiatrist who will conduct an appropriate exam-



ination and assist in *evaluation, preparation, and presentation* of the defense." The appointed psychiatrist must be independent of both the prosecution and the court, must be available for pretrial consultation as well as for trial assistance, and should be dedicated to the defendant's cause. Even though the court limited a criminal defendant's right to free mental health expert assistance by stating that a defendant does not have a constitutional right to choose a psychiatrist of his or her "personal liking" or to receive funds to hire his or her own, the Court's definition of competent expert assistance would seem to encompass almost any activity under the general rubric of "evaluation, preparation, and presentation of the defense" that an attorney would consider necessary (or desirable) for an insanity defense.<sup>17-19</sup>

Narrowly conceived, the *Ake* decision did no more than give constitutional dimensions to assistance that most states were already providing to indigent criminal defendants before *Ake*.<sup>17</sup> Viewed in broad organizational terms, however, the decision did much more than give voice to the constitutional right of indigent criminal defendants to mental health expert assistance. Its lasting significance may lie in the attention it draws to the need to link mental health expert services organizationally with some component of the justice system. It sent a clear signal to the courts that mental health expert assistance is part of the "raw materials integral to building of an effective defense" thereby linking the structure, organization, and administration of mental health expert services provided to indigent criminal defendants with indigent defense systems.

The private bar has a long tradition of assisting the nation's courts on a *pro bono publico* basis or for minimal compensation. Private lawyers provide legal representation to indigent criminal defendants and serve in judicial or quasi-judicial capacities. The assistance they give to the courts has been structured and regularized throughout the country.<sup>17</sup> No such tradition of public assistance exists for mental health professionals recruited to help the courts in cases involving mental health law issues. Although no one would argue that the amounts of help provided indigent defendants by lawyers and mental health professionals are comparable, the nature of the issues are quite similar. How should the help be given? By whom? How and by whom should the expert services be structured and controlled? Who should bear the costs? Should the assignment of mental health experts be ad hoc, coordinated by the courts, or administered through public defender systems? On what basis should the results of the mental health expert assistance be evaluated? By linking the provision of mental health expert assistance to the indigent criminal defense system in its decision in *Ake v Oklahoma*, the Supreme Court may have forced the integration of mental health services

provided to the courts—including those provided by court *clinics*—with judicial administration.

### INTEGRATING COURT CLINICS WITH JUDICIAL ADMINISTRATION

The premise that forensic mental health programs in the courts, such as court clinics, are detached and isolated from the systems that serve mentally disordered defendants raises an important question: What systems are these programs detached and isolated from or, more importantly, what systems or components of the justice, mental health, public safety, and social service systems should these programs be integrated with? As already suggested earlier, it is my belief that these programs are much too detached from, and need to be integrated with, judicial administration and the management of the courts.

Organizational theory tells us that good managers must organize and manage the whole organizational environment, not just a unit or subset of an organization. The environment of court clinics and the work that they do is the environment or the domain of judicial administration. In August, 1969, soon after he became Chief Justice of the United States, Warren E. Burger observed:

The courts of this country need management, which busy and overworked judges, with drastically increased caseloads, cannot give. We need a corps of trained administrators to manage and direct the machinery so that judges can concentrate on their primary duty of judging. Such managers do not exist, except for a handful who are almost entirely confined to state court systems. We must literally create a corps of court administrators or managers and do it at once.<sup>20</sup> (p. 1)

As a result of former Chief Justice Burger's efforts and those of the National Center for State Courts, among other individuals and groups, court managers have become an increasingly important part of the courts. Today, court managers serve in most of the 18,000 court systems in the United States, and court administration has become a growth industry. To repeat the major premise and proposal of this chapter, I contend that it is court administration from which those of us who work within the forensic mental health systems—especially court clinics—have been isolated, and it is with court administration that the system needs to be integrated.

Beginning in the 1980s, an approach, consistent with this premise and proposal, referred to as "social science in the law" appeared to be gaining momentum.<sup>21</sup> This approach diverged with the law and society

tradition in taking an "insiders" perspective of the judge, the court manager, and the legal practitioner, rather than the "outsider" perspective of the social scientist. The approach is applied in nature and asks what mental health professionals and social scientists can contribute to the functioning of the justice system. It is in sharp contrast to the approach that uses such mental health issues as insanity, competency, or civil commitment as the research context or merely the "cover story" for advancement of social science theory (e.g., attribution theory) or as a means for advancing disciplinary concerns (e.g., professional parity between psychologists and psychiatrists).

Assuming that the isolation of the forensic mental health system represented by court clinics is real and that the call for its integration with judicial administration and the management of the courts has merit, what precisely should be done to achieve this integration and put an end to the isolation? Five proposals are offered: (1) increased attention paid by mental health law professionals and researchers to the structure, organization, and administration of mental health assistance provided to the courts; (2) evaluations of court clinics and other related forensic mental health programs in terms of established goals and standards of *court* performance; (3) specific programs of research of forensic mental health issues particularly germane to judicial administration; (4) demonstrations of innovative organizational structures for delivery of forensic mental health services to the courts; and (5) the professionalization of the forensic mental health "practitioner-manager" working within the courts. Arguably, some of these proposals have merit regardless of whether forensic mental health programs are integrated with judicial administration.

#### **Increased Attention to Structure, Organization, and Administration**

A logical first step toward an integration of forensic mental health programs with judicial administration is to focus greater professional and scholarly attention on the structures, organizations, and administration of mental health programs providing services to the courts. As suggested earlier, such attention is likely to stimulate research in an area where little research exists today with results that are likely to be of great interest to the field of judicial administration. Relatively simple descriptive studies, for example, could establish reliable estimates of the number of mental health forensic units as well as their location within the judicial system. It is highly doubtful that each of the 18,000 courts in the United States has its own forensic mental health program, but the total number of courts stands as the outside estimate of the number of such programs. Other descriptive studies could ascertain the structures,

organizations, and various administrative mechanisms of the forensic mental health programs and from this information develop a tentative typology. Further, experimental research could link this typology to outcomes. Does one typology, for example, lead to better justice, swifter justice, or more satisfaction among participants in judicial proceedings?

### **Court Performance Evaluation**

It is axiomatic that court clinics and other mental health programs serving the courts are valued by court managers to the extent that they contribute to a court's performance according to established standards. Such standards are being developed by the National Center for State Courts<sup>22</sup> in six performance areas: (1) access to justice (courts shall be accessible to all those who need to, or are required to, participate in their proceedings); (2) expedition and timeliness (courts should meet their responsibilities to all individuals, groups, and entities affected by its actions and activities without delay); (3) equality and fairness (courts should provide due process and equal protection to those who have business before them and be fair in the decisions they reach and in the actions they take); (4) legality, fidelity, and reliability (courts' actions and decisions, their legal and factual antecedents, and their consequences should be well integrated); (5) institutional integrity (if courts are to fulfill their role within our constitutional form of government, they must assert their distinctiveness and independence from other components of government); and, finally, (6) public trust and confidence (the justice delivered by the courts must be seen and appreciated to be done). Assessment of the structure, organization, and administration of mental health services in the courts on the basis of *court* performance standards and measures in these areas is likely to bring such services into the mainstream of judicial administration.<sup>17</sup>

### **Research in Judicial Administration**

Research of mental health services to the courts applied to specific problems in judicial administration may help bring these services into the mainstream of judicial administration by creating new knowledge that is of interest and utility for court managers. For example, a nagging problem in judicial administration is court delay. Caseload management (i.e., analyzing and evaluating pending caseloads and implementing effective court calendar management) is a basic function of court managers. A promising piece of applied research—one that court managers likely will find very useful—would investigate the effects of requests for mental health assistance on case-processing times. In some courts, cases

in which insanity defenses are asserted—in which a defendant's competency is questioned, or in which mental health information is sought by a trial judge to assist in sentencing—and other cases involving claims of mental disorder are often not considered among those the court can adequately manage. One court administrator, who took considerable pride in his court's successful program of case delay reduction, recently remarked to me that he had repeatedly failed to control the pace of litigation of cases in his court involving claims of mental disorder. Research of delay in processing cases involving claims of mental disorder would create information useful for court managers and, thereby, help to integrate mental health services with judicial administration.

### **Demonstrations of Innovations**

Experimentation with and demonstration of innovative organizational structures of forensic mental health delivery systems may also have some healthy returns for moving court mental health services programs into the mainstream of judicial administration. One such innovative organizational structure may be a comprehensive, unified court clinic that is consistent with a unified court system. A unified court system is one in which a multilevel fragmented system of general, limited, and special jurisdiction courts is replaced with a unified administrative structure responsible for systemwide planning, budgeting, accounting, research, and personnel administration. In a unified court system, it is the individual judges within a general jurisdiction court, rather than the courts, who specialize. That is, the various types of cases brought before the courts—civil, criminal, probate, juvenile, and domestic relations—are heard by individual judges (perhaps organized into court divisions or departments) within a single court rather than by separate courts.

In a similar way, a unified, comprehensive court clinic would merge all functions performed by mental health and social service professionals on behalf of the courts under one organizational structure and one roof rather than keep each function matched with its own separate organizational entity (e.g., a juvenile court clinic performing services for juvenile cases exclusively). The functions of such a unified court clinic would include, but not be limited to, the following: (1) in criminal proceedings, assessments of competency to stand trial, determinations of criminal responsibility, pretrial release suitability, and assessments before and after sentencing; (2) in civil proceedings, examinations to determine a person's suitability for involuntary civil commitment, guardianship, or protective placement; and, determinations of a person's capacity to make decisions regarding treatment and financial matters; (3) in juve-

nile proceedings, interviews and psychological testing to assist in adjudication and disposition of delinquency cases; and (4) in family matters (e.g., divorce and custody), mental health assessments of parents and children to inform decisions about the nature and focus of mental health care or treatment and related social services.

In addition to these functions, a unified clinic may provide a certain amount of consultation and treatment. In Massachusetts, the court clinics, for example, provide a limited treatment to individuals referred by judges and probation officers. The clinics work collaboratively with probation officers on court-referred cases. Clients are accepted for short-term or long-term treatment including psychotherapy, family therapy, group therapy, and chemotherapy.<sup>12</sup>

Traditionally, the functions envisioned for a comprehensive, unified court clinic are performed by separate and fragmented units. In one borough of New York, for example, the criminal court clinic and the family court clinic function totally separately with no overlap in organization, staff, or operation despite the fact that these two clinics occupy two floors of the same building. Although some of the court clinics in Massachusetts come close, the concept of a unified, comprehensive court clinic has not been tried.

### Professionalization

One final proposal, if implemented, may end the isolation of forensic mental health programs aligned with the courts in a more *direct* way. It calls for the professionalization of the forensic mental health clinician-administrator through the creation of a professional organization—perhaps named the National Association of Court Clinic Managers—devoted to the improvement of the structure, organization, and administration of “peripheral” services provided to the courts. Such an organization could seek affiliation with existing professional organizations, such as the National Association for Court Management, established in 1984 by consolidation of the National Association of Trial Court Administrators and the National Association for Court Administration.<sup>10,23</sup> Much like the National Association for Court Management, which represents court managers, a professional organization of clinicians-administrators could become the voice of effective, well-informed professional managers of court clinics.

The staff members of court clinics often have one foot in the mental health system and the other in the justice system. Reminiscent of John Rathbone Oliver's expedient appointment as a bailiff of the Supreme Bench of Baltimore City, court clinic staff may feel themselves isolated—even alienated—from the mainstream of the court's work as well as from

their primary professional group or discipline (psychiatry, psychology, or social work). Court clinic workers may be viewed as misfits by judges and other court personnel, because the peripheral services they perform for the courts may not be considered part of the mainstream of court administration, despite the widespread recognition that the services they provide are a requirement in judicial proceedings.

Within their own professions, court clinic professionals may also view themselves as misfits. Although each of the professions of psychiatry, psychology, and social work has one or more organizations concerned with mental health law issues,<sup>3</sup> the organizations' programs are dominated by scholarly questions (e.g., whether the insanity defense ought to be abolished), technical matters (e.g., appropriate measures of malingering by criminal defendants and plaintiffs in personal injury cases), and relatively narrow and parochial disciplinary issues (e.g., whether only psychiatrists and clinical psychologists ought to be qualified to assess competency to stand trial).

Court management appears to be the professional area where the various disciplines represented by court clinic staff converge. Virtually every writer in the field of judicial administration has stressed the need for good management of the courts by trained professionals to organize and administer nonjudicial matters under the general guidance of judges, just as city managers, school superintendents, and hospital administrators direct, organize, and manage other institutions. The time may be right to bring the peripheral services provided by court clinics into the mainstream of court management. A professional organization of clinician-managers of court clinics may achieve this goal.

## CONCLUSION

In this chapter, I urge those who provide mental health and related social services to the judicial system to become more concerned with the management and improvement of the courts and thereby end their virtual isolation from the system they serve. I recommend that they pay more attention to and refocus their inquiry on the structures, organizations, and administration of forensic mental health programs serving the courts. I also feel that they should apply performance standards established for courts to the work that they do for the courts and do more applied research directly relevant to the concerns of judicial administration (e.g., studies of the effects of mental health examinations on court delay). I urge them to experiment with different organizational structures of forensic mental health services delivery that are consistent with modern court reform (e.g., a unified, comprehensive court clinic). And,

finally. I propose that they establish a national organization of clinician-managers aligned with professional court administration.

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*Handbook on*

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**MENTAL HEALTH  
POLICY IN THE  
UNITED STATES**

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## Legal Issues in Mental Health Care: Current Perspectives

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INGO KEILITZ

Beginning in the 1960s, the plight of mental patients—especially those warehoused in large, public institutions with inadequate professional staff, little or no treatment, and deplorable living conditions—became a civil rights issue of the first order (Brakel, Parry, and Weiner, 1985). Aggressive legal advocacy led to the widespread adoption of legal safeguards for involuntary mental patients resembling the due process guarantees of the criminal justice model. During the late 1960s and early 1970s, mental health law emerged as an identifiable discipline, overlapping with the traditional fields of psychiatry, law, psychology, sociology, and philosophy. Marking this emergence, the Mental Health Law Project, a public interest law firm at the center of much mental health litigation then and now, was formed in 1972; the first casebook in mental health law appeared in 1974 (Brooks, 1974); and professional organizations concerned with mental health law issues established divisions, each with its own journal, focusing on legal issues in mental health care.

In the last twenty-five years, mental health law has flourished as a rapidly growing field of scholarship and practice. Dozens of journals and hundreds of books devoted exclusively to mental health law have produced a burgeoning literature (Shah, 1981: 219–220). “Rivers of ink, mountains of printers’ lead, and forests of paper” have been expended on the topic of the insanity defense alone (Morris and Hawkins, 1970: 176). Indeed, today it would be difficult for

mental health professionals, administrators, and practitioners alike to avoid the confluence of mental health and the law.

This chapter describes a decided shift which has occurred in recent years in the underlying approach, guiding formula, or pattern of inquiry in mental health law, from an emphasis on ideology and doctrine to empiricism and pragmatism. I describe this shift, which I regard as a sign of the maturing of this field of specialization, in general terms. The major portions of the chapter then explore its impact in six areas of interaction between the legal and mental health systems: (1) involuntary civil commitment, (2) compulsory outpatient treatment, (3) the insanity defense, (4) competency to stand (criminal) trial, (5) treatment refusal by mental health patients, and (6) mental health malpractice. Much of the material in these sections draws on the work of me and my colleagues at the National Center for State Courts' Institute on Mental Disability and the Law. The chapter concludes with some observations about implications of the shift for public policy, mental health service delivery, and research.

### **PRAGMATISM AND EMPIRICISM OVER IDEOLOGY AND LEGAL DOCTRINE**

Walter Lippmann (1927: 18) observed that "we do not first see, and then define, we define first and then see." Aggressive legal advocacy on behalf of mental patients during the 1960s and early 1970s was fueled by clashing ideologies that defined the paradigm governing what we "saw." ("Paradigm" as used here refers to the general structure and mode of inquiry used to frame a problem and identify solutions.) Logic and reason were applied in the service of such self-evident native principles as individual freedom, privacy, and human dignity, on the one hand, and the abstract ideas of helping others, the general welfare, and the needs of an organized society, on the other hand. These values and ideologies defined and made us see what *ought* to be. At the heart of this enterprise, which involved a clash of philosophies, values, and professional ideologies, were difficult questions about the proper balance between the need for legal safeguards against improper commitment—which would delay and complicate treatment—and the need to allow mental health and social service professionals sufficient discretion and autonomy in their decision making—which might endanger the civil liberties of involuntary patients. Yet most observers readily agreed that existing laws, particularly concerning the rights of mental patients and the essential obligations of the state, needed to be reformed to eliminate the horrors of insane asylums and to curtail the mistreatment of mental patients.

By the mid-1970s, most states had established laws providing significant substantive rights and entitlements to involuntary mental patients resembling the due process guaranteed criminal defendants (e.g., the right to a lawyer, a judicial hearing, the right to notice, and so forth). Reform was advocated and implemented according to the paradigm that was then the stock-in-trade of the legal

scholar, advocate, and, to a lesser degree, the social philosopher: A social ill was brought successfully to public attention; the question "What ought to be?" was addressed by the application of rational analysis to self-evident, albeit abstract, principles and concepts; and, finally, new rights and entitlements were afforded mental patients who were subjected to state coercion.

This emphasis on reforming the "law on the books" dominated the practice and development of mental health law throughout the mid-1970s. Many academic psychiatrists, psychologists, and sociologists joined ranks with legal scholars in analyzing the substantive and procedural law formally governing criminal defenses based on mental aberration, competency to stand trial, involuntary civil commitment, civil competency, tort liability of mental health professionals, and other legal issues. Though mental health program directors, mental health professionals, mental patients and their families often had difficulty reconciling the abstractions of legal doctrine and rational analysis with their own daily needs and activities, for the most part they deferred to contending medical and legal professionals, whose positions owed much to ideology and varying territorial interests.

Without negating the success of this paradigm in tackling what have been referred to as "first-generation" issues in mental health law (Wexler, 1981: 257-261)—tighter commitment standards, procedural safeguards, durational limits on confinement, and deinstitutionalization—many observers began to question the utility of the governing paradigm by the early 1980s. First, successful litigation and legal reform had spawned a host of "second-generation" issues that did not yield easily to the use of the paradigm. Ideology was seen as largely irrelevant to understanding the wide gap between the "law on the books" and the "law in practice" (Shah, 1981: 255). Second, in many ways the paradigm did not fit well the realities facing the public mental health system: a dramatic decline in the number of patients residing in large public hospitals; an increase in the number of chronically mentally ill persons who were poor, uninsured, or underinsured; a burgeoning homeless population; the transinstitutionalization of mentally ill patients from public hospitals to other institutions including nursing homes, jails, and temporary shelters; a critical shortage of adequate community-based mental health care and related social services; escalating costs of all human services at a time of increased pressures to control expenditures; and continued prejudice against and fear of mentally disabled persons among the general public.

So it was that the predominant question "What ought to be?" began to give way to the questions "What actually is?" and "What can be?" Ideology, doctrine, and theory surrendered ground to pragmatism and empiricism. This shift in governing paradigms, which will be discussed in this chapter in the context of a number of areas of mental health law, has significant consequences for mental health. Not only does it alter the questions that are asked, but the shift inevitably brings into the conversation the great majority of mental health professionals who are not lawyers, legislators, legal scholars, or social philosophers.

## INVOLUNTARY CIVIL COMMITMENT

Involuntary civil commitment is the legal, medical, and psychosocial process—operating at the confluence of the mental health, public safety, justice, and social service systems—whereby an individual alleged to be mentally ill and dangerous to self or others and in need of treatment is forced into involuntary mental health care, presumably for his or her own good and the good of others. The ways in which this authority is exercised reflect different combinations of legal criteria which establish the situations and characteristics of persons who may become subject to commitment, as well as the obligations of the state to function as the protector of society.

Today, involuntary civil commitment is usually the last resort used by family members, law enforcement officers, mental health and social service professionals, and judicial officers for providing treatment and care to individuals who are either unwilling or unable to receive such services voluntarily. Decision making requires a balance among three complex and often competing societal interests: those of the individual, the family, and the state. First and foremost, the individual has an interest in being left alone. Even if compelling reasons exist for infringing on his or her privacy and freedom, the individual maintains an interest in being treated fairly, honestly, and as humanely as possible. Second, the family, as well as the individual's friends, acquaintances, and the community in which he or she lives, have an interest in providing the individual the care and treatment that he or she may desperately need but is unwilling or unable to seek voluntarily. Families may also have an interest in lightening the often overwhelming burden that a failure to provide professional treatment and care to their loved ones may entail. Finally, the state, as the protector of society, has two essential interests: first, to protect its citizenry from dangerously mentally disabled persons and to care for its sick and helpless; second, to carry out its obligations and duties as efficiently and economically as possible. What should be clear is that a perfect balance among the interests of the individual, the family, the community, and the state in involuntary civil commitment may not be possible, because the process involves competing moral values, political ideologies, and different approaches to decision making.

During the last three decades, intense debate and controversy have centered on the factors that commitment courts are legally required to consider in deciding whether or not a person is a proper subject for involuntary civil commitment. These factors make up the standards, criteria, or tests for involuntary civil commitment, factors that many consider the core of commitment laws. They include mental illness; present or future dangerousness to self, others, or property; a likelihood that the person will suffer substantial mental or physical deterioration in the future; impaired capacity to make informed decisions about treatment and care; the probability of successful treatment and care; and the availability of alternatives to involuntary civil commitment. Reflecting the long-standing dominance of abstract legal doctrine over pragmatism and empiricism, much of the

history of involuntary civil commitment in the United States has been a working and reworking of these formal legal tests for commitment, with relatively little regard to whether the different tests make any difference in actual practice.

The November 1986 publication of the National Center for State Courts' "Guidelines for Involuntary Civil Commitment" signaled a new direction. Based on a five-year research project of the National Center's Institute on Mental Disability and the Law, and two years of hard work by a national task force composed of prominent mental health, justice, and law enforcement experts, as well as representatives of citizen and advocacy groups, the guidebook contains fifty guidelines with detailed commentaries and reference notes for use in making involuntary civil commitment as fair and workable as possible.

Departing from the tradition of past initiatives to reform involuntary civil commitment (Parry, 1986), the "Guidelines" does not advocate a particular legal standard for commitment to be applied in all jurisdictions, but instead recommends the careful application of extant standards prescribed by state statutes. The National Task Force on Guidelines for Involuntary Civil Commitment, the group that formulated the "Guidelines," expressed the concern that the calibration of a statutory standard for commitment may have been overemphasized and due consideration of the conscientious administration of those standards underemphasized (National Center for State Courts, 1986: 493-497). The Task Force agreed that an overemphasis on the particular wording and the ideological underpinnings of states' commitment criteria may have prevented attention and valuable resources of the mental health, justice, public safety, and social service systems from being applied instead to improve procedure and practice.

A basic premise of the "Guidelines" is that the tendencies to view complexities of the involuntary civil commitment process in abstract, polar terms—e.g., personal liberties versus treatment needs, doctors versus lawyers, the legal model versus the medical model, or the police power of the state versus its *parens patriae* function—are stultifying and counterproductive. Perhaps theoretically and historically useful, such dichotomies do not fit the realities facing the public mental health system today and are at odds with signs pointing to a virtual breakdown of that system (e.g., the emergence of a dual system of care for the poor and for those who can afford to pay). Rather than focus on the "law on the books," where most of the debate about civil commitment has centered, the "Guidelines" directs attention to the process of involuntary civil commitment, its organization and structural arrangements, and its everyday administration, that is, the "law in practice." Involuntary civil commitment is defined as a process that, though operating within the general framework of legal principles, legislation, and court decisions, is shaped and adjusted by a host of extralegal factors identified with the workings of the various components of the mental health, justice, public safety, and social service systems including hospitals, community mental health centers, social service agencies, courts, law enforcement agencies, bar associations, advocacy groups, and legislatures. Accordingly, the main task set for improvement of the process is not further analysis of legal

doctrine and a resulting press for legal reform, but rather the description of the actual characteristics of the commitment process, the identification of "trouble spots," and the development of promising solutions inspired by empirical research.

Because commitment processes throughout most of the country are fragmented and uncoordinated, the "Guidelines" encourages continuity and better coordination of the interrelated tasks and events for which the various components of the systems assume responsibility, as well as increased communication and cooperation among those responsible for administering the processes. The first three guidelines set the stage for this to occur. Guideline A1 (National Center for State Courts, 1986: 421-423) calls for the creation of interdisciplinary "community coordinating councils" made up of representatives of the components of the mental health, social service, and justice systems involved in involuntary civil commitment. It urges that meetings of the councils become the forum for discussion of informal, expedient solutions to the many systemic problems that arise in the commitment process. To ensure that available mental health and related services in the community are known to those responsible for administering involuntary civil commitment, Guideline A2 (National Center for State Courts, 1986: 423-425) recommends, in part, the preparation and distribution of a comprehensive, up-to-date directory of those services. Finally, to contribute to much needed understanding of the actual operation of involuntary civil commitment, as well as to improve the quality of the process, Guideline A3 (National Center for State Courts, 1986: 425-426) urges that involuntary civil commitment be subjected to vigorous ongoing research and program evaluation.

A suggested role of local community coordinating councils is the encouragement and support of research and systematic evaluation by local, state, and national researchers and research organizations. The noted emphasis on pragmatism and empiricism, and the themes of continuity, coordination, communication, and cooperation, recur throughout the "Guidelines." It may well be that the major value of the "Guidelines" is the redefinition of the "problem" of involuntary civil commitment, which no longer is viewed primarily as a legal issue to be solved by the application and reform of legal doctrine. This relatively narrow definition, appropriate during the 1960s and 1970s when aggressive legal advocacy was necessary to establish the rights of mental patients, is now receding in prominence and giving way to issues of implementation and programmatic outcome.

## **OUTPATIENT INVOLUNTARY CIVIL COMMITMENT**

Dissatisfaction with inflexible involuntary civil commitment laws that sometimes make it too hard to get a person into the hospital and too easy for them to get out, the perceived failures of deinstitutionalization including an alarming number of homeless mentally ill persons, and the "revolving door" syndrome of repeated brief inpatient hospitalizations followed by relapse after discharge



have all spawned an interest in compulsory *outpatient* treatment and care. The attention paid to coerced treatment and care in the community has expanded the fiercely debated issue of the criteria for involuntary psychiatric hospitalization to a much wider frame of reference to include the permissible scope of involuntary treatment and care in noninstitutional settings (Bonnie, 1986).

Simply put, involuntary outpatient civil commitment is the process whereby an allegedly mentally ill and dangerous person is forced to undergo mental health treatment or care in an outpatient instead of an institutional setting. Although procedures authorizing commitment to outpatient treatment have been on the books in almost all states for many years in the form of requirements to commitment to the "least restrictive alternative" and provisions for conditional release from hospitalization (Keilitz and Hall, 1985), involuntary outpatient commitment appears to have become the new battleground for ideological clashes between civil libertarians on the one side, and families and mental health professionals on the other. At the center of the fierce debate are questions about what ought to be, i.e., whether the permissible scope of legally coerced treatment should extend to noninstitutional settings, whether outpatient commitment is really a *more* restrictive alternative, and whether outpatient involuntary civil commitment is going to "widen the net" of social control and be invoked against persons who would otherwise be left alone. Empirical and practical questions of whether involuntary outpatient commitment *can* be achieved (whether it ought to be or not), and *if* it can be achieved, by what mechanisms and to what effects, have been secondary. In the following preamble to its "Guidelines for Involuntary Civil Commitment," the National Center for State Courts (1986: 497) urged caution in the use of less restrictive alternatives to compulsory hospitalizations, such as involuntary outpatient commitment, whenever such use may be appropriate:

Involuntary outpatient commitment, whereby a court orders mental health care and related social service in lieu of institutionalization, should be used cautiously, because its goals are questionable and its implementation is problematic. Administration of involuntary outpatient commitment as part of a general civil commitment scheme requires much more of the mental health-justice system than was required in times when a court order to commitment invariably meant institutionalization.

Caution was urged because, like many other abstract legal concepts (Shah, 1981: 225-256), the translation of involuntary outpatient commitment into fair and workable practices is fraught with difficulties. Most of these difficulties are suggested by a consideration of the sharp differences between commitment to self-contained institutions, where complete responsibility for all treatment decisions and supervision of patients rests with mental health professionals in those institutions, and commitment to fragmented community-based facilities with limited capabilities for case management, patient supervision, treatment monitoring, review of compliance with court requirements, and so forth. The diffi-

culties enumerated in the National Center's "Guidelines" (1986: 499, 513) include:

1. uncertainties about whether state laws and local rules authorize court orders to involuntary mental health care and related social services in the community;
2. serious questions of policy, professional attitudes, and practice regarding the obligation of community-based mental health programs to accept involuntary patients ordered to undergo outpatient treatment and care by a court;
3. few organizational structures, procedural mechanisms, and limited resources for the supervision of outpatients and the monitoring of their compliance with the conditions of an involuntary outpatient commitment order;
4. the lack of standards and procedural mechanisms for reviewing and for certifying respondent's compliance with an outpatient treatment program; and
5. the lack of procedural mechanisms whereby commitment courts and mental health professionals could impose sanctions or remedies for respondent's noncompliance with a court order or with the terms of release from an institution under an outpatient commitment order.

Other related difficulties and problems likely to be confronted in the implementation of involuntary outpatient civil commitment include:

6. because of lack of resources, an understandable (though not laudable) disinclination by community mental health centers to accept, treat, and adequately monitor indigent chronically mentally ill and potentially dangerous patients in outpatient programs (Miller and Fiddleman, 1984);
7. the variability of social supports for outpatients (Hiday and Goodman, 1982), including adequate housing and transportation to and from outpatient settings;
8. political and fiscal barriers to a smooth transfer from care in institutions to care in the community; and
9. the threat of increased liability realized by community-based mental health facilities in providing compulsory outpatient treatment and care.

Undoubtedly, the use of legal coercion for treatment and care in the community will receive more careful and systematic attention in the next few years. Empirical questions are many. What are the histories and characteristics of involuntary outpatients as compared to involuntary inpatients? How are they selected? By whom? What are the structural, operational, administrative, and fiscal characteristics of compulsory outpatient programs? Are outpatient programs successful in terms of clinical efficacy, social protection, patient functioning, service utilization, family satisfaction, and other outcomes when compared to voluntary programs and simple release? Seen in the context of the operational problems enumerated above, the answers to these questions are central to the ongoing development of public policy regarding compulsory outpatient treatment.

## THE INSANITY DEFENSE

The June 21, 1982, acquittal of John Hinckley by reason of insanity ignited swift and vociferous public outrage. The legislative response to the public indignation over defendants like Hinckley "beating their rap" and the related fear that thousands of insanity acquittees are being released to the community was equally swift. A total of thirty-three states made changes in their laws governing the insanity defense during the Hinckley trial and its aftermath (Callahan, Mayer, and Steadman, 1987; Keilitz and Fulton, 1984). Although the heat of the debate has abated in the last five years, the insanity defense remains one of the most controversial issues in mental health law. The observations made by Goldstein (1967: 20) more than twenty years ago remain valid today:

The insanity defense is caught up in some of the most controversial, ideological currents of our time. The direction it takes depends, essentially, upon the place in social control one assigns to the criminal law as it competes with other methods of regulation by the state, to each of the themes underlying the criminal law, to the confidence one has that the mentally ill offender can be identified and treated, and the importance one attaches to the idea of blame. However difficult it has been in the past to find one's way among considerations of this sort, events are conspiring to make the problem even more complex.

The insanity defense is rooted in the fundamental concept of Anglo-American jurisprudence that holds criminal behavior punishable only when it is blameworthy. The insanity defense and its procedural apparatus define the extent to which persons accused of crime may be relieved of criminal responsibility because of serious mental disorder which substantially impairs his or her knowledge or appreciation of the wrongful act (cognition) or his or her behavioral controls (volition).

Much like the preoccupation with the tests for involuntary civil commitment discussed earlier in this chapter, the modern history of the insanity defense has been primarily one of periodic calibration of the standard of criminal responsibility. For the most part, the prevailing standards have all turned on two excusing conditions that are embodied in contemporary criminal law and are as old as the writings of Aristotle, namely, *ignorance* of fact or of law and an uncontrollable *compulsion* to act contrary to law and morality (Moore, 1984: 460). These two excusing conditions, ignorance and compulsion, if caused by mental illness, make up the contemporary tests for legal insanity.

The oldest and most venerable test is the M'Naughtan test, stemming from the 1843 English case of Daniel M'Naughtan who, intending to assassinate the British prime minister Sir Robert Peel, mistakenly shot and killed Peel's secretary, Edward Drummond. Evidence presented at the trial established that M'Naughtan was suffering from what today might be characterized as paranoid schizophrenia. The jury returned a verdict of not guilty by reason of insanity (Moran, 1981).

The McNaughtan test turns on the ignorance of the accused about the nature of his or her own actions. Essentially, a defendant will be acquitted by reason of insanity under the test if the defense establishes three requirements: disease of the mind; defect of reason causally related to the disease; and lack of knowledge about the act itself, its legality or morality. By the end of 1985, twenty-five states employed a version of the McNaughtan test (Callahan, Mayer, and Steadman, 1987: 56).

The McNaughtan test does not exculpate defendants who knew that their actions were morally wrong or illegal but who, as a result of mental disorder, were unable to control their actions. Attempts to broaden the McNaughtan test by incorporating impairments in a defendant's ability to control his or her behavior led to the development of the "irresistible impulse test." Generally speaking, under this test an accused is not criminally responsible if, because of mental illness, he or she could not exercise proper control over unlawful actions (Goldstein, 1967: 90). In the 1950s, the American Law Institute (ALI) developed a test which sought compromise among the previously developed tests including the McNaughtan and irresistible impulse tests, that were considered to be either too narrowly or too broadly formulated. Under the ALI test,

A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect, he lacked substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law. (American Law Institute, 1962: 74)

Approximately twenty states employed some version of the ALI test at the end of 1985 (Callahan, Mayer, and Steadman, 1987: 56).

The newest test to dominate scholarly debate brings full circle the search for the best formulation in determining an accused person's criminal responsibility. In 1983 the American Bar Association (ABA) endorsed a test for criminal responsibility that echoes the 1983 McNaughtan test's reliance on cognitive incapacity (Keilitz, 1987). While the ABA rejected altogether the volitional prong of the ALI test (the principal difference between the ALI test and the McNaughtan test), it retained the more "modern" wording of its cognitive prong by replacing the familiar McNaughtan phrase "know the nature and quality" with the word "appreciate." Thus, under the Appreciation test, a person is not responsible for criminal conduct if, at the time of such conduct, that person was unable to *appreciate* the wrongfulness of such conduct. On the basis of logic and reason—not empirical data—the ABA argued that the language of the Appreciation test is preferable to both the McNaughtan and the ALI test because the former takes into better account all aspects of a defendant's mental and emotional functioning and is in better concert with current clinical knowledge (American Bar Association, 1984: 323–335). However, one must wonder whether, as Shah (1981: 244) has noted, "all this obsessing over the subtle nuances of words and their meaning and interpretations makes very much actual difference." One can ques-

tion whether changes in the language of the insanity test really matter in terms of a lawyer's decision to try a case in front of a jury or the actual frequency of insanity acquittals, for example. Notwithstanding the apparent reasonableness of various theories and assertions, in the absence of reliable, detailed data, the empiricist position requires an attitude of skepticism.

Although it is probably prudent not to be overly optimistic about what empirical research on its own can do to help solve social problems, replacing some of the dogma with hard data may well refresh the dialogue about the insanity defense. Wexler (1984: 25) undoubtedly expressed the sentiments of many observers when he noted that it is "tiring—even embarrassing—to be arguing in 1984 whether we should return to the M'Naghten [*sic*] Rule of 1843 or to the rule of an even earlier era."

However modest, there have been signs within the last five years that scientific findings about the operation, administration, and outcome of the insanity defense have begun to inform public policy and compete with the influence wielded by the long tradition of legal scholarship. Empirical research on the insanity defense has been of two types. The first is descriptive, addressing such questions as how many and what types of defendants plead insanity, how often they are successful, how long those acquitted by reason of insanity are detained in a hospital compared to how long they would have been imprisoned had they been found guilty, and how likely acquittees are to repeat crimes. Much of this research has been conducted by Steadman and his colleagues (see, e.g., Steadman, 1985; Steadman and Braff, 1983) and has often been called into service to counter misconceptions about the insanity defense. Today, few commentaries on the insanity defense fail to acknowledge at least some of the conclusions of this empirical research, namely, that the insanity defense is seldom raised, and even more infrequently successful; that most insanity defendants are not murderers who commit random acts of violence; that the great majority of insanity cases reflect agreement, rather than disagreement, among mental health experts' testimony, not a "circus" of conflicting testimony; and that insanity acquittees rarely go free immediately after trial (Keilitz and Fulton, 1984). Even if this descriptive research on the insanity defense were entirely consistent across jurisdictions—which it is not—its value to policymakers would be limited because it does not address the major question that is the focus of policy debate: What difference does the reform of the insanity defense make?

The second type of empirical research on the insanity defense addresses this basic question and therefore holds greater promise for affecting public policy. It is concerned with understanding and evaluating the effects of changes in the insanity defense, especially major statutory reforms. Relatively little research of this type yet exists, though its potential significance for public policy has been acknowledged (Keilitz, 1987; Callahan, Mayer, and Steadman, 1987).

Four major questions about the *outcomes* of changes in the insanity defense deserve close empirical attention. First, does the reform measure curtail the use of the insanity defense? That is, does it decrease the size of the class of defendants

pleading and succeeding with insanity defenses? Second, does it lengthen or shorten the period of time that insanity acquittees spend in confinement? Third, even if the reform does not curtail the use of the insanity defense, does the reform alter the composition of the class? For example, does it reduce the number of crimes of homicide for which the defense of insanity is raised? Fourth, does the reform reduce the "trouble" that this class of defendants causes the criminal justice and mental health systems before, during, and after trial? For example, will insanity cases be easier to prosecute and harder to defend?

These questions are central to widespread concerns about the insanity defense. Despite frequently made arguments that deliberation of reform proposals must turn on strictly legal and normative grounds, assumptions about the empirical consequences of the insanity defense lie at the heart of most changes in policy and practice. In the past, reforms of the insanity defense have been based largely on untested assertions and polemics instead of on actual experience and experimentation resulting in hard data. Yet such a sterile, out-of-context approach may have brought us to a point of intellectual stagnancy. At least one commentator has been struck by the fact that "suggestions for reform seem invariably to fall on one side or the other of the standard philosophical, legal, and psychiatric arguments" (Wexler, 1984: 17).

### COMPETENCY TO STAND TRIAL

Competency to stand trial is an issue usually addressed at the threshold of criminal proceedings. It concerns a defendant's capacity to assist in his or her defense and understand the criminal process. By contrast, insanity, or lack of criminal responsibility, concerns the mental state of a criminal defendant at the time of the commission of the alleged crime. A criminal defendant may be considered mentally fit to participate in the criminal process, but following a trial, the same defendant may be found not criminally responsible for his or her acts. Conversely, criminal defendants adjudged incompetent cannot be put to trial, though once restored to competency, they may be tried and held responsible for criminal actions.

The doctrine of incompetency to stand trial, establishing the "nontriability" of a defendant found mentally unfit to stand trial, is the law's most far-reaching provision for criminal defendants who may have mental disorders. While the insanity defense, the focus of intense debate and media attention, affects a small few, the threshold issue of a criminal defendant's competency to stand trial affects a much larger number of defendants. For every criminal defendant found to be insane, at least a hundred are determined to be incompetent to stand trial (Steadman et al., 1982: 33).

The prohibition against subjecting a mentally incompetent defendant to a criminal trial stems from the common law ban against trials in absentia, that is, when the accused is not present at trial. The accepted legal test for competency to stand trial follows from the U.S. Supreme Court decision in *Dusky v. United*

*States* (1960). The Dusky test is whether the defendant has "sufficient present ability to consult with his lawyer with a reasonable degree of rational as well as factual understanding of the proceeding against him" (*Dusky v. United States*, 1960: 402).

Principles of fundamental fairness and notions of common humanity underlie the need to suspend a criminal trial against an accused who is found to be unable to participate meaningfully in criminal proceedings. First, the accuracy of the criminal proceedings demands a certain level of competence in criminal defendants in order to acquire the facts of the case. This is particularly crucial when the accused may be the only person, other than the complainant, who has direct knowledge of the facts and circumstances of the alleged crime. Second, the protections afforded by due process of law depend on a defendant's ability to exercise his or her rights in the criminal process, including the right to choose and assist legal counsel, to confront accusers, and to act as a witness on his or her own behalf. Third, notions of common humanity would be offended and the integrity and dignity of the legal process undermined by the trial of an incompetent defendant. Fourth, the objectives of punishment would not be served by the criminal sentencing of a defendant who fails to comprehend punishment and reasons for its imposition.

In practice, judges routinely tend to approve motions for forensic mental health examinations for competency to stand trial even though such motions do not relate to real concerns about the competency of a client. Instead, such motions often are used as the only available legal device whereby a defense attorney or a court can obtain mental health care for mentally disordered defendants who are charged with minor crimes (Gutheil and Appelbaum, 1982; Roesch and Golding, 1980). In such circumstances, theory obviously departs from practice.

Today, throughout the country, increasing numbers of transient, poor, homeless, and mentally disordered individuals are straining the resources of law enforcement agencies, the courts, and all of the other human services. More often than not, the charges and complaints—sometimes called "junk charges"—that bring these individuals into contact with the criminal justice system are minor (e.g., trespassing, being drunk in public, or failing to pay for a meal). The great need for an array of social services for these individuals, e.g., mental health treatment, drug rehabilitation, food and shelter, is typically grossly disproportionate to the seriousness of the misdemeanor offenses committed by them. Meloy (1985: 382–385) has characterized this general patient type as follows:

The . . . type is called the "sunshine chronic," an individual who is schizophrenic, has a lengthy but misdemeanor criminal history, and is often booked on charges such as trespassing, petty theft or defrauding an innkeeper. This individual has a long history of noncompliance with medication and is usually quite content to live as a transient. He has slowly drifted to the bottom of the socioeconomic ladder, but knows how to "survive on the street." He is most likely to abuse alcohol. When the inpatient program has first

contact with him, he is usually psychotic, gravely disabled, and harmless. He has no contact with family or relatives, and has usually never been married.

In many jurisdictions, a large number of individuals like the "sunshine chronic" described by Meloy are ostensibly referred by the courts for forensic mental health examinations of competency to stand trial but, in fact, they are being referred for other reasons that have little to do with fitness to stand trial *per se* (Gutheil and Appelbaum, 1982: 263–264). Judges and defense attorneys may use the competency issue as a vehicle for "criminally" committing the defendant to a state hospital or other inpatient facility. As a result, defendants may spend a considerable amount of time in a forensic treatment facility undergoing long-term observation and examination to determine competency or, alternatively, they may receive treatment aimed at restoration of competency. An individual arrested on petty charges who, if convicted of those charges, would probably spend no more than a few days in jail, may be denied bail and a speedy trial because the competency referral is being used to hold the defendant for the well-intentioned (albeit extralegal) purpose of providing mental health treatment that is either otherwise unavailable or that the defendant would not accept voluntarily. Of course, the competency referral may be misused for less benevolent purposes such as the social control of certain socioeconomic and racial groups.

Some observers blame the misuse of the competency concept by the courts on restrictive civil commitment statutes that have left large numbers of severely ill, but presently nondangerous, persons in the community with no means for the state to provide treatment. Paradoxically, based on the benevolent intent of providing misdemeanor defendants with mental health treatment and care—even if only for short periods of time and even in jail if necessary—judges and attorneys (often with the encouragement of some families of severely mentally ill persons) have used the issue of incompetency to stand trial as the only available means to keep mentally disordered defendants *in* the criminal justice system rather than to divert them *from* the criminal justice system as was intended by the concept.

As was pointed out in the earlier discussions of involuntary civil commitment, outpatient commitment, and criminal responsibility, it should be clear that in questions of competency to stand trial there are also important distinctions between pronouncements of law that are primarily *prescriptive* (telling people how they should behave and how things ideally *ought* to be) and a *descriptive* approach (describing events and behaviors as they actually occur). This again points out the gap between legal fiction and fact (Feeley, 1976). As suggested in the following quotation by Professor David B. Wexler, the exploration of the actual antecedents (e.g., reasons for referrals for competency examinations), operation and administration (e.g., inpatient or outpatient competency examination), and actual consequences (e.g., treatment in jail versus release without treatment) of raising the issue of incompetency to stand trial may be far more interesting and important than the abstract rules of law.



[V]arious incentives (fiscal or otherwise) that are purposely or often intentionally built into the criminal commitment system, and the consequences that flow from those incentive patterns, are generally of far more interest and importance than are the tests for determining whether one is incompetent to stand trial, not guilty by reason of insanity, and so forth. (Wexler, 1981: 118)

## TREATMENT REFUSAL

Parry (1986: 334) recently lamented that at the height of our sophistication in mental health law, we seem to be grounded in a number of intractable problems such as "simultaneous litigation that advocates for the right to services and the right to refuse services without rationally or effectively demarking the lines between the two." Much that has been written about refusal of care and treatment (for a recent review, see Rapoport and Parry, 1986) has centered on the nature and scope of mental patients' legal right to exercise this option. With some notable exceptions (e.g., Gutheil and Appelbaum, 1982: 91-139; Appelbaum and Hoge, 1986), commentators on the topic typically begin with a discussion of the legal grounds for the right to refuse treatment in common law, state statutes, and the Constitution. This may include extended legal analyses of a potpourri of constitutional arguments about the First Amendment rights to freedom of speech, Fourth Amendment rights to freedom from illegal search and seizure, Eighth Amendment rights to freedom from cruel and unusual punishment, Fourteenth Amendment rights to due process and to equal protection, the right to privacy, and the right to treatment in the least restrictive setting. Deductive logic is then applied to derive from these abstract concepts or principles a right to treatment that somehow strikes a balance among the varying interests of the individual, the family, the community, and the state. In such an exercise, personal values are critical, whether they are made explicit or not.

Meanwhile, questions with important practical implications remain unanswered. For example, given the opportunity, how many mental patients actually refuse treatment? What types of treatments, in what settings, are refused and why? What are the characteristics of refusers as compared to patients who comply with the treatment and care offered to them? What is the natural history, as well as the clinical and social consequences, of treatment refusal? What are the responses to treatment refusal by individual treatment providers and the mental health delivery system as a whole? Roth and Appelbaum (1982) have noted that, unfortunately, the right to refuse treatment has generated far more questions than reliable, empirical answers. Appelbaum and Hoge (1986) recently reviewed the results of the few published and unpublished studies of refusal of antipsychotic medication by psychiatric inpatients. They succinctly summarized the current state of knowledge about refusal of treatment:

Short-term refusal is frequent, but long-term refusal rare. Refusers are likely to be sicker than accepting patients, but it is unclear if they are legally incompetent. Over the short

term, many refusers do poorly in the hospital, but if ultimately treated, they do at least as well as other patients. Finally, patients' refusals are usually not upheld, with the vast majority of refusal patients being treated, at least initially, over their objections. (Appelbaum and Hoge, 1986: 95)

Though studies of treatment refusal are limited in number and embody certain methodological flaws (Appelbaum and Hoge, 1986: 87), their contribution to the debate is informative and refreshing. Clearly, more and better research is needed.

### MALPRACTICE LIABILITY

In every house where I come I will enter only for the good of my patients;  
keeping myself far from all intentional illdoing and all seduction . . .

—Hippocrates  
*The Physician's Oath*

Malpractice, in legal terms, is an action in tort, a noncriminal wrong committed by one individual against another. It is considered a negligent tort when a mental health professional damages a patient or a client to whom that professional owes a duty to care. Four basic elements need to be established to sustain a claim of malpractice: (1) a relationship existing between the patient/client and the mental health professional that creates a duty to care; (2) a negligent breach of that duty defined by some external standard of professional care; (3) demonstrable harm to the patient/client (a mental health professional will not be liable for damages, even for a grossly negligent act, unless some harm ensues); and (4) causation, i.e., the negligent act must be the "proximate cause" of the harm.

The most common categories of malpractice actions against mental health professionals involve sexual activity between patients and therapists, misdiagnoses (or failures to diagnose) mental disorder that causes or is likely to cause harm to the patient or others (e.g., attempted suicide, suicide, homicide, and damage to property), negligent use of somatic treatments (e.g., use of the wrong or improper dosage of medication), and failure to warn others of potentially dangerous patients (Gutheil and Appelbaum, 1982: 150–157). Notwithstanding unprecedented media attention focused on the "litigation explosion," the "liability insurance crisis," and our "litigious society," the threat of malpractice liability often seems more imagined than real (Daniels and Martin, 1986; Bales, 1987). The factual basis for assertions regarding the wide scope of malpractice is shaky at best.

According to Gutheil and Appelbaum (1982: 144), psychiatrists are the least frequently sued medical specialists. Among the approximately 26,000 psychologists who hold malpractice insurance policies through the American Psychological Association's Insurance Trust, 940 had suits filed against them between 1982 and 1986 (Goodstein, 1986). Compared to physicians, psychologists have

a lower chance of being sued for malpractice and pay less for malpractice insurance. According to the American Psychological Association's Insurance Trust, members of the American Psychological Association have only a 0.5 percent chance of being sued for malpractice, while members of the American Medical Association have a 26 percent chance. A psychologist pays an annual premium of \$450 for \$1 million of liability coverage; a physician pays \$25,000 (Bales, 1987).

No doubt, malpractice claims against mental health professionals will continue to rise, no less than claims against firemen, police officers, municipal employees, baseball coaches, and lawyers, this being the nature of our litigious society. Also, it is likely that increased litigation will continue to refine the concept of mental health malpractice, potentially creating new grounds for suits against mental health professionals. However, as noted by Gutheil and Appelbaum (1982: 178), this state of affairs justifies neither despair nor nihilism. A number of relatively simple, practical measures based in common sense should go a long way toward prevention of malpractice suits: adherence to professional standards, staying within one's area of competence and expertise, consultation with colleagues, documentation of procedures and treatment decisions, clarification of all relevant procedures with patients, obtaining informed consent, written permissions, and releases from patients, checking treatment histories, and avoidance of physical contact (Bales, 1987).

Ironically, by giving in to a perceived threat of liability, by practicing what has been referred to as "defensive" mental health care, and by abandoning common sense, a mental health professional may, in fact, be exposed to *increased* liability. Consider the situation of a mental health professional employed by an inpatient facility that has admitted an involuntary patient on an emergency basis and has detained that person pending a judicial hearing on involuntary civil commitment some time in the future. Three days after admission, the mental health professional determines that the person has become relatively stable and, in any event, no longer meets the statutory requirements for involuntary civil commitment. Assuming that the professional has clear statutory authority to release the person at any time (a provision in most states), and the statutory criteria for commitment in fact no longer apply, the question is, Should the mental health professional release the individual immediately, perhaps risking a third-party suit for negligent release, or detain the person until the commitment court orders release? Arguably, the therapist who detains an involuntary patient pending the outcome of a judicial hearing, knowing full well that the patient no longer meets involuntary commitment criteria, is as vulnerable to claims of false imprisonment, an intentional tort, as he or she is vulnerable to a claim of improper release causing harm to a third party.

Unfortunately, as in other areas of mental health law, very little reliable empirical data exist regarding the frequency of mental health malpractice claims, judgments, awards, and final payments. Large monetary awards for damages in mental health malpractice cases are newsworthy and visible but probably tell an

incomplete story because they do not represent a random sample of suits. Anyone can initiate a lawsuit against anyone else for reasons that need not be valid. Many suits are dropped or simply abandoned without further actions by the mental health professional as defendant. Still more are dismissed before trial. Even when a malpractice claim is proven, the trial court's judgment and award for damages may not be the final judgment upon appeal to a higher court.

Amid abundant charges and countercharges as to who should be blamed for the malpractice crisis—negligent health care providers, lax professional regulations, poor management of the insurance industry, a tort system in desperate need of repair, greedy lawyers, or inefficient courts—one thing is painfully clear. Too little is known about key matters regarding malpractice, even so fundamental an issue as whether a professional liability crisis exists at all. Who sues whom and for what reasons? Who makes what types of malpractice claims (e.g., sexual misconduct, neglect in suicide cases, failure to warn, fraud, or bad faith) against whom (public or private individuals, classes of mental health providers, number of defendants in a case, etc.)? What is the nature of the malpractice claims resolution process? What are the "disputing behaviors"? Are there discernible trends or patterns over time? What are the immediate and intermediate outcomes, and the ultimate consequences of this process on individual mental health providers, the helping profession as a whole, as well as the provision of mental health services to patients? What are the actual effects (or likely effects) of potential changes in the malpractice resolution system (e.g., a limitation on the scope of liability, a cap on the size of damage awards, arbitration, and pretrial investigation and screening panels)? An understanding of the crisis in mental health malpractice awaits answers to such questions as these.

## CONCLUSION

This chapter traces what this author believes has been an important shift in the last five years in the paradigm governing inquiry and implementation in six important areas of mental health law: involuntary civil commitment, compulsory outpatient treatment and care, the insanity defense, competency to stand (criminal) trial, treatment refusal, and mental health malpractice. The emphasis is on the nature and the content of the shift, not on a thorough review of the development of the six areas themselves. (The interested reader will find an excellent review of these and other areas in mental health law in *The Mentally Disabled and the Law*, by Brakel, Parry, and Weiner [1985].)

My discussion of the nature of this shift from an emphasis on legal doctrine and ideology to empiricism and pragmatism does not pretend to offer a systematic, comprehensive analysis. Instead, my perceptions are largely impressionistic and based on or inspired by the work of me and my colleagues on the interaction of the mental health system and the civil, criminal, and juvenile law over the last ten years. It is worth noting, however, that this same shift has been discerned by others (e.g., Shah, 1981: 257–258) and can be viewed as part of a larger

movement in law toward greater emphasis on social science (Loh, 1984; Monahan and Walker, 1985) and what has been referred to as the "sociology of law" (Friedman and Macaulay, 1969; Melton, 1987).

Perhaps more difficult than describing the current shift in orientation is discerning its causes and antecedents. No doubt, it reflects a more pragmatic temper and greater impatience with legal abstractions among those who are relatively late entrants into the field, for example, family self-help advocacy groups. The shift may also be attributed to a growing realization among academic scholars and legal advocates that it is reckless to advocate reform based on their professional values and ideologies if they do not know and cannot tell if such reform will achieve its goals or simply evoke more litigation (Bok, 1983). The single-minded manner in which reforms were advocated and implemented may have demonstrated the "rule of the instrument" (Kaplan, 1964): The handyman whose tool box contains only one tool will approach every job the same way. If that tool happens to be a hammer, he may have considerable success in hanging a picture, but he is unlikely to get much return business repairing watches.

What does the shift in the governing paradigm in mental health law mean to mental health policymakers, program administrators, and practitioners? To recapitulate briefly, it will allow more mental health professionals who are involved in mental health law interactions, but who are not legal scholars, lawyers, or legislators, into the conversation about positive change. (Indeed, what is there to do within the old paradigm except litigate, legislate, or advocate for reform of mental health law on the books?) Second, the shift will cause a redefinition of the problem and the terms of inquiry in mental health law. Questions about "what is" and "what can be" are taking precedence over the question "what ought to be?" For example, if improvement of the involuntary civil commitment process is seen as a human resource management problem, instead of strictly a legal issue viewed in terms of rights and entitlements, the natural consequence would be an attempt to break down the process into a series of tasks and events for which the various components of the mental health, public safety, justice, and social service systems share responsibility. Trouble spots in the process—much more likely to occur as duties are transferred across, instead of within, components and systems—could be identified and various corrective measures evaluated.

Perhaps most important, not only for mental health professionals but for the sake of progress in mental health law and its administration, is that increasing attention to empiricism and pragmatism will build capacities for new knowledge. Whether a discipline is vital or stagnant often is said to be gauged by how far and often it must reach back into its own history to find answers, and how long it clings to those answers even when they are found wanting. Although we certainly should not expect the redefinition of the terms of inquiry to deliver quick and final answers to some of the seemingly intractable problems in mental health law, it can help untangle some of the complexities, downscale the problems, and guide improved policy and practice.

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# **Boundary-Spanners: A Key Component for the Effective Interaction of the Justice and Mental Health Systems**

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President  
Policy Research Associates

## Outline of Presentation

Wednesday, 2:10 - 3:00 pm, November 7, 1990

### **I. What Is A "Boundary-Spanner"?**

- A. Any organization or system has boundaries. (Often it is hard to establish where these really are)
- B. An organization or system must interact with its environment which includes numerous other organizations
- C. Roles which are created ". . . link two or more systems whose goals and expectations are likely to be at least partially conflicting," i.e., boundary-spanners
- D. Figure 1 is a generic depiction of these roles (e.g., competency examinations)
- E. In the "structural, organizational and administrative aspects of the interactions of the justice and mental health systems [in] the delivery of justice" nothing may be any more important than boundary-spanners
- F. These issues may be especially acute for criminal justice-mental health issues because boundary-spanning involves different branches of government
  - 1. Often there are explicit rules governing boundary-spanning activities
  - 2. However, the key for effective performance in these positions often is how to bend rules to obtain desired outcomes
- G. Another major problem is the real world complexities missing from Figure 1. (Figure 2 offers what may be the more typical situations)

**II. A Second Conceptualization That May Be Equally Important For Facilitating Appropriate Justice-Mental Health Interactions Is To Think Of How They Fit Into The Processing Of Criminal Charges From Police Contact To Expiration Of Sentence Or Parole**

- A. Figure 3 depicts this (including multiple levels of government)
- B. Goals of mental health interventions vary by the point in this flowchart at which a defendant/inmate is

**III. Examples of Concepts That Demonstrate How They Can Work Effectively**

- A. Ideas grew from people and programs observed, not from systematic research
- B. Examples
  - 1. Multnomah County (Portland, Oregon) Jail Diversion Program
  - 2. Palm Beach County (Palm Beach, Florida) Jail Treatment Program
  - 3. Oregon's PSRB Model for NGRIs

**IV. How Can You Create And Maintain These Positions?**

- A. Where would they work in your system?
  - 1. Just about anywhere
  - 2. Jail as entry point especially important
  - 3. DA's office
  - 4. State Mental Health Authority
- B. How do you pay for them?
  - 1. Anyway you can - be creative
  - 2. Job title
  - 3. Can be a distinct funding mechanism
  - 4. Can be precarious as a result
- C. How to you avoid high job stress that has been shown to be inherent in boundary-spanning positions?
  - 1. Proper recruitment
  - 2. Knowledge of both sides
  - 3. Mutual credibility
  - 4. Reasonable pay

D. Where do you find people to do these jobs?

1. Probably already have them on staff
2. Great promotional opportunity

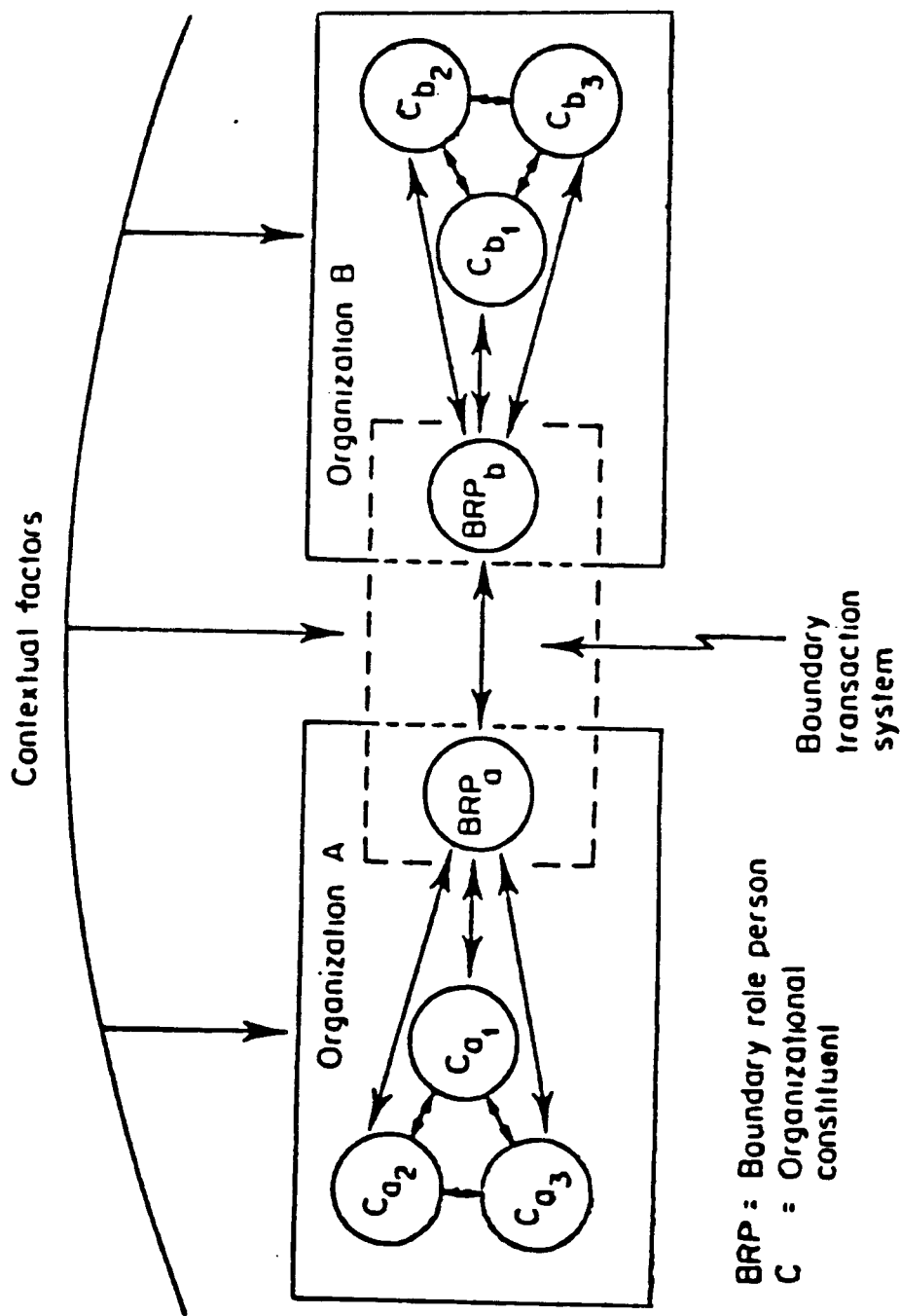
V. **Conclusions**

A. There are many important research questions that emerge from a consideration of boundary-spanners

1. Maybe there are some "best" ways to pay and set up such positions (e.g., are there ways to insulate them from one side backing out of a co-funding arrangement)
2. In which situations do the interactions work better where there is specialization versus diffuseness in boundary-spanning responsibilities?

B. Important not to forget the concept of boundary-spanners and the interorganizational perspective

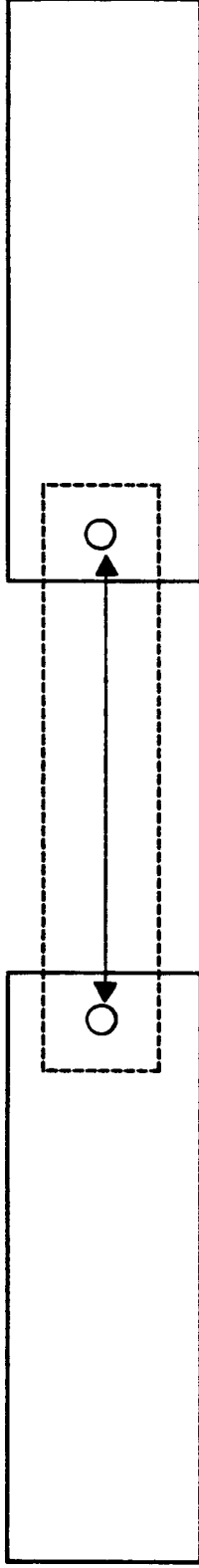
FIGURE 1



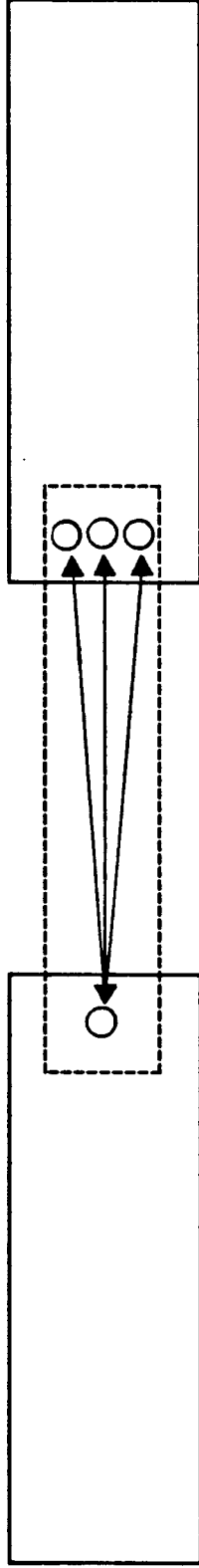
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FIGURE 2

MODEL A



MODEL B



MODEL C

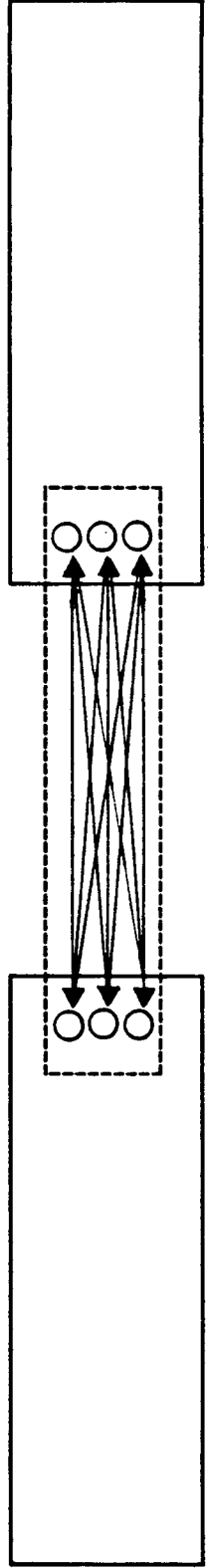
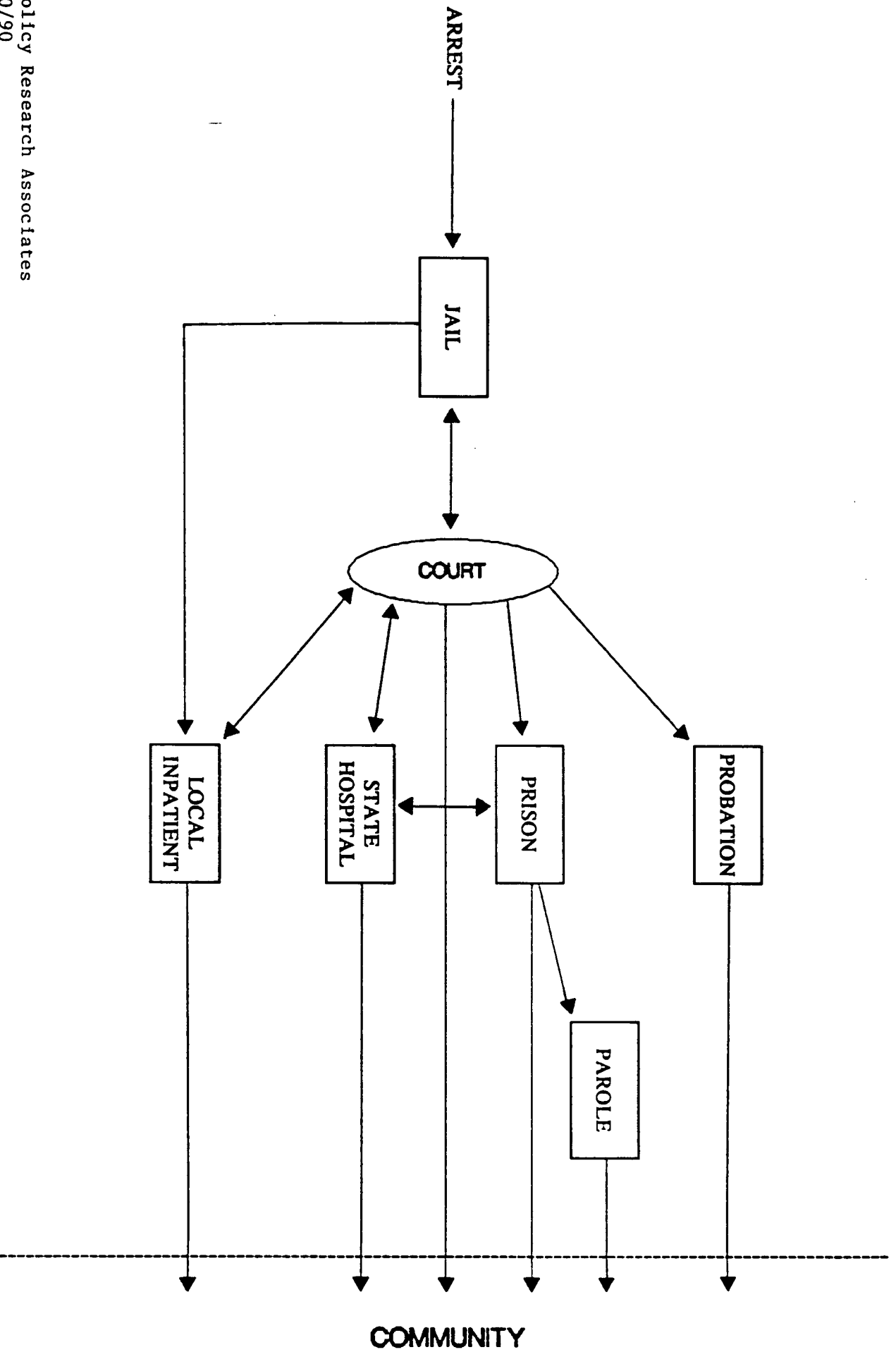
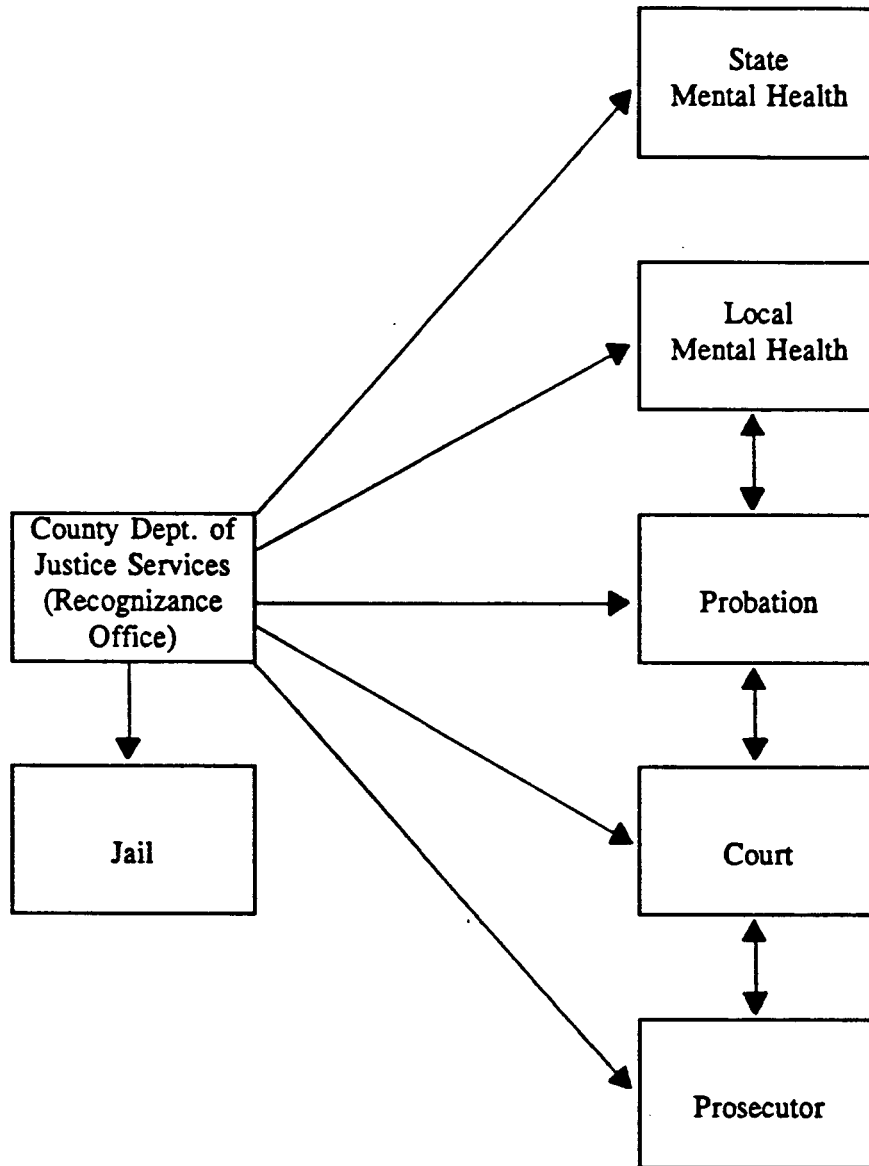


FIGURE 3

**SCHEMATIC MODEL OF CRIMINAL JUSTICE - MENTAL HEALTH SYSTEM INTERACTIONS**



# MULTNOMAH COUNTY JAIL DIVERSION PROGRAM



## **Comment: Community Forensic Services and Today's Criminal Justice System**

**By Henry J. Steadman\***

A popular issue in social science and psychiatric literature for the past fifteen years has been whether and how much criminalization of the mentally ill has occurred in the United States since the deinstitutionalization of state mental hospitals in the 1970s.<sup>1</sup>

Most law enforcement personnel and correctional administrators have heard little of these debates and have even less interest in them. They are more concerned with how to respond to the issues they confront when they meet bizarre, disturbed, and disturbing people on the streets and in their jails and prisons.<sup>2</sup> Whether there are more such people is irrelevant in determining how police can make appropriate responses to them. Their questions do not focus on more or less but on "what do we do?" How can the proper balances be struck between community safety and individual rights, between community rights and the needs of the mentally ill? What are the proper roles of the mental health system in today's criminal justice system? Regardless of how the situation came about, what is to be done? These are the relevant questions.

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\* Policy Research Associates, Inc., Delmar, New York. Dr. Steadman is one of the foremost U.S. authorities on issues of dangerousness and mental health in the criminal justice system.

Many of the ideas discussed in this article were developed following site visits to Palm Beach County, Florida, with Joel Dvoskin, Ph.D., without whom this work would not have been nearly as productive. This article also reflects the insightful comments of Lisa Callahan, Ph.D.

<sup>1</sup> Abramson, "The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law," 23 *Hosp. & Community Psychiatry* 101 (1972); Steadman, Monahan, Duffee, Hartstone & Robbins, "The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations," 75 *J. Crim. L. & Criminology* 474 (1985); Teplin, "The Criminalization of the Mentally Ill: Speculation in Search of Data," 94 *Psychological Bull.* 54 (1983).

<sup>2</sup> See Finn & Sullivan, *Police Response to Special Populations: Handling the Mentally Ill, Public Inebriates and the Homeless* (National Institute of Justice, Washington, D.C. 1988).



## COMMUNITY FORENSIC SERVICES

### Community Forensic Services: A Florida County's Answer

A concept that has recently emerged offers prospects for solving many of these dilemmas. The idea is called community forensic services, and one program embodying the concept is operating in Palm Beach County, Florida. There, the Palm Beach County Forensic Mental Health Services (FMHS) program was designed to be a comprehensive, county-based service system for all persons receiving mental health services while involved in the criminal justice system and for those on conditional release status after inpatient care is completed. This program was developed in the mid-1980s with the leadership of a community mental health center (CMHC) whose staff closely collaborated with staff in the public defender's office and the county jail.

FMHS's general program goals were drawn from *Guidelines for Community Forensic Mental Health Programs*, developed by the Office of State Mental Health Programs of the Florida Department of Health and Rehabilitative Services (HRS). In August 1984, these guidelines proposed: "Within each district, services for clients involved with the Criminal Justice System should be as comprehensive as those provided to other clients. It will require, however, certain services unique to their circumstances and must in some cases be delivered where the clients are incarcerated."<sup>3</sup>

The general orientation of these guidelines, as well as the specific program components, called for:

- Screening;
- Pretrial evaluation;
- Post-trial, presentence investigation;
- Evaluation that would provide information for probation determination and process;
- Treatment services (e.g., outpatient services in jail or elsewhere, inpatient services in a receiving facility, day treatment, and residential services); and

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<sup>3</sup> Florida Department of Health & Rehabilitation Services, Office of State Mental Health Programs, *Guidelines for Community Forensic Mental Health Programs* 1 (1984).

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- Case management services (aimed at linking all of these service elements so they could be provided to a consumer and at coordinating the system to achieve a successful outcome).

### Whose Leadership?

FMHS provides services to the jail, the community, and several state institutions (e.g., prisons and civil and forensic state mental hospitals). Management control for FMHS resides in a CMHC, whose staff's normal responsibilities cover all of the settings and services in which forensic mental health clients may find themselves.

In determining the most appropriate lead agency for a community-based forensic program, one should consider all of the agencies that were involved in the Palm Beach County program. The county criminal justice system, including the sheriff and the jail administration, seem inappropriate, since their responsibilities end when the accused is delivered for trial or at the completion of a misdemeanor sentence. Their obligation does not extend into other dispositions, such as release into the community. Similarly, the responsibilities of the public defender and the state's attorney's offices end when the criminal charges are disposed of and all appeals are exhausted. The state HRS office, while appropriately involved in the planning of services, is not a direct provider of services for people at the county level, which is a responsibility of various county agencies.

By contrast, the CMHC must have responsibilities for individuals at every stage of the criminal justice process. Since the jail is a community institution, the CMHC should be responsible for individuals who are in the jail and particularly for linking people in the jail with community services. The CMHC should also be responsible for citizens who are in the community following court disposition (e.g., through conditions of probation). CMHC clients also include individuals who have satisfied the claims of the criminal justice system and are in the community but in need of specific services and case management. Also, inmates in the jail who need inpatient services could be appropriately served by inpatient units operated by CMHCs. Further-

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more, when individuals who have been found incompetent to stand trial or not guilty by reason of insanity are returned to the community, there is usually no other agency that has legal responsibilities for them unless they commit a crime or are on conditional release status. They are, therefore, appropriate clients for a CMHC.

It is important to recognize that at virtually any point in the criminal justice process, an accused person can be returned to the community. A person can arrive in the community with identified mental health needs, with or without treatment conditions imposed by the courts. Similarly, an accused may return to the community after a stay in the state hospital system. In regard to identifying and providing mental health services, it may not matter at which point a person returns to the community; the services required will be the same. Ultimately, the ability of these clients to remain successfully in the community will depend on the quality of the case management *and* the availability of the appropriate services in the community, not at all unlike the situation of nonforensic clients returning from inpatient stays in state mental hospitals or general hospital psychiatric units.

To be effective, the community case management process must begin before the client returns to the community. The FMHS CMHC-based case workers were spending several hours a week in the jail and conducting occasional visits to the state inpatient forensic facility in another part of the state to plan for clients' service needs when released to the community. Typically, community case management services will not be of short duration. This client population typically has had both mental health and legal problems for a number of years, and it is inappropriate to think that these problems will be resolved with only several months of case management or therapy. Further, it is inappropriate to assume that the only successful resolution of these cases is that a person will no longer need mental health services. Many are chronically and seriously mentally ill and become engaged in the criminal justice system upon the failure of community mental health and residential services.

Ideally, a successfully resolved case should result in a forensic client's becoming involved in the same service delivery system that anyone else in the community would use. A core ele-

ment, therefore, in a comprehensive community-oriented forensic mental health program includes case managers on the forensic staff who are located in community settings and who work toward integrating forensic clients into the generic mental health, social service, and health systems.

Case management alone, however, will not be enough. While case management is essential for linking the client with services and for managing the predictable failures and regressions that will occur, it will be fruitless in the absence of other substantive mental health services. Particularly important for this population are residential alternatives within which specialized mental health, social, and health services can be delivered. Unfortunately, most communities lack an adequate range of special residential alternatives. It will be difficult for forensic clients to succeed in the community without having a place to live. Further, access to mental health services that are available to most of the community often excludes forensic clients. It is also important for case managers to be aware of, and skillful in obtaining, appropriate entitlements for patients who have been unable to gain access to such resources.

While highlighting the CMHC's many roles in a community forensic system, it is important to remember the proper role of the local jail. To ensure its appropriate role in regard to the mentally ill, it is essential that the jail be seen as only one agency in a continuum of county services. It cannot be seen and operated as an isolated building whose residents' problems must be handled within its perimeter security. Indeed, some mental disturbances are a function of incarceration, which can be frightening and depressing. However, the more common mental health problems are presented by persons whose problems are exacerbated by jail or whose current acute episode precipitated their arrest and incarceration. For these persons, the jail must perform its custodial function of safe pretrial detention while serving the mental health needs of community members whose access to services is often highly restricted. An adequate response cannot be expected if the mental health service needs are defined simply as a jail problem. The jail is a community institution, and the mentally disturbed inmate is a community problem.

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### Conclusion

Ultimately, the concept of community forensic services must focus on the entire system of criminal justice agencies and these agency relationships to the mental health, medical, and social services agencies in the community. It must avoid defining the problem of the mentally ill as that of the police officer on the beat, of the correctional officer in the county jail, or of the sheriff's road patrol officer in the local lockup as each confronts a disturbed individual. It must place these officials in a context of possible responses, which designates the situation not as "their" problem but as "our" problem. Whether the decreased number of beds now available in state mental hospitals has contributed to an increase in the number of people now being caught up in the criminal justice system makes little difference in resolving such situations. What is important is how to create, configure, and manage appropriate services to meet the pressing needs that the mentally ill place on the criminal justice system. The concept of community forensic services may be one step in that direction.

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## MENTAL HEALTH LAW AND THE CRIMINAL OFFENDER: RESEARCH DIRECTIONS FOR THE 1990's

Henry J. Steadman, Ph.D.\*

### I. INTRODUCTION

An analysis of research on mental health law and the criminal offender begins by first, identifying the groups of offenders involved and second, correcting popular misconceptions about the relative and absolute size of these groups. Four major classes of criminal offenders, generically called "mentally disordered offenders," come under the aegis of mental health law: (1) insanity acquittees; (2) defendants incompetent to stand trial;<sup>1</sup> (3) mentally ill jail and prison inmates;<sup>2</sup> and (4) mentally disordered sex offenders.

Legal scholarship in this field presents a paradox: most of the research has focused on the criminal offender groups comprised of fewer numbers, and little research has been done on the largest category of criminal offenders. For example, while much has been written on the insanity defense, in 1978, the most recent year for which data are available, insanity acquittees throughout the United States represented only eight percent of all admissions of mentally disordered offenders.<sup>3</sup> Mentally ill prison inmates comprised the largest category, fifty-four percent of all admissions of mentally disordered offenders, and was the subject of the least amount of legal scholarship.<sup>4</sup> Between these two extremes incompetent defendants represented thirty-two percent of the total and mentally disordered sex offenders accounted for the other six percent.<sup>5</sup>

The size of these groups should be important in assessing research priorities. In identifying productive directions for future research one criterion should be how any initiative might impact on the largest number of disadvantaged persons.

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1. This group is comprised only of pretrial detainees who have not as yet been adjudicated as offenders.

2. This group includes two subgroups which are distinguished in terms of their relationships to law and of the types of mental health service problems they present. These two subgroups are mentally disordered *jail* inmates and mentally disordered *prison* inmates.

3. Steadman, Monahan, Hartstone, Davis & Robbins, *Mentally Disordered Offenders: A National Survey of Patients and Facilities*, 6 L. & HUM. BEHAV. 31-38 (1982) [hereinafter *Mentally Disordered Offenders*].

4. *Id.* at 33.

5. *Id.* at 33.

## II. RECENT RESEARCH DIRECTIONS

### A. Research in the 1950's and 1960's

Prior to the mid-1960's there was very little research dealing with mental health law and the criminal offender, most of it being impact assessments of specific laws. In 1950, Sutherland published his classic work on the diffusion of sexual psychopath laws.<sup>6</sup> Zeidler and colleagues published in 1955 a notable follow-up study of incompetent defendants and sex offenders.<sup>7</sup> Morrow and Petersen's thorough follow-up of insanity acquittees was published in 1966.<sup>8</sup>

This discontinuous flow of work in widely different topic areas from numerous perspectives represented the mainstream throughout the 1960's. A director of a major American Bar Foundation research effort during the 1960's summarized this state of affairs:

In 1962 when the American Bar Foundation proposed a field study of "Mental Illness and the Criminal Law" the legal community had focused its attention primarily, if not exclusively, on the defense of insanity, tracing the historical and philosophical development of the legal notion of "guilty mind" and putting forward competing and conflicting answers to what definition of legal responsibility might accommodate both traditional criminal law notions of personal responsibility and current medical concepts of mental disorder and its treatment.

Other areas where mental illness and criminal law overlapped were, for the most part, ignored. . . .<sup>9</sup>

Several interrelated factors dramatically changed the level of research activity by the late 1960's. First, the United States Supreme Court's decision in *Baxstrom v. Herold*<sup>10</sup> marked the first mental health law case decided on constitutional grounds. In *Baxstrom*, the Court ruled that New York's penal law procedures for detaining mentally disordered inmates considered "dangerous" at the termination of their prison sentences violated the equal protection rights of a mentally disordered prison inmate.<sup>11</sup> The *Baxstrom* decision, and subsequently *Pate v. Robinson*,<sup>12</sup> and *Dixon v. Attorney General*<sup>13</sup> signified the beginning of

6. Sutherland, *The Diffusion of Sexual Psychopath Laws*, 56 AM. J. SOC. 142-48 (1950).

7. Zeidler, Haines, Tikuisis & Uffelman, *A Follow-up Study of Patients Discharged From a Hospital for the Criminally Insane*, 1 J. SOC. THERAPY 21 (1955).

8. Morrow & Peterson, *Follow-up on Discharged Offenders—"Not Guilty by Reason of Insanity" and "Criminal Sexual Psychopaths"*, 57 J. CRIM. L., CRIMINOLOGY & POLICE SCI. 31-34 (1966).

9. Matthews, *Mental Illness and the Criminal Law: Is Community Mental Health an Answer?*, 57 AM. J. PUB. HEALTH 1571, 1571 (1967).

10. 383 U.S. 107 (1966).

11. *Id.* at 110.

12. 383 U.S. 375 (1966) (insufficiency of evidence presented and failure of trial court to afford hearing on defendant's sanity violated defendant's due process right); see also *United States ex rel. Shuster v. Herold*, 410 F.2d 1071 (2d Cir.), cert. denied, 396 U.S. 847 (1969) (prison inmate transferred to institution for criminally insane, where effectively entitled to hearing on question of his sanity, with all procedures afforded to noncriminals who are involuntarily committed).



judicial activism in mental health law, particularly as it related to criminal defendants.

Lawyers emerged who were willing and eager to litigate mental health law issues. An increasing awareness of abuses of the mental health systems produced considerable litigation involving the practice of institutional psychiatry, particularly in state-run facilities.

The establishment of the National Institute of Mental Health Center for Studies of Crime and Delinquency in 1966 was also enormously significant.<sup>14</sup> In particular, the hiring of Dr. Saleem Shah in 1967 as chief of the new Center initiated a major NIMH focus on research on law and mental health activities.<sup>15</sup>

Finally, another significant factor in the generation of legal decisions, whose sequelae became a major research focus, was the founding in January, 1972 of the influential Mental Health Law Project. The staff of this largely litigation-oriented project participated in a series of landmark cases which dealt with such civil mental health law issues as the right to treatment,<sup>16</sup> the right to education,<sup>17</sup> and the use of experimental psychosurgery.<sup>18</sup> The Mental Health Law Project quickly became a leading source of expertise on mental health law and legal tactics. Further, it provided role models and psychic support to the array of young lawyers who committed themselves to the mental patient's advocacy movement in the late 1960's and early 1970's. Although the Mental Health Law Project had less direct involvement in the criminal part of

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13. 325 F. Supp. 966 (M.D. Pa. 1971) (holding that 586 mentally ill offenders had been unconstitutionally committed to state hospital).

14. The new Center was not NIMH's first incursion into the law and mental health area. NIMH had previously funded a 1962 American Bar Foundation study of the impact of mental health law on the criminal justice system, which had produced several major reference works. See e.g., A. MATTHEWS, *MENTAL DISABILITY AND THE CRIMINAL LAW* (1970); R. ROCK, M. JACOBSON & R. JANOPOL, *HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL* (1968); F. LINDMAN & D. MCINTYRE, *THE MENTALLY DISABLED AND THE LAW* (1961). NIMH had also funded both Simon's work on the insanity defense, see R. SIMON, *THE JURY AND THE DEFENSE OF INSANITY* (1967), and Szasz' work on *Law, Liberty and Psychiatry*, see T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* (1963).

15. Among the major products supported by NIMH funds from the Center were: T. THORNBERRY & J. JACOBY, *THE CRIMINALLY INSANE* (1979); H. STEADMAN & J. COCOZZA, *CAREERS OF THE CRIMINALLY INSANE* (1974); G. BRACKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* (1971); R. ARENS, *MAKE MAD THE GUILTY* (1969); I. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND LAW* (1967).

16. See, e.g., *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (United States Constitution guarantees persons civilly committed to state mental institutions a right to treatment).

17. See, e.g., *Mills v. Board of Education*, 348 F. Supp. 866 (D.D.C. 1972) (failing to provide children labeled as behavioral problems, mentally retarded, emotionally disturbed or hyperactive, and the class they represented with publicly supported specialized education violated controlling statutes and denied due process).

18. See, e.g., *Kaimowitz v. Michigan Department of Mental Health*, 1 MENTAL DISAB. L. REP. 147 (1976) (Mich. Cir. Ct. July 10, 1973) (use of experimental psychosurgical techniques on mental patient involuntarily confined in state institution, even with patient's formal consent, violates patient's first amendment right to generate ideas, as well as his constitutionally protected right to privacy).

mental health law, indirectly it was a major contributor to many of the judicial decisions and administrative responses by various state agencies that provided a fertile basis for the major research activity examining the results of this legal advocacy.

These developments created a dynamic that led to a general increased flow of research on mental health law and the criminal offender. The total work that was produced in the 1970's will not be comprehensively reviewed. Rather, major thrusts will be highlighted insofar as a description of them is needed as indicative of current gaps and initiatives in the 1980's.

#### B. *Research in the 1970's*

The major research thrusts produced by these and other forces in the 1970's in the area of mental health law and the criminal offender were threefold: (1) studies of how statutes dealing with incompetency to stand trial actually functioned; (2) studies of the accuracy of psychiatric predictions of dangerousness, using data derived from studying mentally disordered offenders; and (3) descriptive studies of the insanity acquittee.

In the area of incompetency to stand trial, each of the studies<sup>19</sup> demonstrated significant misunderstandings of the concept of incompetency, inappropriate competency evaluations, excessive security concerns, and inordinately long detentions. In response to these findings, Roesch and Golding recommended a new model for incompetency determinations.<sup>20</sup>

A second major research thrust in mental health law used the criminal offender for the study of psychiatric predictions of dangerousness which

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19. Pioneering work was done by McGarry and colleagues in Massachusetts. See NATIONAL INSTITUTE OF MENTAL HEALTH, CENTER FOR STUDIES OF CRIME AND DELINQUENCY, *COMPETENCY TO STAND TRIAL AND MENTAL ILLNESS* (1973). In his clinical work at Bridgewater State Hospital McGarry became aware that many defendants who had been found incompetent to stand trial remained hospitalized for substantially longer periods than they would have served had they been convicted of the crime charged. His observations led to a number of research initiatives to determine how competency to stand trial actually operated and was being abused. This line of inquiry was similar to earlier studies made by Hess and colleagues on Michigan's incompetency procedures and practices. See Hess & Thomas, *Incompetency to Stand Trial: Procedures, Results and Problems*, 119 AM. J. PSYCHIATRY 713 (1963). This author conducted a follow-up study of the implementation of the 1971 revision of New York's Criminal Procedure Law to examine the impact of shifting incompetent defendants from a correctional to a mental health department. See H. STEADMAN, *BEATING A RAP?* (1979). Nine years later, Roesch and Golding scrutinized the operation of the incompetency system in North Carolina. This was done at the request of the North Carolina Department of Mental Health, which had been considering revamping the central hospital where such defendants were treated. See R. ROESCH & S. GOLDING, *COMPETENCY TO STAND TRIAL* (1980).

20. See R. ROESCH & S. GOLDING, *supra* note 19, at 201-20. A major aspect of their model was the collaborative joint screening and evaluation panel, designed to facilitate communication and understanding between legal and mental health professionals. The model also proposed the use of a provisional trial for defendants whose competency remained questionable even after a brief treatment period. See *id.*

were used in determining detention.<sup>21</sup> In each of these studies a group of mentally disordered offenders was examined to test general questions about the accuracy of predictions of dangerousness. All but the Kozol study<sup>22</sup> raised serious questions about the accuracy of clinical predictions of dangerousness and the appropriateness of the use of such predictions in the courtroom.

Identifying the characteristics and post-acquittal experiences of insanity acquittees was a third area which had considerable research activity in the 1970's.<sup>23</sup> In general, this work has demonstrated that regardless of jurisdiction, insanity acquittees are a predominantly white male group, and older than the average criminal.

For the most part these studies have dealt with acquittees, rather than defendants entering a plea.<sup>24</sup> Thus, little is known about the rates of defendants entering the plea, the characteristics of those persons, the change in the volume of pleas, or how the characteristics of defendants attempting the not guilty by reason of insanity defense may have changed over time. Further, little is known about the duration of subsequent detention and the criminal and hospital recidivism of insanity acquittees. Nonetheless, even though in early stages, this area of investigation represents a major area of recent research effort.

These areas, incompetency processing, dangerousness, and insanity acquittees, represent the major thrusts of research in mental health law and the criminal offender in the 1970's. There were occasional empirical forays into mentally disordered sex offenders,<sup>25</sup> but nothing of conse-

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21. See, e.g., T. THORNBERRY & J. JACOBY, *THE CRIMINALLY INSANE* (1979); Steadman, *A New Look at Recidivism Among Patuxent Inmates*, 5 BULL. AM. ACAD. PSYCHIATRY & L. 200-09 (1977); H. STEADMAN & J. COCOZZA, *CAREERS OF THE CRIMINALLY INSANE* (1974); Kozol, Boucher & Garafalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQ. 371-92 (1972).

22. See *Diagnosis and Treatment*, *supra* note 21, at 371-92.

23. The state from which the majority of the work emanated was New York, see, e.g., Braff, Arvanites & Steadman, *Detention Patterns of Successful and Unsuccessful Insanity Defendants*, 21 CRIMINOLOGY 439-48 (1983); Steadman, Keitner, Braff & Arvanites, *Factors Associated With a Successful Insanity Plea*, 140 AM. J. PSYCHIATRY 401 (1983); Pasewark, Pantle & Steadman, *Detention and Rearrest Rates of Persons Found Not Guilty by Reason of Insanity and Convicted Felons*, 139 AM. J. PSYCHIATRY 892 (1982); Steadman, *Insanity Acquittals in New York State: 1965-1978*, 137 AM. J. PSYCHIATRY 321 (1980); Pasewark, Pantle & Steadman, *Characteristics and Disposition of Persons Found Not Guilty by Reason of Insanity in New York State, 1971-1976*, 136 AM. J. PSYCHIATRY 655 (1979), although significant work was performed in Missouri, see, e.g., Petrila, *The Insanity Defense and Other Mental Health Dispositions in Missouri*, 5 INT'L J. L. & PSYCHIATRY 81 (1982); Michigan, see, e.g., Cooke & Sikorski, *Factors Affecting Length of Hospitalization in Persons Adjudicated Not Guilty by Reason of Insanity*, 2 BULL. AM. ACAD. PSYCHIATRY & L. 251 (1974); Oregon, see, e.g., Rogers & Bloom, *Characteristics of Persons Committed to Oregon's Psychiatric Security Review Board*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 155 (1982); and New Jersey, see, e.g., Singer, *Insanity Acquittal in the Seventies: Observations and Empirical Analysis of One Jurisdiction*, 2 MENTAL DISAB. L. REP. 406 (1978).

24. This limitation has resulted from the absence of centralized records on pleas, which are recorded only at the county level in district attorney offices. Insanity acquittees, in contrast, are generally admitted to state facilities, thus making data concerning them accessible through centralized information systems.

25. See, e.g., Konecni, Mulcahy & Ebbesen, *Prison or Mental Hospital: Factors Affecting the*

quence on mentally disordered jail or prison inmates, other than recent work examining post-*Vitek*<sup>26</sup> conditions in six states<sup>27</sup> and an overview of jail issues.<sup>28</sup>

Given the limited scope of recent research, identifying gaps and areas in need of major initiatives in the 1980's and beyond is disconcertingly easy. The areas discussed below reflect this author's view about the particular areas in which lack of empirical data most inhibits informed public policy formation. The policymaker, the clinician, and the researcher equally could profit from more empirical data in these areas.

### III. RECOMMENDED RESEARCH INITIATIVES FOR THE 1990's

There are six areas for major research initiatives in the 1990's, presented in the order of their priority for informed policy making and legal scholarship.

It is important to note at the outset, however, that research strategy cuts across all of the areas articulated below. This is the strategy of *cross jurisdictional research*. Regardless of whether or not a research study involves incompetency to stand trial, the insanity defense, or any other area dealing with the mentally disordered offender, the assurance with which conclusions can be stated increases in studies of multiple jurisdictions. For example, research in New York on insanity acquittees found that just over half had been charged with murder or attempted murder.<sup>29</sup> A second study in Michigan<sup>30</sup> produced similar results. Other data from New Jersey,<sup>31</sup> Oregon,<sup>32</sup> and Missouri,<sup>33</sup> however, revealed that such serious offenses accounted for only five to twenty-five percent of the not guilty by reason of insanity cases. Thus, with new data from additional jurisdictions, a new hypothesis was framed: the higher the level of urbanization, the greater the proportion of insanity acquittals for serious crimes against persons. Hence, there should be little doubt that the most productive studies in almost all areas are cross-jurisdictional.

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*Processing of Persons Suspected of Being "Mentally Disordered Sex Offenders"*, in *NEW DIRECTIONS IN PSYCHOLEGAL RESEARCH* 87-124 (Lipsitt & Sales eds. 1980); M. FORST, *CIVIL COMMITMENT AND SOCIAL CONTROL* (1978).

26. See *Vitek v. Jones*, 445 U.S. 480 (1980) (due process requires that inmate facing involuntary transfer to mental hospital be provided qualified and independent assistance).

27. Hartstone, Steadman & Monahan, *Vitek and Beyond: The Empirical Context of Prison-to-Hospital Transfers*, *LAW & CONTEMP. PROBS.*, Summer 1982, at 125.

28. C. DUNN & H. STEADMAN, *MENTAL HEALTH SERVICES IN LOCAL JAILS* (1982).

29. See, e.g., *Detention Patterns*, *supra* note 23, at 439-48; *Detention and Rearrest Rates*, *supra* note 23, at 894.

30. See *Factors Affecting Length of Hospitalization*, *supra* note 23, at 257.

31. See *Insanity Acquittal in the Seventies*, *supra* note 23, at 406-07.

32. See *Persons Committed to Oregon's Psychiatric Security Review Board*, *supra* note 23, at 159.

33. See *Other Mental Health Dispositions*, *supra* note 23, at 81.

A. *Impact Assessment of Legal Decisions and Revised Statutes*

The area in greatest need of a concerted research initiative concerns the effect of major judicial decisions and significant statutory changes on mental health law and the criminal offender. An earlier example of this type of research was the research undertaken after the *Baxstrom*<sup>34</sup> and *Dixon*<sup>35</sup> decisions. Both studies followed a large cohort of patients from maximum security, correctional hospitals to regular security, civil state hospitals as a result of judicial decisions. Both studies suggested that the level of violence exhibited by the patients did not warrant their continued retention in maximum security facilities and that the treatment of the patients in civil state hospitals did not overly disrupt the latter's regular treatment responsibilities.

The *Baxstrom* and *Dixon* projects illustrate one type of research studying the impact of legal changes. Another type of research may focus on administrative impacts. A recently published example of this approach is a study of the *Vitek v. Jones*<sup>36</sup> decision giving prisoners a right to a hearing before being transferred to a mental hospital.<sup>37</sup>

A second illustration of how this type of research might assess both structural and personal impacts is work that should have followed the Supreme Court's decision in *Jackson v. Indiana*.<sup>38</sup> No mental health case decided in the 1970's was more important than *Jackson* which established a limit on the maximum detention of defendants incompetent to stand trial who were not expected to be restored to competency to stand trial. The Court held that unless there is a "substantial probability" that within the "foreseeable future" a defendant can proceed with a trial, continued retention requires using the customary civil mental health statutes for involuntary commitments.<sup>39</sup>

To date, there has not been a single systematic study of the actual impact of *Jackson* in any jurisdiction. What adaptations have states actually made? How many *Jackson* hearings occur in any given year? Has *Jackson* lowered the number of defendants incompetent to stand trial in the system? What has been the impact of patients successfully petitioning for release or transfer under *Jackson*? How often does a *Jackson* petition result in outright release because a defendant does not meet civil commitment standards? Has *Jackson* impeded or enhanced treatment for defendants incompetent to stand trial?

These and other such questions remain untouched by the research

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34. See H. STEADMAN & J. COCOZZA, CAREERS OF THE CRIMINALLY INSANE 43-189 (1979).

35. See T. THORNBERRY & J. JACOBY, THE CRIMINALLY INSANE (1979).

36. 445 U.S. 480 (1980).

37. See *Vitek and Beyond*, *supra* note 27, at 125-36 (study of empirical data on inmate transfers which concludes that the *Vitek* decision must be read broadly to apply to transfer to any mental hospital).

38. 406 U.S. 715 (1972).

39. *Id.* at 738.

community. It is possible that the considerable legal interest in the *Jackson* precedent is much ado about nothing as far as real impact on the processing of defendants incompetent to stand trial is concerned.

The lack of research on mental health law and the criminal offender is further illustrated by the following. Legal scholars and social scientists were at a loss to provide various state and federal legislative committees with meaningful data on the insanity defense immediately following the 1982 insanity acquittal of John Hinckley, Jr., who had attempted to assassinate President Reagan. One witness after another appeared before these committees, but few could offer the lawmakers any empirical data about the actual operation of the insanity defense in their home jurisdictions, much less nationally. Although a number of jurisdictions had moved towards adoption of a statutory "Guilty But Mentally Ill" category, Michigan was the only state in the post-Hinckley era that could provide even cursory data about the volume of cases after such a change.<sup>40</sup> How new administrative arrangements were working and whether the characteristics of the acquittees and their offenses had changed was still unknown. Hence, it is obvious that legislatures should begin to mandate an apparatus that provides empirical feedback concerning the impact of their legislation.

One of the major obstacles to the successful execution of this type of impact assessment research is the "research grant" model. The scenario is as follows: after a law is changed researchers often see the emerging opportunities for research. The researchers write a grant proposal which is submitted six months after the legal change. Six to nine months later, it is reviewed. Finally, eighteen months or so after the initial idea, the proposal *might* be funded. Unfortunately, by the time the research is ready to be undertaken many of the opportunities have passed. For example, if a researcher wanted to study changes in the negotiation process between the public defender and the district attorney after a guilty but mentally ill statute, he would have to collect data beginning with the effective date of the revision, if not earlier. Attempting to reconstruct what transpired by interviewing people about their recollection eighteen to twenty-four months later is not very effective.

These practical problems suggest the merit of a "disaster research" model.<sup>41</sup> Researchers interested in natural or man-made disasters must be ready to commence their research immediately, depending, of course, on precisely what they wish to study about the disaster. To be successful, a research center should provide ongoing funding so that it is prepared to

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40. See, e.g., Smith & Hill, *Evaluating Michigan's Guilty But Mentally Ill Verdict: An Empirical Study*, 16 J. L. REFORM 75 (1982).

41. Quarantelli & Dynes, *Response to Social Crisis and Disaster*, 3 ANN. REV. SOC. 23 (1977) (study of literature on response to social crises and disasters noting the deficiency in past research models and advocating a disaster research model).

begin work when an opportunity is presented. While no such model center has been established and there is no indication that such a model will be funded, this model would ensure the full effectiveness of legal impact assessment research.

### B. *Dangerousness*

Mental health law and the criminal process intersect most clearly and most often with the issue of dangerousness. One commentator has indicated that there are at least fifteen ways in which dangerousness plays a role in mental health law.<sup>42</sup> Approximately eleven of these occur in criminal contexts such as bail, sentencing, and the imposition of capital punishment.<sup>43</sup> While it has long been acknowledged that dangerousness is a legal issue rather than a medical issue,<sup>44</sup> this has not discouraged psychiatrists and psychologists from continuing to assess dangerousness in a wide variety of criminal contexts. This clinical input is often couched in terms of "classification," "pre-sentence reports," "parole review," "post-acquittal evaluation" of a defendant considered not guilty by reason of insanity, and other amorphous labels. Whatever the label, a substantial portion of the activities of mental health professionals in criminal justice relate to assessments of dangerousness.

Despite the importance of the concept of dangerousness and contrary to many scholarly and public expectations, with the exception of a few studies,<sup>45</sup> virtually no empirical research currently exists either on the ability of clinicians and others to predict accurately dangerousness, or on the implications of inaccurate predictions of dangerousness. Almost all of the research on clinical predictions of dangerousness has been limited to long-term treatment situations among criminally committed persons.<sup>46</sup> Although this limitation is noted in practically all reviews of the field, the circumstances, criteria, and outcomes of predictions made in short-term civil hospitalization situations remain virtually unstudied.<sup>47</sup> New directions in dangerousness research should involve taking a situational perspective on violence (e.g., the recognition that violent behavior is often

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42. See Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOLOGIST 224-25 (1978).

43. *Id.*

44. This was acknowledged over a decade ago by the American Psychiatric Association Task Force on Violence. See AMERICAN PSYCHIATRIC ASSOCIATION, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL (1974).

45. See Menzies, Webster & Sepejak, *The Dimensions of Dangerousness: Evaluating the Accuracy of Psychometric Predictions of Violence Among Forensic Patients*, 9 L. & HUM. BEHAV. 49 (1985); Sepejak, Menzies, Webster & Jensen, *Clinical Predictions of Dangerousness: Two-Year Follow-up of 408 Pre-Trial Forensic Cases*, 11 BULL. AM. ACAD. PSYCHIATRY AND L. 171 (1983).

46. J. Monahan, *Prediction Research and the Emergency Commitment of Dangerously Mentally Ill Persons: A Reconsideration*, 135 AM. J. PSYCHIATRY 198-201 (1978).

47. But see D. McNeil & R. Binder, *Predictive Validity of Judgments of Dangerousness in Emergency Civil Commitment*, 144 AM. J. PSYCHIATRY 197 (1987).

a product of the environment or situation) and examining predictions in treatment settings that are more typical than the criminal commitment facilities generally examined.

The results of the research on clinical judgments of dangerousness have been quite consistent. Even among what are generally considered extremely high risk groups, such as convicted felons or the criminally insane, the accuracy of clinical estimations rarely exceeded that which was obtainable simply by chance.<sup>48</sup>

The research studies where the false positive rate was low<sup>49</sup> demonstrated little special clinical acumen. Rather, the base rate of the behavior in both the dangerous and non-dangerous groups was so high that regardless of the category in which the individual was placed clinically, an 80-90% chance existed that he would exhibit assaultive behavior. Given the extremely low distributions of most types of dangerous behavior predicted, in most studies the greatest accuracy obtainable was by predicting that no one would be dangerous. All other types of predictions increased the error rate, usually by identifying many persons as dangerous who were not. Obviously, such a tactic is completely unacceptable in actual clinical settings given the social and personal costs involved.

One reason for the lack of progress in this type of research either in mental health or criminological approaches to the prediction of violence is that the research tends to be *offender-focused*. The research separates those in the sample who commit violent acts from those who do not, and compares the groups on such factors as demographic characteristics, psychiatric, symptomology, and previous life history, typically including prior criminal and mental health histories.

This offender-focused research has tended to ignore the effect of situational factors on violent behavior. To date, research on situational variables in violence is limited.<sup>50</sup> These studies usually report descriptive statistics on homicides, assaults, and other violent offenses. Although useful, they are limited in that: (1) they usually examine only violence that results in arrest and conviction; and (2) they do not examine how situational variables affect variations in the outcome of aggressive encounters. Nonetheless, it has become increasingly documented that

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48. Phrased in another way, the predictive accuracy rarely exceeds the base rate of the behaviors predicted, i.e., where 40% accuracy is attained, about 40% of the total group for whom predictions are made exhibited the criterion behaviors. Thus, clinical prediction attaining 40% accuracy would be obtainable strictly by chance alone. Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1096-98 (1976); Slobogin, *Dangerousness and Expertise*, 133 U. PA. L. REV. 97, 110-17 (1984).

49. Hedlund, Sletten, Altman & Evenson, *Prediction of Patients Who Are Dangerous to Others*, 29 J. CLINICAL PSYCHOLOGY 443, 444 (1973).

50. See Steadman, *A Situational Approach to Violence*, 5 INT'L J.L. & PSYCHIATRY 171 (1982); S. STEINMETZ, *THE CYCLE OF VIOLENCE: ASSERTIVE, AGGRESSIVE AND ABUSIVE FAMILY INTERACTIONS* (1977); R. GELLES, *THE VIOLENT HOME* (1972); H. TOCH, *VIOLENT MEN* (1969); M. WOLFGANG, *PATTERNS IN CRIMINAL HOMICIDE* (1958).



behavior is a joint function of personal and environmental characteristics.<sup>51</sup> The recognition that behavior is at least in part situationally determined opens an entirely new perspective on the prediction and prevention of violence, and on prediction research.

Prior research has consistently documented the absence of demonstrable expertise on the part of clinicians to predict accurately future violent behavior. Nonetheless, practically no research is underway. Despite its importance, research about dangerousness and the criminal offender is more sparse than it appears.

### C. Policing and the Mental Health System

Almost no empirical knowledge is available concerning the apprehension, arraignment, and referral phases of the mental health-criminal justice interface. The apprehension stage of these interactions is particularly in need of work. Most studies concerning criminal offenders in the mental health system begin at a post-adjudication point.<sup>52</sup>

Research is also lacking with respect to the pool of all persons considered for competency evaluation or actually *evaluated* for competency, those who *plead* insanity, or those who are *referred* for screening within a prison for transfer to the maximum security mental hospital. These gaps are due in large part to the logistics of the research process: until the relevant subjects are identified for study, they comprise such a small proportion of all offender populations as to make the rate exceedingly high and the costs excessive. Prior to such adjudication, records tend to be found, if at all, at the county level, where the cost to obtain them is relatively higher. By contrast, after adjudication, these offenders often become part of a centralized information system at the state level from which they can be identified and from which various records can be obtained at a lower cost.

Little is known about the initial contacts between criminal offenders and the mental health system.<sup>53</sup> For example, whether a person becomes labeled a criminal or a mental patient at the outset may be due in large part to a decision made by a police officer. It is unclear why an individual is brought to the emergency room of a general hospital rather than being arrested and booked and perhaps later found incompetent to stand trial.

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51. See, e.g., Felson & Steadman, *Situational Factors in Disputes Leading to Criminal Violence*, 21 *CRIMINOLOGY* 59 (1983); Athens, *Violent Crime: A Symbolic Interactionist Study*, 1 *SYMBOLIC INTERACTION* 70 (1977); Luckenbill, *Criminal Homicide as a Situated Transaction*, 25 *SOCIAL PROBS.* 176 (1977).

52. Teplin's current work on police patrolmen's front-line decision-making in dealing with the mentally ill in Chicago is a notable exception. See Teplin, *The Criminality of the Mentally Ill: A Dangerous Misconception*, 142 *AM. J. PSYCHIATRY* 593 (1985).

53. Teplin's work on police-mentally ill person encounters in Cook County is a notable exception. See L. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 *AM. PSYCHOLOGIST* 794 (1984).

The considerable exercise of discretion on the front lines has major ramifications as to how these two systems function. In New York, for example, whether a defendant is charged with a low grade felony rather than a misdemeanor would have a tremendous impact if the person subsequently were found unfit to proceed with a trial (as a defendant incompetent to stand trial is called in New York). If the defendant is charged with a felony, he would be confined after an incompetence adjudication to an appropriate facility for ninety days. The district attorney has six months from that time to obtain an indictment to proceed with prosecution.<sup>54</sup> In contrast, if the defendant is charged with a misdemeanor, a finding of incompetence terminates all criminal proceedings and the defendant is committed to an appropriate facility for a maximum of ninety days.<sup>55</sup>

Any discussion of research directions for mental health law and the criminal defendant must consider the important area of police decision-making. It is impossible to understand adequately how the two systems interact without a full picture of their respective operations. What little is known deals almost exclusively with the post-adjudicatory stages; the prior stages may be more important in many ways.

#### D. Jails

If there is any area in the criminal justice system that has been impacted upon by state mental hospital deinstitutionalization, it is the local jail. A recent work suggests that there is very little that has changed in six large states between 1968 and 1978 with respect to the proportion of state prison inmates with prior mental hospitalization histories.<sup>56</sup> In contrast, research literature and reports emanating from the United States jails demonstrate a major influx of mentally ill persons in local jails in that same period.<sup>57</sup>

These possible changes in service needs combined with current federal initiatives to transfer funding and programmatic responsibilities back to the county level suggest that the local jail may be a focal point of advocacy activity in the 1980's. The relevant issues include conditions of confinement that intimately involve all types of health issues, least restrictive alternatives for persons for whom the courts may wish to mandate mental health treatment, as well as *Vitek*-type questions about the rights of the inmate to protect his transfer from the jail into other county facilities for

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54. N.Y. CRIM. PROC. LAW § 730.40 (McKinney 1984).

55. *Id.* at § 730.50.

56. Steadman, Monahan, Duffee, Hartstone & Robbins, *The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations 1968-1978*, 75 J. CRIM. L. & CRIMINOLOGY 474 (1984).

57. Lamb & Grant, *The Mentally Ill in an Urban County Jail*, 30 ARCH. GEN. PSYCHIATRY 17 (1982); Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101 (1972).

the purpose of mental health treatment.

#### E. Outcome Studies

In a discussion of mental health law and the criminal offender, it may initially appear inappropriate to call for studies of treatment efficacy. Such studies are, after all, the grist of clinical research. However, they are also relevant to the issues examined above. Their relevancy relates to the fact that the operation of the mental health system in criminal justice is contingent on certain presumed outcomes. That is, various types of interventions in the lives of the criminal offender are permitted on the assumption that they have positive results. What rights and protections the criminal offender may have, however, can only be properly ascertained when the benefits to them of the mental health interventions can fairly be assessed.

#### F. Special Groups

Three potentially overlapping groups are of special concern for research purposes. These groups are women, juveniles, and the mentally retarded or developmentally disabled. Each group presents special concerns in law and in treatment that may warrant special initiatives.<sup>58</sup> This section is not intended to articulate all of the specific questions raised by each of these special groups. Instead, an example on incompetency to stand trial should be sufficient to indicate why research targeted to these groups would be productive.

Few women are found incompetent to stand trial.<sup>59</sup> Many states are unable to identify the number of women found incompetent. This in large part results from the lack of discrete programs for them. As opposed to their male counterparts, female defendants found incompetent to stand trial often are placed in some general purpose mental health or correctional facility where they are distinguished only by their legal status. An intriguing question that arises from this lack of discrete programs is whether women are being deprived of equal protection under the law. Questions to consider include: Do they have equal access to appropriate facilities for treatment if found incompetent? Do they have equal access to the incompetency status? That is, if no programs exist for women, is the court equally willing to order a competency examination or to find women defendants incompetent? A careful look at the processing of women evaluated for incompetency to stand trial is needed to even begin to answer some of these questions. No such research now exists.

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58. These groups are characterized to have special needs within the criminal justice system due to the fact that adult males predominate among mentally disordered offenders and are most feared by the public. As a result, adult males tend to be both the focus of research and the target of resources.

59. See generally, *Mentally Disordered Offenders*, *supra* note 3.

Numerous issues raised by the use of juvenile incompetency to stand trial may also stimulate legal scholars. Initially, some empirical assessments of the impact of legislation in those jurisdictions that have introduced incompetency procedures for juveniles would help frame legal analyses. Further, an examination of the mental health services for juveniles in the family court system would be helpful to evaluate the extent to which incompetency legislation may impact in the future.

The special problems of the retarded and developmentally disabled are highlighted in *Jackson v. Indiana*.<sup>60</sup> The Court in *Jackson* reasoned that there was no probability that the plaintiff would be rendered competent in the future because of her disabilities (deafness and dumbness). That such a question would remain so long into the plaintiff's confinement is simply one indication of the lack of sensitivity of the mental health and legal systems to special problems within the criminal offender populations. It also indicates the need for research on the retarded and developmentally disabled.

#### IV. CONCLUSION

In general, current research in mental health law as it pertains to the criminal offender has very little direction. In the 1970's, the substantive and empirical questions surrounding dangerousness seemed to provide some overriding focus on emergent issues such as the right to treatment, right to refuse treatment, informed consent, and least restrictive alternatives. The research directions, however, tend to be short-lived.

It is intriguing to speculate about the extent to which this diffuseness is a function of the interdisciplinary nature of this research field. Since the empirical and theoretical issues in the mental health and criminal law area are not neatly compartmentalized into psychology, sociology, or political science, relevant courses rarely appear in departmental offerings.

The concept of academic-based research institutes on mental health law has yet to be implemented, although much research has come from treatment-based programs such as the University of Pittsburgh Western Psychiatric Institute's Law and Psychiatry Program and the University of Virginia's Institute of Law, Psychiatry and Public Policy. These and similar programs may be necessary to introduce a new generation of researchers to the important and challenging questions in mental health law. Clearly, traditionally structured, discipline-bound programs cannot achieve these goals.

Further, use of the computer could greatly contribute to both the research and treatment of mentally disordered offenders. For whatever reasons, whether forensic patients cut across mental health or correc-

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60. 406 U.S. 715 (1972).

tional information systems, or money is available only for security, readily available information on forensic populations for research, administration, or individual treatment is rarely routinely available. With low cost microcomputers becoming pervasive, major improvements in forensic information systems may provide essential breakthroughs in research and in treatment.

The purpose of this Article has been to highlight major recent initiatives in the area of mental health law and the criminal offender and to suggest some of the major areas that could profit from research in the remaining 1980's and the 1990's. Unfortunately, such suggestions are worth nothing without researchers to pursue them and dollars to support them. Both now seem to be in short supply. It is this author's hope that a symposium such as this may lead to the amelioration of both of these problems.

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# **Civil Commitment from a Systems Perspective**

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## Outline of Presentation

Wednesday, 3:10 - 4:00 pm, November 7, 1990

### **I. Characteristics of a Dual (Bisystemic) Approach to Civil Commitment**

- A. Goals of the commitment process
- B. Means for implementing goals
- C. Division of labor between the mental health and justice systems

### **II. The Consequences of Bisystemic Approach**

- A. Failure of either system to internalize goals of civil commitment
- B. Effects on mental health system functioning
  - 1. Primacy given to the value of treatment may lead to neglect of statutory criteria
  - 2. Fear of litigation may lead to overcommitment
- C. Effects on justice system functioning
  - 1. Lack of investment in commitment process may lead to failure to allocate sufficient resources
  - 2. Judges and attorneys often perform in perfunctory manner
- D. Net results
  - 1. Mental health decisionmaking often driven by clinical desiderata
  - 2. Justice system unable to provide effective counterbalance
  - 3. Commitment hearings assume pro forma character

### **III. Improving the Commitment Process**

#### **A. Due process approach**

1. Narrower substantive standards
2. Tighter procedural requirements
3. But depends on good faith of mental health and justice systems, and therefore often leads to few changes

#### **B. Efforts to induce shared perspective**

1. National Center for State Courts' *Guidelines for Involuntary Civil Commitment*
2. Therapeutic jurisprudence
3. Paradox is that success is dependent on preexistent desire to make system work

#### **C. Existing proposals may be the best we can do, but systems perspective leads us to explore innovative alternatives**

### **IV. A Monosystemic Approach to Civil Commitment**

#### **A. Independent system to manage civil commitment process**

1. Description of possible organization
2. Analogies to existing systems for disability evaluation and other purposes
3. Analogies to partial reforms of civil commitment

#### **B. Advantages and disadvantages**

### **V. Conclusion**



# PSYCHIATRY

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*volume five*

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# Civil Commitment

Involuntary civil commitment, the primary nexus of interaction between psychiatry and the law, raises profound questions about the relative scope of paternalism and individualism in American society. The legal struggles over the process of civil commitment, which have been going on for more than a century, can only be understood as a manifestation of society's ambivalence about the extent to which the expressed wishes of its members can be ignored for the ostensible sake of promoting their interests or the interests of others. Psychiatrists have often been caught in the currents of this ambivalence—the same society that has placed them in command of an extensive system of coercive care has simultaneously feared and criticized them for filling the role thus created.

This chapter explores the dimensions of the issues raised by the civil commitment system, with the goal of helping perplexed practitioners understand the legal maelstrom in which they have been enveloped. To achieve this goal it is necessary to review the evolution of civil commitment in the United States, to explore the current controversies that beset the system, and to inspect the empirical data that shed some light on the commitment process. Finally, since commitment raises therapeutic, as well as philosophic and legal, issues, the clinical aspects of the commitment process are also addressed.

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## The Evolution of the Civil Commitment System

Prior to the establishment of hospitals for the treatment of mental illness, which began to appear in large numbers with the development of state hospital systems in the second quarter of the nineteenth century, there was little formal legal regulation of the care of the mentally ill. Some states, such as New York, had enacted statutes permitting the detention of the "furiously mad," while others responded to individual cases of particular need with appropriations to permit families to care for ill relatives at home.<sup>1</sup> It is clear, however, that these represented the exceptional cases. For the most part, the mentally ill were either ignored or dealt with by the two major systems of social control—the criminal laws and the poor laws.

The detailed memoranda of Dorothea Dix, who combed much of the nation in the 1840s and 1850s to document the need for hospitals in which to treat the "insane," reveal that nearly every county jail had its share of deranged inmates, confined there in abominable conditions for want of more suitable alternatives.<sup>2</sup> When the mentally ill could not be charged with a crime, they were likely to end up in the public almshouse—an important institution in almost every county in nineteenth-century America—confined on the order of the overseers of the poor. There they received basic

sustenance, but often in filthy and disorderly circumstances. In either case, their liberty was constrained, without therapeutic pretext, and often with frankly punitive intent.

At the same time as jails and almshouses were filling up with mentally ill inmates, a number of experiments were being launched in hospital care of the mentally ill. The first psychiatric admission in the American colonies occurred at the Pennsylvania Hospital in Philadelphia in 1752. By the third decade of the 19th century, a handful of similar charitable institutions, under private auspices but often supported by public funds, had developed in such major cities as New York and Boston. In addition, a few states, such as Virginia and Kentucky, had opened small public facilities for the care of the mentally ill.

Before the 1830s, admission to the institutions that existed was almost entirely free of legal regulation. The private institutions established their own rules, which often required that the potential patient's admission be accompanied by a guarantee of payment by a family member or friend and be certified by an attending physician.<sup>3</sup> It was assumed that admissions would be involuntary, since insane persons were thought as a matter of course to be unable to recognize their own interests. Family members and friends were assumed to have the right to act for the patient's interests, a right that was supported by a number of early court decisions.<sup>4,5</sup>

The beginning of legal regulation of the commitment process came with the great wave of state-run hospitals established for the insane in the second quarter of the century. State involvement brought a need for enabling legislation, and some modicum of outside control. In many states commitment could still be effected by concerned family members who were willing to pay the costs of care, but if the state were to assume the costs, some judicial certification of the need for commitment, along with medical approval, was generally required. In the early days of the formal commitment system, judicial involvement sometimes appeared to be more a form of cost control than a mechanism for the protection of individual rights.<sup>6</sup> In some states, for example, those paupers already supported in almshouses could be committed by overseers of the poor with no further legal intervention.

Immediately following the Civil War, the situation began to change. Widespread allegations of abuse of the commitment process, for example, the charges by E.P.W. Packard that she had been "railroaded" into a mental hospital by her husband and a collusive physician, caught the attention of the public media. Although the legitimacy of many of

these allegations is in doubt,<sup>7</sup> they provided an impetus for two substantial changes in the civil commitment system: an extension of legal regulation to nonpublic facilities, and the introduction of a number of procedural safeguards, including several that were borrowed from the criminal justice system. States began to require hearings at which the allegedly mentally ill person had the right to object to the proposed confinement, often with a jury making the ultimate decision. Physicians in some states were required to examine patients before signing affidavits testifying to the need for their commitment and were required to state that they were not related to the patients and had no financial interest in their hospitalization.

The debates that accompanied these changes were remarkably similar to contemporary discussions of these issues. Proponents of the procedural reforms urged that individual liberty was too sacred to be sacrificed without stringent safeguards to guarantee the legitimacy of the need for confinement. Since the most elaborate model of protection of individual liberties had evolved in the criminal law, and since the deprivation of liberty in both systems seemed analogous, it was urged that commitment procedures be modified to accord with the usual criminal trial. Opponents of such changes argued that the primary value at stake was the rapid treatment of mental disease. To the extent that elaborate procedures delayed hospitalization or threatened public awareness of the person's illness, treatment would be deferred and patients needlessly shamed. Advocates of nonjudicial commitment felt that physicians, and not judges, and certainly not juries, were in the best position to determine the patient's need for hospital care.

These reforms in the commitment process were entirely limited to the procedures by which hospitalization was accomplished. No one suggested until much later that the substantive criteria that defined who might be committed be altered. There was a consensus that hospitalization was appropriate for all of the "insane" or at least those, generally acute, cases who might be expected to benefit from treatment. Even in the latter part of the century, when the level of care in state hospitals deteriorated so substantially that little treatment was rendered and the institutions were serving largely custodial functions, the treatment-oriented rationale for civil commitment remained unchanged and essentially unquestioned. Few people doubted that the state had the right to hospitalize the mentally ill for their own benefit.

The history of civil commitment law for the 100 years since the first wave of reform has largely been

a matter of waxing and waning procedural protections. As public attitudes shifted between concern with deprivation of liberty and concern with deprivation of treatment, procedures were tightened accordingly and relaxed.

There were two important periods of loosened procedures. Major changes in many states statutes occurred during the first two decades of this century, when the psychopathic hospital movement, which emphasized the importance of prompt diagnosis and treatment, led to passage of provisions for short-term commitment on the certification of one or two physicians, without a judicial hearing. Another wave of relaxed commitment procedures followed World War II, a time when the public perception of psychiatry was favorable. In 1948, the prestigious Group for the Advancement of Psychiatry issued a report objecting to "the worst features of contemporary commitment laws," including legal service and notice to the patient; insistence on personal appearance in court; criminal-like procedures, including trial by jury; failure to separate determinations of commitability and legal incompetency; and use of anachronistic terminology (*e.g.*, insanity and lunacy).<sup>8</sup> Critiques such as this stimulated the formulation of the Draft Act Governing Hospitalization of the Mentally Ill by the then newly established National Institute of Mental Health. The Draft Act proposed a streamlining of commitment procedures, including a certification process that was entirely in medical hands.<sup>9</sup>

Periods of procedural relaxation have inevitably been followed by efforts to tighten commitment statutes. The most recent swing of the pendulum toward more rigorous procedures began in the late 1960s, and grew out of the general concern with civil rights of the less fortunate that marked that period. It has led to important changes in both substantive and procedural standards, which continue to affect the status of civil commitment law in every state.

## Current Status of the Law of Civil Commitment

### PROCEDURAL STANDARDS

The most recent period of statutory reform in commitment law has been marked by a progressive diminution in the differences between civil com-

mitment and criminal trial procedures. Foundations for this move were laid in the late 1960s and early 1970s, when the United States Supreme Court, considering challenges to delinquency proceedings involving juveniles, declared that the potential for deprivation of liberty was a more important factor than the status of the defendant in determining appropriate procedures.<sup>10,11</sup> A number of federal courts were quick to apply these principles to the mental health context. "It matters not," wrote the Tenth Circuit Court of Appeals in *Heryford v. Parker*, "whether the proceedings be labeled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process."<sup>12</sup>

*Lessard v. Schmidt*, a 1972 Wisconsin case, offered the most thoroughgoing application of this rationale.<sup>13</sup> The *Lessard* court required, on constitutional grounds, the following due process protections in civil commitment proceedings: comprehensible and timely notice of the allegations that may result in commitment; similar notice of all rights, including the right to trial by jury; no detention longer than 48 hours without a hearing on probable cause; no detention longer than 2 weeks without a full hearing on the grounds for commitment; the rights to representation by adversary counsel, to exclusion of hearsay evidence, and to remain silent when examined by a psychiatrist or at trial; the burden on the state of proving that the patient meets the substantive commitment criteria beyond a reasonable doubt; and a consideration of less restrictive alternatives prior to involuntary commitment.

Although most courts have not gone as far as did the decision in *Lessard* in mandating criminalized procedures in civil commitment, the case has been influential in providing guidance to other courts and stimulating many states to revise their commitment procedures, prior to court challenge. The rights to notice, a timely hearing after detention, and assistance of counsel have been widely accepted. The need for and timing of a probable cause hearing, use of hearsay evidence, and the right against self-incrimination have been subject to differing reactions by other courts and by legislatures.

Despite this diversity in procedural protections among the states, the United States Supreme Court has largely avoided direct rulings on procedural aspects of civil commitment, except for *Addington v.*

*Texas*, and *Parham v. J.R.*, both 1979 cases.<sup>14</sup> In addition, the Court, considering the standard of proof the state ought to meet, struck a more moderate position than found in *Lessard* and similar cases. Distinguishing the juvenile delinquency cases as involving situations in which punitive intent is present, the Court held that "a civil commitment proceeding can in no sense be equated to a criminal prosecution." The liberty interests of the individual demanded that the state prove its case by more than a simple preponderance of the evidence ("more likely than not") standard, but the uncertainty of psychiatric diagnosis mitigated against requiring a standard of beyond a reasonable doubt. The Court settled on the intermediate measure of "clear and convincing evidence" as "a fair balance between the rights of the individual and the legitimate concerns of the state." Some state courts have since opted for the beyond a reasonable doubt standard as a matter of state law, but *Addington* probably helped to slow the movement toward the adoption of some of the more controversial of the *Lessard* standards.

The other United States Supreme Court foray into procedural aspects of civil commitment came in *Parham v. J.R.*, dealing with commitment of children.<sup>15</sup> In *Parham*, the Court refused to find that children who were admitted to a psychiatric facility by their parents were entitled to the full panoply of due process protections that now characterize adult commitment. Chief Justice Burger's majority opinion reasoned, in view of the presumption that parents will act in their children's interest, that due process required only that the children's admission be reviewed by an impartial decision maker. Since the admitting psychiatrist was held to fill this role adequately, no further review of children's admissions was required. Although it is inconceivable (given other precedents) that the Supreme Court would rule similarly in a case involving adults, *Parham* provides another indication that the high court is more cautious about expanding patients' procedural rights than many lower federal tribunals.

Even in the absence of Supreme Court guidance about most civil commitment procedures, almost all states have adopted models grossly analogous to the criminal system. A notable exception here is New York, which for two decades has had a unique commitment statute.<sup>16</sup> In New York, patients can be committed for up to 60 days on the certification of two physicians, without judicial involvement. All involuntary patients, however, are contacted shortly after admission by an attorney representing the state's Mental Health Information Service, (an

arm of the state supreme court), informed of their right to appeal their commitment, and provided representation in court if they desire to contest hospitalization. In a recent challenge to this statute, *Project Release v. Prevost*, federal courts upheld the broad discretion conferred on New York physicians, primarily because of the intricate web of protections simultaneously provided for patients.<sup>17</sup> The Second Circuit Court of Appeals explicitly rejected the contention that the *Lessard* standards are mandated by constitutional considerations, holding that patients' interests may be protected in a variety of constitutionally acceptable ways.

It is unclear at this point whether *Project Release* represents a new tendency for courts to accept less rigorous procedural standards than they demanded a decade previously, or whether the case is best viewed as a judicial anomaly. In one form or another, however, clinicians in most jurisdictions will probably be confronted with criminalized commitment procedures for the foreseeable future.

## SUBSTANTIVE STANDARDS

For more than two centuries of psychiatric hospitalization in this country, the criteria that permitted involuntary confinement were the subject of wide consensus. It was generally agreed that hospitalization was the primary means by which treatment could be effected, that treatment was a socially desirable goal, and therefore that the presence of a mental illness was sufficient grounds for confinement. The state's power to act in these instances was seen to stem from its "*parens patriae*" function, the traditional power to care for those incapable of caring for themselves. Because the public was also concerned about the danger presented by the violent mentally ill, separate procedures were often created for their more rapid hospitalization. Different procedures in this case could be justified on the basis of the state's "police powers," which mandated protection of the public safety, but in so far as a major intent of commitment was to provide treatment, the *parens patriae* powers were exercised here as well. Even when rigorous procedures were introduced in commitment hearings, the substantive criteria for commitment and the underlying rationale remained unchallenged.<sup>18</sup>

By the mid 20th century, however, *parens patriae* commitment based only on the presence of mental illness and the patient's need for treatment began to arouse dissatisfaction. It was argued that society had no right to force those able to make

decisions for themselves to undergo unwanted treatment, even when they might be benefited by such care. Such action was seen to violate the principle of individual autonomy. In response to these sentiments, the National Institute of Mental Health (NIMH) Draft Act in 1951 proposed a modified version of the traditional "need for treatment" formula—that to be committable a patient must be "in need of care or treatment in a mental hospital, and because of his illness, lacks sufficient insight or capacity to make responsible application therefore."<sup>9</sup> This limited the state's *parens patriae* powers to those genuinely unable to make decisions for themselves.

The argument that the benevolent power of the state should be restricted, perhaps even more drastically than proposed by the Draft Act, began to be widely accepted by the late 1960s. A number of factors coalesced to increase the attractiveness of marked limitations on the state's commitment powers—the legitimacy of psychiatric diagnosis and of the concept of mental illness were under severe attack; the recognition was growing that little effective treatment was being provided in many state hospitals; and the profession itself had embraced an ideology, embodied in the community psychiatry movement, that questioned the use of hospitalization for the treatment of psychiatric disorders.

As a result of these factors, and stimulated by an efflorescence of constitutional argumentation emphasizing the rights of the individual as against the state, the idea gained ground that involuntary commitment should be restricted to a narrow set of circumstances, specifically when patients represented a danger to their own physical well-being or that of others. Intervention in the case of a danger to oneself continued to be justified on the basis of the state's *parens patriae* powers, but the scope of those powers was constricted to encompass only life-threatening situations. Commitment of those who were dangerous to others came to be seen as a pure exercise of the state's police powers, with no benevolent intent, and therefore no basis in the doctrine of *parens patriae*. These limited criteria for commitment were known as the "dangerousness" standard.

Dangerousness as the sole grounds for commitment was first embraced by California, with the passage of the Lanterman-Petris-Short Act, which took effect in 1969. California's statutory scheme served as the basis for similar changes in other states, permitting involuntary hospitalization only of those who were dangerous to themselves or to others, or who were so "gravely disabled" as to be

unable to meet their minimal needs for survival (a variant on danger to self).<sup>19</sup>

A series of court decisions accelerated the switch to a dangerousness standard by constructing a constitutional rationale for excluding the nondangerous person from involuntary hospitalization. Again, the court in *Lessard v. Schmidt* led the way.<sup>13</sup> The existing Wisconsin statute had authorized hospitalization for persons with "mental disease to such an extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community." The *Lessard* court ruled that the statute was unconstitutionally vague and overbroad, unless it were read to require (without any textual foundations) a finding of dangerousness to self or others before a person might be involuntarily deprived of liberty.

The vagueness that worried the court in *Lessard*, and in similar cases around the country, was reflected in the difficulty of formulating clear standards of when a person "so afflicted requires care and treatment for his own welfare." In the absence of clear criteria defining this situation, it was feared, commitment decisions would be unreviewable by the judiciary and thus subject entirely to the whim of the committing clinician. The fragmentation of psychiatric opinion as to when hospitalization was necessary made an appeal to consensus impossible.

The *Lessard* court's additional concern about overbreadth was based on its belief that the statute reached beyond those persons for whom the state had a legitimate interest in hospitalization. Drawing on the argumentation for the restriction of state power to coerce treatment described above, *Lessard* and subsequent decisions in other states granted a constitutional basis to the belief that the state can intervene only when the lives of the patient or others are endangered.

During the 1970s, almost every state revised its commitment statute to conform to the dangerousness criteria endorsed by the California legislature and the *Lessard* court.<sup>20</sup> When legislatures were slow to act, they were often stimulated by court decisions invalidating commitment statutes based on a need for treatment. As in the procedural area, however, the United States Supreme Court has avoided addressing and definitively resolving the major constitutional issues. On the only occasion when the Court addressed the issue of criteria for commitment, in the 1977 case of *O'Connor versus Donaldson*, its comments were so ambiguous as to leave both sides claiming victory.<sup>21</sup>

*O'Connor* had come to the Court ostensibly for resolution of the question of whether patients who

have already been committed have a constitutional right to receive treatment. The Court ducked that issue, turning the case instead into one that addressed the circumstances in which continued confinement of a mentally ill person is warranted. The decision was narrowly tailored to the facts of the case—Donaldson had been denied discharge for 14 years despite the absence of dangerousness, the presence of a friend willing to assume responsibility for his care, and the lack of any treatment while he was committed to the Florida State Hospital. In what appeared to be the clearest statement of its holding in the case, the Court declared that “a State cannot constitutionally confine *without more* a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.” (emphasis added) The key phrase “without more” has been read to mean that discharge was required only when a nondangerous patient was being confined without something more being done to improve his condition (*i.e.*, without treatment); conversely, if treatment were provided, or if the patient were dangerous, commitment could continue.

Read in this fashion, *O'Connor* indicated that the Court was not ready to reject commitment on the basis of a need for treatment, as so many lower federal courts had done, as long as treatment, in fact, was provided. Proponents of a dangerousness standard, however, point to other passages earlier in the opinion to claim that the Supreme Court actually endorsed their position—“there is still no constitutional basis for confining (mentally ill) persons involuntarily if they are dangerous to no one and can live safely in freedom:” “the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the state may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom.” Numerous courts have cited these sentences to assert that the Supreme Court has endorsed the requirement for a dangerousness standard on constitutional grounds: in a recent dissenting opinion, three justices of the Court themselves expressed a similar position.<sup>22</sup>

What conclusion can be drawn from this dispute? Although the lower courts have been nearly unanimous in asserting the constitutional necessity of a dangerousness standard, it would be disingenuous to claim that the Supreme Court has resolved the issue. Whether a need for treatment standard, in some form, may be constitutionally acceptable remains to be determined.

The nationwide change, in less than 20 years, from need for treatment to dangerousness as the basis for civil commitment has by no means resolved all controversies in the area. A number of aspects of the various dangerousness standards remain in need of clarification. Some courts and several legislatures have required that an “overt act” indicating the patient’s dangerousness occur prior to commitment. Other courts have rejected this requirement, arguing that whatever is gained thereby in the accuracy of prediction is outweighed by the danger in which the patient or others are placed while awaiting the occurrence of the overt act. Even in those jurisdictions that require an overt act, there is great variation as to the recency with which the act must have occurred.<sup>23</sup>

Several commentators have pointed to areas of ambiguity in the formulation of the standards themselves, most of which fail to specify the seriousness of the threatened harm that must be shown, the period over which the harm must be likely to occur, and the degree of probability of harm required before the patient can be committed.<sup>23–24</sup> Although most statutes deal only with physical harm to self or others, the constitutional acceptability of other forms of harm (*e.g.*, psychological harm to one’s family) has not been determined. Nor has the scope of constitutionally permissible interventions on *parens patriae* (danger to self) grounds been defined; whether serious physical harm is required, as some early court decisions indicated, or whether mental suffering can be sufficient has not been definitively resolved. Finally, though minor harm to property may not warrant commitment, it is unclear if the threat of substantial property damage would be accepted by the courts as an adequate grounds for hospitalization.<sup>25</sup>

A major remaining issue is whether commitment must be the “least restrictive alternative” before it can be effectuated. The term derives from a principle of constitutional law that limits state intervention in protected areas to the smallest amount necessary to achieve the state’s interest. Many court decisions and statutes have applied this analysis to the commitment setting, requiring that the unavailability of other alternatives be demonstrated prior to authorization of commitment.<sup>26</sup> Although the United States Supreme Court has generally been hostile to least restrictive alternative argumentation in the mental health area, it has never ruled directly on the issue. A related question deals with whether the state is required to create less restrictive alternatives (*e.g.*, community residences) if none currently exist. In some jurisdictions, the courts have ruled that such affirmative action is constitutionally required, and in other

states consent decrees have been entered into in which the state agreed to undertake this burden voluntarily. Regardless of how the obligation has come into existence, it has proven difficult to enforce in the face of recalcitrant legislatures who are unwilling to appropriate the needed funds.<sup>27</sup>

Despite the ubiquity of statutes based on dangerousness, many questions concerning the shape of substantive standards for commitment remain unanswered. There is a continuing prospect of further litigation in this area, but the probable direction of future changes is not at all clear.

### CONTEMPORARY CRITIQUES OF COMMITMENT LAW

It should be evident that the status quo in commitment law represents only the most recent accommodation of interests that have been competing for the dominant position in mental health policy for well over a century. The latest swing of the pendulum has taken us in the direction of criminalization of procedures and narrowing of substantive standards, but a reaction to this change is already apparent. Although criticism is occasionally directed at the rigidity of criminal-style procedures, it is the substantive criteria for commitment that have borne the brunt of the assault. The dangerousness standard has been attacked on three grounds—(1) the current system makes it unreasonably difficult to obtain involuntary treatment for patients who are not overtly dangerous, but desperately in need of care; (2) dangerousness is not susceptible to reliable determination by clinicians, thus the new standards force them to perform a task for which they have no particular skills; and (3) basing commitment on dangerousness, particularly dangerousness to others, alters the character of the mental health system, changing its mission from providing treatment to the quasi-policing function of protecting the public from harm.

Numerous publications, many written by clinicians and accompanied by anecdotes from their practices, have argued that the restriction of civil commitment to those who are overtly dangerous leaves too many severely ill individuals suffering silently without care.<sup>28,29</sup> Anecdotal accounts of patients who have "died with their rights on," of course, are easily countered by other stories of patients who, under looser commitment criteria, have been needlessly confined for decades.<sup>30</sup> What is needed to resolve the dispute are comparative studies of the effects of need for treatment and dangerousness-based commitment systems; only then would we know whether a system that inclines in

favor of involuntary treatment, as a treatment-oriented system does, is liable to create a greater amount of needless suffering than one that errs in favor of liberty. Since such data do not now exist, this portion of the debate is stalemated.

Criticism of the ability of clinicians to predict dangerousness has a somewhat more substantial foundation. Since current statutes require clinicians to certify the likelihood that patients will harm themselves or others, their accuracy at the task would seem to be crucial to the system. Existing data suggest, however, that clinicians are not particularly good at identifying those persons who are likely to be dangerous in the future.<sup>31</sup> A small number of studies, most of which are based on experiments of nature (*e.g.*, court-ordered releases of patients who had previously been predicted to be dangerous), have demonstrated that clinicians are wrong four out of five times when they predict that someone is likely to exhibit long-term dangerousness: the best results, in a carefully conducted study (albeit with a highly atypical population of sex offenders), showed two out of three predictions of violence to be mistaken.<sup>32</sup> (Interestingly, similar studies of predictions of dangerousness to self have not been undertaken.) The apparent conclusion is that asking clinicians to predict dangerousness to others as a basis for commitment is no more valid, and may be less so, than asking them to base their decisions on the "vague" standard of a need for treatment.

Unfortunately, the matter is not that simple. Methodological problems were present in all the studies that attempted to assess predictions of dangerousness to others and to determine whether dangerous behavior materialized. Further, the extant studies have almost all dealt with predictions made after patients had been hospitalized or incarcerated for considerable periods of time, about behavior that might occur in the distant future. Because dangerousness at any point in time is likely to be dependent on a number of variables specific to the individual's situation at that time, (*e.g.*, social supports, sources of stress, mental state), it is not surprising that studies performed on patients who have been out of their native environment for some time, based on predictions as to what might happen if they returned to that environment in the future, showed consistently poor results. It is unclear, however, if the same limited predictive capacity applies to the clinician in an emergency room who is evaluating a patient's likelihood of dangerous behavior in the immediate future, given circumstances as they exist at the time.<sup>33</sup> Experimental analyses of the hypothesis that predictions of acute violence are more valid than those of long-



term violence would be desirable, but they are difficult to perform because predictions of dangerousness almost always lead to interventions designed to prevent its occurrence. The most obvious design for a controlled study, in which patients predicted to be dangerous are released and observed to see if dangerous behavior materializes, would have serious ethical and legal problems.

The argument as to clinicians' inability to predict dangerousness to others or to self, however, rests on more than just the studies mentioned above. Analyses using multivariate techniques have looked for clinical, historical, and demographic factors that might correlate with the patient's violence or suicidality.<sup>34,35</sup> No factors or combinations of factors have been found in these studies that would give any substantial guidance to clinicians. There is, in addition, an impressive statistical argument that suggests inherent limits on the accuracy of prediction in this area.<sup>36</sup> Because dangerous behavior is a relatively rare event, even fairly accurate tests are likely to lead to substantial overpredictions of dangerousness. The only solution to this problem is to identify populations with much higher than average base-rates of dangerousness. Although some starts have been made in this direction, a greater understanding of the causes of violence and suicidality is required before this task can be meaningfully accomplished.

Even if clinicians could predict dangerousness accurately, there would be those who would still object to their performing this function.<sup>37</sup> These commentators would argue that focusing on dangerousness, particularly dangerousness to others, distorts the therapist-patient relationship, as patients come to see clinicians performing functions ordinarily associated with the police. This may make patients more reluctant to share information, thereby impairing their treatment. In addition, the concentration of large numbers of patients who may be dangerous to others in psychiatric hospitals (especially public facilities), many of whom are not amenable to existing forms of treatment, alters the milieu, as security needs take precedence over treatment interests. Other patients are thus denied optimal therapeutic care, and dedicated staff members are driven from those facilities most in need of them. Many of these alleged effects are difficult to measure; relevant studies have, for the most part, not been performed, although data from certain states indicate that state hospitals are becoming repositories for high concentrations of dangerous patients.<sup>38</sup>

Taken together, these arguments amount to a potent, if not always empirically validated, critique

of the dangerousness standard. Yet, given existing concerns about civil liberties, and a large number of court decisions grounded in constitutional principles, a simple return to the *status quo ante* seems out of the question. The most elaborate effort to formulate a constitutionally acceptable alternative to a dangerousness-oriented system is embodied in the American Psychiatric Association's (APA) Model State Law on Civil Commitment of the Mentally Ill.<sup>39</sup> This statute, which is based on the work of Alan Stone and later of Loren Roth, incorporates many of the procedural reforms of the 1960s and 1970s, but allows a partial return to treatment-oriented commitment criteria.<sup>40,41</sup>

The APA Model Law is an ideological grandchild of the NIMH Draft Act of the early 1950s. Although it allows for commitment based on mental illness and dangerousness, it also permits commitment if the patient "will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own." All patients, including those committed for dangerousness, must, in addition, lack "capacity to make an informed decision concerning treatment;" treatment must be available at the facility to which the patient will be sent; and commitment must be "consistent with the least restrictive alternative principle."<sup>39</sup>

With these provisions, the APA has attempted to meet many of the objections to the previous generation of need for treatment statutes. The vagueness problem is addressed by attempting to define more carefully when treatment may be needed: this definition is based on the determination that severe mental illness has caused a deterioration of previous capacity for independent survival. An attempt is made to circumvent the overbreadth issue by limiting commitment to patients who are unable to make competent treatment decisions of their own, arguably the threshold requirement for legitimate state intervention.<sup>42</sup> It is not clear if these provisions would withstand constitutional scrutiny, given the current climate in the courts, but the Model Law represents a notable effort in that direction.

For those who object to the distorting effects of dangerous-to-others commitments on the mental health system, the APA's Model Law would provide partial relief. Only those dangerous patients who were suffering from severe mental disorders, who were incompetent to make treatment decisions, and for whom treatment was actually avail-

able would be subject to commitment. In effect, even dangerous persons would have to qualify for commitment on *parens patriae* grounds. In addition, patients hospitalized because of need for treatment would dilute the pool of dangerous individuals in mental hospitals.

The desire for reform reflected in the APA Model Law has motivated many other suggestions for relaxation in commitment criteria, particularly expansion of *parens patriae*-oriented criteria.<sup>43</sup> Some states have already moved in this direction. Texas has adopted the APA's language in creating a category of patients who can be committed if they are in distress and if deterioration is likely.<sup>44</sup> Washington state now also permits commitment on the grounds of a likely severe deterioration in a patient's condition, or because of the likelihood of serious harm to property.<sup>45</sup> Pennsylvania altered its statute to permit threats of harm, as well as overt acts (as long as there was "an act in furtherance of the threat"), to serve as grounds for commitment.<sup>46</sup> Among recent changes in the North Carolina statute was a broadening of the definition of danger to self to include an inability to exercise self-control, judgment, and discretion in daily responsibilities or social relations; grossly irrational or inappropriate behavior, or other signs of severely impaired insight and judgment create a presumption that patients are unable to care for themselves.<sup>47</sup>

Resistance to such changes can be expected from civil libertarians, but also from other groups. Although community-based approaches to psychiatry no longer constitute as powerful an ideology as they once did, many practitioners, especially non-psychiatrists, still look askance at any changes that would tempt clinicians to rely more heavily on hospital-based care. More importantly, there may be significant fiscal consequences of looser commitment criteria. The neglect of many severely mentally ill persons in the community has been cost-effective from the perspective of many states, especially since such individuals are often supported by federal disability and supplemental security income (SSI) payments. Reassumption of state responsibility for their welfare would increase state expenditures on mental health, an area in which state legislatures traditionally have been reluctant to appropriate funds. Recognizing this reluctance, which would have to be overcome before substantial changes in commitment criteria could be accomplished, some patient advocacy groups with a civil libertarian bent have assumed the anomalous position of arguing against new commitment statutes on the ostensible grounds that they would lead to increased expenditures for the mentally ill.

It should not be assumed that pressure to alter the current dangerousness-based commitment system is coming solely from those in favor of relaxed commitment criteria. Some commentators use the flaws of the current system to argue for abolition of all civil commitment.<sup>48</sup> As advanced by Morse, this argument is premised on the lack of legally justified differentiation between mentally ill and nonmentally ill persons, the tendency toward overprediction of dangerousness, the likelihood that adequate care will not be provided to committed patients, and the belief that hospitalization is not necessary for adequate treatment of the mentally ill. These points will be considered in turn.

First, the contention that there is no basis that would be acceptable to the law for distinguishing between mentally ill and normal persons is a powerful challenge to the prevailing dangerousness standard. Our legal system has traditionally frowned on preventive confinement—detention of a person because of the fear that he might later commit a crime—yet as currently constituted, this appears to be an important function of the commitment system. The suppositions that mentally ill persons are less able to control their behavior or more likely to be dangerous to others are difficult to sustain as a basis for singling them out for differential handling. Of course, this argument for abolition is considerably less potent when directed at a commitment standard based on need for treatment, or at criteria governing danger to self. A requirement, such as proposed in the APA Model Law, that patients be incompetent and treatable before they could be committed, may well provide a legally valid basis for distinction between the severely mentally ill and others.

Second, the tendency toward overprediction of dangerousness, because of the rarity of the phenomenon and the desire of mental health professionals to avoid false-negative determinations, is another problem that genuinely afflicts the dangerousness standard. There may be a similar tendency to overpredict need for treatment under treatment-oriented criteria, but this may be somewhat less troublesome if appropriate treatment is actually available.

Third, insofar as commitment is opposed on the grounds that state hospitals will never be able to provide adequate treatment to committed persons, recent statistics suggest a line of rebuttal. In 1980 and 1981, of approximately 1,150,000 civil admissions to all mental health facilities (excluding veterans' hospitals), about 300,000 were involuntary.<sup>49</sup> But of the involuntary group, only about 190,000 patients were committed to state and

country hospitals, while more than 110,000 were sent to private facilities or psychiatric units in general hospitals. Thus, one can no longer oppose civil commitment simply because of the deficiencies of state hospital systems. To a considerable degree, the locus of commitment has shifted elsewhere, almost undoubtedly to facilities better able to provide treatment.

The final basis for opposition to involuntary hospitalization is the belief that most patients can be treated successfully outside of hospital settings.<sup>48,50</sup> Numerous studies have demonstrated as good or better results on some measures for patients who are diverted to community-based or brief hospitalization programs as for those who undergo traditional hospitalization.<sup>50</sup> But the neglected point in this argument is that these experimental projects have taken place entirely with patients who are willing to accept care voluntarily. Although there might be a small number of patients who resist hospitalization but would cooperate with outpatient treatment, the majority of committed patients are hospitalized involuntarily because of their denial of the need for any care, or their demonstrated failure to cooperate with outpatient programs. Even the existence of ample community-based alternatives is unlikely to accommodate this population.

The argument for the abolition of involuntary hospitalization makes some telling points but also has significant flaws. The two most potent reasons why abolition is unlikely to occur, however, have not yet been considered. Whether based on realistic perceptions or not, the public fears the mentally ill and has always demanded a measure of protection from them exceeding that provided by the criminal justice system. The United States Supreme Court has recently acknowledged and echoed this desire.<sup>21</sup> At the same time, most people pity the mentally ill, recognize that many mentally ill persons are undergoing a substantial degree of suffering, and from purely humanitarian considerations, want to provide them with care. Thus, public attitudes, more than academic refutations, make it probable that some form of civil commitment will endure.

One additional factor—the right to refuse treatment—must be considered as a destabilizing force that lends weight to both the treatment-oriented and the abolitionist critiques of the current commitment system. The last decade has seen a dissociation between commitment and treatment in several jurisdictions that reflects the recently altered function of civil commitment. When commitment was explicitly for the purpose of treatment, the

question of whether involuntary patients might have the right to refuse treatment never arose. Commitment was assumed to be a sufficient legal predicate to the provision of usual forms of care. When the substantive criteria changed to focus on the patient's dangerousness, however, the question began to be asked whether the state's interest in the committed person extended beyond confinement, which presumably removed the danger presented by the patient, to actual treatment of the underlying condition. The latter was opposed for the same reason that commitment based on need for treatment was attacked—it was urged that the state's right to intervene in individual lives (at least in the lives of legally competent persons) was limited to situations in which danger existed.<sup>51</sup>

A number of state and federal courts have accepted this argument, creating a right to refuse treatment based on patients' constitutional rights to privacy and substantive due process.<sup>52</sup> As usually formulated, this right can only be overridden in emergencies, or when some outside reviewer determines that the patient should be treated. The courts have divided both on the identity of the reviewer (judge, guardian, or independent physician) and on the standard this reviewer should employ. Some courts have held that a determination of incompetency is necessary before treatment can proceed;<sup>53</sup> others have required only independent review of a genuine need for treatment.<sup>16</sup>

For our purposes here, however, the importance of a right to refuse treatment lies in the challenge it presents to the structure of the involuntary commitment system. A disjunction between criteria for commitment and criteria for treatment leaves a group of committed patients who cannot be treated and for whom the psychiatric hospital becomes literally a place of detention. Any widespread adoption of the right to refuse treatment will provoke further dissatisfaction among both sets of critics of the current commitment system. Those who believe that the dangerousness standard has already distorted the function of psychiatry will see the new developments as drawing psychiatric institutions (particularly state-operated facilities, which have high concentrations of committed patients) into the orbit of the criminal justice system. Some psychiatrists predict in that event a massive efflux of dissatisfied clinicians from public facilities.<sup>54</sup> On the other hand, advocates of the abolition of civil commitment will see their contention strengthened that the system is really just a thinly disguised form of preventive detention. The argument for abolition will thereby become more appealing.

The increasing acceptance of a right to refuse

treatment is one of the most dramatic expressions of public ambivalence about a coercive system of psychiatric care. Unwilling to give up the protections afforded by the possibility of involuntary confinement for noncriminal behavior, the public is at the same time uneasy about the intrusion on individual autonomy inherent in such a process. To allow continued confinement, but to limit involuntary treatment, may appear as a valid compromise of these concerns. In reality, however, it can only heighten the internal tensions of a system with therapeutic pretensions, but with goals related increasingly to the preservation of public safety. Thus, the right to refuse treatment may bring current concerns about the commitment system to a head and force widespread reconsideration of the objectives of civil commitment.

## Empiric Research on Civil Commitment

A large number of studies have been performed of the civil commitment process. Despite this body of data, however, our knowledge of the realities of civil commitment remains spotty, and many of the most crucial questions have not yet been addressed. Further, the literature is heavy with observational and other studies that raise serious methodologic issues, and an unfortunate number of authors appear to have entered the empiric arena with ideological presuppositions that they desired to confirm. Individual studies must therefore be examined carefully before reliance is placed on them for policy purposes.

The earliest empiric studies began in the late 1960s, apparently stimulated by the contemporary ferment in the civil commitment system. Observers in a number of jurisdictions found that the commitment process deviated markedly from the norms of due process familiar to criminal settings, and that even those substantive and procedural protections already in place were routinely ignored.<sup>55,56</sup> Representative of these studies was Wexler and Scoville's study of commitment in two counties in Arizona.<sup>56</sup> Using law students as observers and interviewers, they found that precommitment screening was ineffective, commitment petitions did not address statutory criteria, hearings were often based on conclusory testimony, and patients' attorneys adopted a nonadversarial posture. Of 763 commitment hearings observed, 96% to 98% ended with psychiatrists' recommendations being adopted.

When the student observers rated the dangerousness of 32 committed patients, they found that under a preponderance of the evidence standard seven patients should not have been committable, while under a beyond a reasonable doubt standard 15 patients should have been released. The authors used their data to argue for substantive and procedural tightening of the Arizona statute.

These early studies were both a result of and a stimulus to the reform in commitment laws that was gaining momentum at that time. As more states began to modify their statutes, researchers took advantage of the opportunities presented to explore the effects of the changes. The earliest and most comprehensive of the before-and-after studies assessed the effects of procedural changes in the California statute, including requirements for screening patients before *de novo* commitment hearings could be held, a reduction in the length of involuntary court commitments, and an increase in the length of time for which physicians could order patients committed.<sup>57</sup> The study revealed that most of the expected benefits of the new act did not accrue, but some unexpected side-effects were apparent. Patients tended to be diverted from the court-controlled to the physician-controlled components of the system, and both length of stay and readmission rates increased. Diagnostic patterns and demographic characteristics of committed patients, however, were unchanged. Further, many of the admissions did not appear to meet the dangerousness criteria of the statute.

In many ways, the results of the California study are typical of other investigations of the effects of statutory changes. Regardless of the particular reform involved, most studies (with some exceptions<sup>58</sup> have shown little long-term effect on commitment rates or on the nature of the committed population.<sup>59,60</sup> Evaluated with the caution required by their methodological deficiencies, these studies suggest that the commitment system is often resistant to externally imposed alterations. The reasons for this resistance are unclear, but they may relate to an intuitive feeling on the part of participants that certain persons require the treatment or protection afforded by psychiatric hospitalization. When substantive or procedural standards interfere with the commitment process for these persons, the law will be bent or ignored.<sup>61</sup>

A related question has concerned the effect of changes in commitment laws on the criminal justice system, since one way of accomplishing desired confinement in the face of tightened commitment statutes would be to shunt patients to jails and prisons. Frequent charges that this has hap-

pened are heard,<sup>62</sup> but the allegations have not yet been convincingly substantiated.<sup>62</sup> One California study that supported this contention estimated that 100 mentally ill people were processed by the Los Angeles police each day, presumably because of the unavailability of involuntary care in the mental health system, and that of these 15 were incarcerated.<sup>63</sup> Other studies have shown increases in referrals for evaluations of competency to stand trial (suggesting that mentally ill persons are arrested for minor crimes and then referred as an alternative means of obtaining hospitalization and treatment),<sup>62-64</sup> and increases in the number of mentally ill in jails or handled by the police.<sup>65,66</sup> These studies, however, either fail to link convincingly the changes observed with statutory innovations, or by examining only one segment of a large system (*e.g.*, commitments to a single state hospital) fail to rule out likely alternative explanations to the conclusions drawn.

Another area that has been the subject of substantial investigation is the role played by various participants in the civil commitment process. The functioning of psychiatrists has been examined in a number of ways. Questionnaire studies have suggested that many psychiatrists are ignorant of the statutory guidelines under which they operate.<sup>67</sup> Studies of actual commitment forms have consistently shown deficiencies in the way in which they are completed, particularly the omission of documentation of alleged dangerousness or other statutorily required criteria for commitment.<sup>68,69</sup> Of course, this does not necessarily imply that commitments are being accomplished in the absence of required circumstances;<sup>70</sup> it may simply be that in the heat of committing a patient the full completion of forms has a relatively low priority. It is interesting that in one jurisdiction in which criminal justice personnel can complete commitment forms, those forms too were found to suffer from the same deficiencies.<sup>71</sup>

More direct means have also been used to assess the basis for psychiatric decision making in commitment. A survey of Washington, DC and Connecticut psychiatrists revealed good agreement about hospitalization decisions (based on rather sketchy vignettes) when patients were both psychotic and suicidal, but a high level of divergence if only one of those factors were present.<sup>72</sup> Another survey comparing the opinions of judges and psychiatrists showed that both were willing to see patients committed on the basis of a low probability of subsequent dangerous acts, but that psychiatrists demanded a higher probability than judges and were also more strict about their definition of a

dangerous act.<sup>73</sup> Two naturalistic studies in different jurisdictions of psychiatrists' decision making about whether to commit voluntary patients who had requested discharge have shown a heavy reliance on statutory dangerousness criteria.<sup>74,75</sup> In sum, despite a large number of studies, the nature of psychiatric decision making in civil commitment is largely undefined. Suggestive data that psychiatrists do not adhere to dangerousness criteria, even when required to do so by statute, have been disputed by more recent studies showing a fairly good conformance to legal requirements.

The behavior of attorneys in the commitment process has also been examined. With one exception,<sup>76</sup> studies have shown that most attorneys tend to think in terms of their clients' best interests rather than automatically advocating their clients' expressed desires to avoid commitment.<sup>77</sup> Thus, they often retain a need for treatment orientation and avoid adversary confrontation with mental health professionals. Several of these studies have been critical of attorneys' preparation for commitment hearings and the technical adequacy of their performance. These findings suggest that even defense attorneys share the perception that some individuals ought to be hospitalized, and they collaborate in that process. Of particular interest is a study in which an attempt was made to train Texas attorneys to take a more aggressive, adversarial stance at commitment hearings.<sup>78</sup> Despite the training, these attorneys did not adopt an adversarial posture; they attributed their failure to do so to their belief that their clients would benefit from commitment.

Observation of court hearings has been a favorite strategy for researchers who are attempting to divine the role of the judge in civil commitment. Most of the older studies (before the mid 1970s), found that commitment hearings were extraordinarily brief (down to 1.6 minutes each), judges and attorneys were improperly deferential to psychiatric testimony, patients were rarely adequately defended or given an opportunity to defend themselves, and legal criteria for commitment were ignored by psychiatrists and judges alike.<sup>37</sup> More recent studies, however, particularly the extensive work of Hiday, who has observed over 1000 commitment hearings, have been less critical of the courts.<sup>79,80</sup> Judges in these studies did not seem unduly deferential to psychiatric opinions, and commitment decisions were generally correlated with more significant degrees of physical danger to the patient or to others. The two most likely explanations for the differences between these two sets of studies are that with time the courts may be

moving more into line with the mandates of the new statutes, and that Hiday seems to have been more careful in drawing conclusions from her observations than earlier authors.

The final area of investigation has concerned the characteristics of committed patients. Uncontrolled studies have found committed patients to be at the extremes of age, male, unmarried, black, and schizophrenic.<sup>81</sup> Studies using comparison groups of voluntary patients revealed that involuntary patients were more likely to be schizophrenic, nondepressed, belligerent, and uncooperative with inpatient and outpatient care;<sup>82</sup> and less likely to be married, have children, friends, or a job.<sup>83</sup> One study found that 10% of 189 patients for whom a commitment petition had been filed died during a 19-month follow-up period.<sup>84</sup> The authors concluded that these patients, whether or not they were committed, represented a severely ill group at high risk for future harm.

The controlled studies mentioned above found patients mostly appreciative, in retrospect, of the care they received. Two controlled studies found involuntary compared to voluntary patients no less satisfied with the outcome of hospitalization,<sup>85</sup> and likely to function as well after discharge despite being sicker on admission.<sup>86</sup> These data, combined with decades of clinical experience, suggest that involuntary commitment is likely to produce at least short-term gains in patient functioning, and that after the fact most patients will be appreciative of the intervention. Long-term effects of commitment (*e.g.*, on readmission rates and functioning in the community after discharge) remain to be explored.

Two major questions are unaddressed by this vast body of empiric literature. There has been no methodologically adequate comparison of the effects of a commitment statute based on dangerousness criteria with a need for treatment standard. The enormous opportunities for before-and-after comparisons created by the mass redrafting of commitment laws in the last 15 years, for the most part, has been wasted. We are therefore left with legal, philosophical, and anecdotal arguments on which to base our discussions of the advantages and disadvantages of the two most common models of commitment law, but little useful empiric data. It can only be hoped that the apparent trend toward relaxation of commitment criteria in some areas will be accompanied by careful outcome studies as new statutes are implemented. Cross-jurisdictional studies, although methodologically complex, represent another means of comparing the effects of different approaches to civil commitment.

The second deficiency in the existing literature has been the failure to address the effects of various commitment standards on the outcome of the mentally ill. For reasons of convenience, most studies in this area have looked at the process of commitment, rather than the outcome, or have examined outcome in terms of easily obtainable statistical data (*e.g.*, changes in rates of commitment by age, sex, and diagnosis). This information in no way addresses the bottom line of the commitment conundrum—whether the mentally ill do better or worse (in the manifold senses in which those terms can be employed) with one or another set of substantive and procedural standards. Researchers must be torn away from aggregate data, and set to the more difficult task of evaluating individual functioning, if this most important issue is ever to be meaningfully addressed.

## Clinical Aspects of Civil Commitment

Three issues would appear to be of paramount importance to the clinician who must participate in the civil commitment process—defining an approach to assessing patients' suitability for commitment, dealing with involuntary hospitalization as a threat to the therapist-patient relationship, and resolving conflicts between legal mandates and ethical imperatives in the commitment setting.

The difficulties in assessing patients' committability derive from the nearly universal requirement that patients be predicted to be dangerous to others or to themselves before commitment can occur. As discussed earlier, empiric studies and theoretic analyses suggest severe limitations on the accuracy of clinicians' predictions of dangerousness. How can the clinician meaningfully make such predictions when so much evidence points to the difficulty of the task?

Monahan's recent monograph on predicting violent behavior provides an initial answer as far as dangerousness to others is concerned.<sup>30</sup> After analyzing the empiric literature, Monahan notes that the first step in increasing the accuracy of predictions of rare events such as violence lies in identifying populations with higher than ordinary base rates of the behavior. Empirically verified predictors of future violent acts that would identify such populations include a history of previous violence (by far the most valid measure of the propensity for future dangerousness), age in late teens and early

twenties, male gender, black race, lower social class, history of opiate or alcohol abuse, low IQ, and residential and employment instability. The assessment, of course, cannot stop at this point. Although these factors increase the likelihood that an individual will act violently, further individualization of the prediction is necessary.

Because violence is so often situationally determined, the environment to which the patient will return must be considered, along with aspects of the patient's mental functioning. Gutheil and Appelbaum suggest conceptualizing these issues in terms of the patient's "risk factors" and "resource factors," and subdividing each of these into external and internal categories.<sup>87</sup> External risk factors include loss of significant objects (*e.g.*, spouse or therapist) or supports (*e.g.*, school or job). The more acute the losses, the greater the risk they represent. Internal risk factors include any conditions that would decrease behavioral controls and induce impulsive behavior, such as psychosis, current alcohol or drug use, organic or toxic states, low IQ, and intolerable dysphoria. Conversely, external resource factors include the availability of family, friends, therapist, or protective settings (*e.g.*, halfway house); means of restoring losses (*e.g.*, a boss who is willing to restore patient's job); and the availability of specialized resources (*e.g.*, social agencies, homemaker services) to address long-term problems. Internal resources include obsessional defenses, higher intelligence, good object relations and social skills, flexibility in responding to crises, and durable religious or ethical convictions. Empiric verification for many of these items is lacking, but they reflect years of clinical observations distilled through a massive literature on violence.

Having evaluated the presence or absence of these factors, the clinician must then embark on the most difficult portion of the assessment. Risks and resources must be balanced, with base rates taken into account, to arrive at an overall assessment of the likelihood of violence. At present, this balancing process is more art than science, and is likely to result in incorrect assessments on many occasions. Nonetheless, the law requires only that the effort be made, not that perfection be achieved in the undertaking. If patients who need help are to receive it in the current system, if liability is to be avoided for the negligent discharge of violent patients, and if progress is ultimately to be made in refining techniques of prediction, clinicians must engage in the prediction process to the best of their current abilities.

The evaluation of patients' suicidality should

proceed along similar lines. Numerous studies have shown that base rates of suicide are higher in persons with previous suicide attempts, depression, mania, schizophrenia, and those who live alone.<sup>88</sup> Risk and resource factors are much the same as outlined above for violent behavior, with particular emphasis given to the increase in risk caused by significant recent losses. When previous suicide attempts have occurred, their seriousness as future risk factors can be estimated using the risk/rescue rating system suggested by Weisman and Worden.<sup>89</sup> This approach calls for the categorization of attempts by the risk of death inherent in the method employed (*e.g.*, wrist slashing and pill ingestion being less lethal than hanging or drowning) and the likelihood of rescue (*e.g.*, pills taken 10 minutes before husband's anticipated return from work being less lethal than an overdose taken in a motel room). The patient's subjective intent should also be taken into account. Formulation of a definite plan by the patient and the availability of the means chosen must also be considered as risk factors. Again, a balancing process must ensue, drawing on the clinical judgment of the evaluator, but suffused by an awareness of data on base rates.

A final area of prediction called for in almost all current statutes involves the ability of patients to meet their basic needs in the absence of hospitalization (*i.e.*, the presence of grave disability). Much less attention has been paid in the literature to this area than to prediction of more overt forms of dangerousness. It might be thought that psychiatrists should be better able to predict inability to care for oneself than violence or suicide because of a more direct correlation with the patient's clinical state. For severe forms of psychopathology (*e.g.*, advanced senile dementia or acute psychosis), that is undoubtedly the case. In more chronic forms of illness, however, the clinician must be aware of a dissociation between psychopathology and level of functioning. Many chronic schizophrenics, for example, meet their needs quite well outside the hospital, despite continuing delusions and thought disorder. The assessment of functional ability, therefore, should be addressed directly to the tasks that are essential for personal survival—can the patient obtain food, manage finances, maintain adequate clothing and shelter, and care for health needs? The best means of estimating these capacities are to obtain a detailed history of how the patient has been managing these functions in the recent past, or actually to observe the patient performing these functions.<sup>90</sup>

As with the other assessments discussed so far, the evaluation of ability to care for oneself requires



a consideration of environmental circumstances. The collapse of supportive services can have an obvious and immediate effect on the ability of a patient to function outside the hospital. Conversely, the ingenuity of the clinician in assembling a package of supports can obviate the need for the patient's commitment.

The second major clinical issue raised by civil commitment is the seemingly paradoxical need to maintain a therapeutic alliance with a patient who is being coerced to receive care. Previously cited data on the posthospitalization responses of committed patients provide a clue as to how this may be accomplished. Studies have consistently found that civilly committed patients evaluate their hospitalization experience positively in retrospect.<sup>85</sup> This suggests that even at the time of admission and early in the hospitalization there may be some gain in appealing to that part of the patient's ambivalence that acknowledges illness and recognizes the need for care. As the patient improves and insight is recovered, the clinician can then build on this foundation to develop a collaborative basis for further work.

There are several corollaries to this approach. In the process of evaluating patients for commitment, and after commitment has been decided on, the patient should be involved in the decision-making process. This means that the evaluator's impressions and the basis for the hospitalization decision should be shared with the patient. Questions should be solicited and responded to, much as if the patient were confronting a voluntary admission decision. Although by definition the decision is being taken out of the patient's hands, making the patient privy to the rationale for commitment builds an alliance with that part of the ego that retains the capacity to assess realistically his or her functioning. As treatment restores the dominance of this healthier aspect of the ego, patient and clinician can retrospectively consider the experience of being committed and the emotions it evoked. Even if the committing clinician does not follow up the patient after admission, adopting this approach eases the task of the therapist who will be working with the patient.

Suggestions have been made for divorcing the patient's therapist from both the initial commitment decision and the decision to release, which is usually in medical hands.<sup>91</sup> It is argued that for the therapist to retain decision-making power creates a situation of dual allegiance—in deciding when admission or discharge are appropriate, the therapist must consider the needs of society as well as the desires and interests of the patient. This raises both

ethical problems, as the psychiatrist's empathic approach is used to obtain information that may lead to the patient's recommitment, and practical issues because patients may come to distrust and withhold data from a psychiatrist who is perceived as an adversary.

Some institutions, in part because of these issues, have split the roles of therapist and administrator (*i.e.*, the person responsible for commitment decisions) between two different staff members. There may be some clinical advantages, however, to lodging both responsibilities in the same person. The therapist is then compelled to confront the patient with reality-based assessments of his functioning and the need for external controls. While this may lead to a stormy early relationship, the patient may later come to perceive the therapist as an honest and caring individual who can be relied on to provide controls when the patient is unable to exercise them. An important foundation for the therapeutic relationship can thereby be created, particularly with more severely and chronically ill patients.

The final clinical issue that must be addressed is the resolution of perceived conflicts between the legal and ethical demands on the therapist. Current statutory approaches to civil commitment require the clinician to assert with a high degree of confidence that narrowly specified kinds of future harm are likely to accrue. The spirit of these statutes, made explicit in the court decisions that often stimulated their enactment, is to restrict commitment tightly, encouraging error in the direction of liberty rather than confinement. This approach, however, may conflict with clinicians' views of their ethical responsibilities to protect their patients from harm and, whenever possible, to ameliorate suffering.

The extreme cases are the easiest to resolve. When patients may benefit from hospitalization, but the commitment criteria clearly have not been met, it is difficult to argue that psychiatrists should detain and attempt to commit them. Psychiatrists' responsibilities to relieve distress are surely tempered by the requirement that they, like all other citizens, operate within the framework of the law. The remedy for defective laws lies in statutory change, not covert efforts to subvert them.

Borderline cases, however, are more troubling. If the clinician has reason to believe the patient may be dangerous, but remains uncertain about the conclusion—a frequent occurrence given the difficulties with prediction discussed above—and there would be clear benefit to the patient from hospitalization, a stronger argument can be made for encouraging the clinician to err on the side of



commitment. Though some may disagree, it seems preferable for psychiatrists to rely in doubtful situations on their instincts as to which course is truly in their patients' interests, allowing the courts, which must ultimately review commitment decisions, to temper clinical biases with a more skeptical legal eye. This may mean having a lower threshold for petitioning for commitment in emergency situations, and petitioning in some nonemergent situations even when some doubt exists as to the presence of required criteria.

## Conclusion

Involuntary civil commitment has, for a century-and-a-half, ensured some measure of care and treatment for, and protection from, those mentally ill persons who cannot or will not seek care for themselves. Legal regulation of the commitment process alternatively has encouraged and restricted commitment, depending on the balance struck in contemporary society between impulses to help the unfortunate and fears of infringements of liberty. The current period is one in which concerns for liberty have predominated, but the inevitable reaction has begun as therapeutic interests have again evoked concern. Psychiatrists, however, are still confronted with the difficult—some would say impossible—task of working with a dangerousness-oriented commitment system. This task can be made less onerous by efforts to employ existing knowledge about prediction, to recognize the clinical implications of the commitment process, and to use interactions with committed patients to the greatest therapeutic advantage.

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# Promoting Justice in Child and Family Services

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## Outline of Presentation

Thursday, 9:00 - 10:05 am, November 8, 1990

### **I. Dilemmas in Child and Family Policy**

- A. Despite the practical, symbolic, and constitutional significance of child and family policy, policy goals rarely have been carefully articulated and analyzed
- B. Essentially the same children and families are served by agencies having essentially congruent missions, with the result that policy reform in a single system tends merely to move the locus of intervention, not to transform the nature of the intervention
- C. De facto policy promotes intrusions on family privacy, restrictions on minors' liberty and privacy, and provision of ineffective, unduly costly services
- D. Problems of moral and social philosophy have been treated as matters of science answerable by expert opinions
- E. On matters that are potentially informed by empirical, social-science evidence, such evidence often has been unavailable, or when available, not considered
- F. Change in family life and the social context of youth development has occurred more rapidly than has change in the service system

### **II. The Place of the Juvenile and Family Court in "Doing Justice"**

- A. The invalidity of historic assumptions underlying the juvenile and family court
- B. The need for a separate juvenile court: Presuming a *Gault* model and acknowledging empirical evidence, due process is different for juveniles
- C. The potential roles of mental health professionals in a new juvenile "super-court"
- D. The potential roles of mental health professionals in family law matters pertaining to children and in related criminal matters in cases of child maltreatment

**III. The Place of the Juvenile and Family Court in Child and Family Services**

- A. The primacy of promotion of justice
- B. The unsuitability of the court for delivery of services
  - 1. The inapplicability of individual models of pathology
  - 2. The Jericho Principle
- C. The role of the court in the development and regulation of services

**IV. What Mental Health Professionals Can and Cannot Contribute to the Resolution of Juvenile and Family Cases in the Present System**

- A. Juvenile issues
- B. Family issues

**V. Conclusions: In A Context Of Generally Shared Values, What Are The Concrete Tasks To Be Accomplished If The Mental Health And Justice Systems Are To Enhance Children's And Parents' Sense That They Are being Treated Fairly?**

## Law and Random Events: The State of Child Mental Health Policy

Gary B. Melton\*

In popular parlance, lawfulness and randomness are polar opposites. Indeed, in some jurisprudential theories (see, e.g., Pospisil, 1971), predictability is the *sine qua non* of law. Without reliability of application, law cannot be expected, as a practical matter, to guide the behavior of the citizenry (cf. Melton & Saks, 1985) or, as an ethical matter, to ensure justice in the conduct of affairs of state (cf. Rawls, 1971).

Assertion of such a principle is likely to engender little controversy. Predictability is, after all, the foundation of the doctrine of *stare decisis* that serves as the major principle of legal decision making in common-law jurisdictions, and it is embedded in the fundamental legal constructs of due process and equal protection. With predictability's status as an elemental feature of law, one might expect particular care to ensure reliable application of state authority in those areas of law that govern the relationships and institutions that are most basic in society. Indeed, without such care the integrity of the legal system itself is questionable.

### The Need for Care in Child and Family Policy

A reasonable corollary to such a theorem would be that randomness of policy and its application would be especially abhorrent in matters involving children and families. Judges have written eloquently about the significance of child development and family life and the consequent need for the state zealously to protect the welfare of children and the integrity of the family. No other area of law is as fundamental in the nature of the relationships that it seeks to regulate. Indeed, the notion of privacy in American law is founded in the sanctity of the home.<sup>1</sup> The family stands as a zone of privacy protecting the autonomy of individuals and the diverse and free expression of ideas (see, e.g., *Meyer v. Nebraska*, 1923). Care in development of policies involving children and families thus is critical, because the relationships that are regulated within family law are those that are most basic to our personal lives and, therefore, that we

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<sup>1</sup>The Supreme Court's decision in *Roe v. Wade* (1973, pp. 152-153) contained a litany of cases related to the family as foundation for recognition of a right to privacy in abortion decisions.

most want to protect against government intrusion (cf. Tremper & Kelly, this issue).<sup>2</sup>

Questions about children and families have profound meaning for the state as well as individuals. No institution is more basic than the family in providing for the survival of the core values of the society. Recognizing the significance of the family in that respect, American constitutional law adheres to a cardinal principle "that the custody, care, and nurturance of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder" (*Prince v. Massachusetts*, 1944, p. 186).<sup>3</sup>

Preservation of the society is a basic consideration in aspects of child and family policy other than those that bear directly on support for families. The host of ways in which the state regulates children's lives in extraordinary fashion (e.g., compulsory school attendance) is derived from the belief that a "democratic society rests, for its continuance, upon the healthy well-rounded growth of young people into full maturity as citizens, with all that implies" (*Prince v. Massachusetts*, 1944, p. 168). Through the provision of substantive entitlements (e.g., education, health care, child protective services), the state guards the well-being of its future voters and workers.

The significance of the state's role in children's lives does not end, though, with the vigor of its exercise of its power and duty as *parens patriae*. Beyond the substance of the state's activity, the model that it provides in dealing with children and youth may have substantial long-term consequences in citizens' understanding of and support for democratic values and their perception of themselves as participants in legal and political decision making (Melton & Saks, 1985; Tapp & Levine, 1974; Tapp & Melton, 1983).

In decrying his Brethren's refusal to hear a case involving dragnet searches of schoolchildren (including strip searches of some), Justice Brennan forcefully described the symbolic importance of the state's interaction with children and youth:

We do not know what class petitioner was attending when the police and dogs burst in, but the lesson the school authorities taught her that day will undoubtedly make a greater impression than the one her teachers had hoped to convey. I would grant certiorari to teach petitioner another lesson; that the Fourth Amendment protects "the right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures," and that before police and local officers are permitted to conduct dog-assisted dragnet inspections of public school students, they must obtain a warrant based on sufficient particularized evidence to establish probable cause to believe a crime has been or is being committed. Schools cannot expect their students to learn the lessons of good citizenship when the school authorities themselves disregard the fundamental

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<sup>2</sup>In view of the deep significance of family relationships in our lives, it should come as no surprise that the most emotion-laden controversies in legal policy (e.g., abortion, Baby Doe cases, standards for resolution of custody disputes) are matters pertaining to the family.

<sup>3</sup>In Asian legal systems based at least in part on Confucian precepts, the protection of the family assumes an even greater significance than it does in Western law (see, e.g., Moser, 1982).

principles underpinning our constitutional freedoms. (*Doe v. Renfrow*, 1981, pp. 1026-1027)

In view, then, of the critical significance of child development and family life for the very survival of the society and its ideals, one might expect particular care in making and implementing child and family policy. Such policy is apt to affect the integrity of personal relationships, the availability of resources to assist in children's development into productive citizens, and the attitudes and beliefs that children acquire about the law itself. Within the broader context of child and family policy, mental health policy may be especially important.<sup>4</sup> However, as we shall see, children's law has been remarkable for its lack of lawfulness, and child mental health policy is no exception to this general lack of planfulness and reliability.

### Randomness in Children's Law

#### *Indeterminacy*

At an individual level, the greatest impediment to reliable decision making in juvenile and family cases is the vagueness of dispositional standards. In an important article, Mnookin (1975) pointed out the pervasive indeterminacy of legal standards to resolve disputes regarding children and families. The dispositional questions are variable: custody arrangements following divorce or a finding of maltreatment; conditions of probation or confinement (for an indeterminate period) after a finding of delinquency or status offenses. In each instance, though, the standard for resolving the case in most jurisdictions is the best interests of the child, a standard that leaves virtually unbridled discretion in the hands of the trial judge. In child protection and status offense cases, the situation is aggravated by the fact that the standards for assumption of jurisdiction by the juvenile court commonly are vague themselves.

As the Supreme Court has recognized, standards in family law often are so vague as to be no standards at all, "Permanent neglect proceedings employ imprecise substantive standards that leave determinations unusually open to the subjective values of the judge" (*Santosky v. Kramer*, 1982, p. 762). As might be expected in such a circumstance, notorious unreliability persists in the assessment of the circumstances under which invocation of juvenile court jurisdiction is warranted (see, e.g., Atteberry-Bennett & Reppucci, 1986; Giovannoni & Becerra, 1979).

The general indeterminacy in juvenile and family law applies specifically to child mental health issues in several ways. First, when a child is brought into the juvenile court, the probability is high that his or her "best interests" will be said to demand some form of mental health treatment.<sup>5</sup> Second, despite the lack of

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<sup>4</sup>As Tremper and Kelly discuss elsewhere in this issue, the mental health consequences of policies about minors' self-determination in other contexts may be substantial. Moreover, because child mental health problems tend to persist into adulthood (see, e.g., Gould, Wunsch-Hitzig, & Dohrenwend, 1980; Robins, 1966; Rutter & Sandberg, 1985), the efficacy of mental health policy may have particularly significant downstream effects.

<sup>5</sup>As I note later in this Article, the treatment may be delivered outside the mental health system. However, this distinction is meaningful only in a bureaucratic sense.



scientific foundation for such opinions (see Aber & Reppucci, this issue; Melton, 1984; Melton, Petrila, Poythress, & Slobogin, 1987), the determination of best interests is apt to be based at least in part on clinicians' recommendations. Third, in terms of legally sanctioned admission of juveniles into the mental health system per se, the decision is apt to be based on a largely unreviewed assessment of need for treatment at a particular level of restrictiveness (see *Parham v. J. R.*, 1979).

In that regard, mental health constructs are likely to offer little improvement over the intuitive determination of best interests, vague and value-laden though the latter term may be. Even gross assessment by potential referring agents of whether a child has significant mental health problems is extremely unreliable (see, for review, Melton, 1987c). Even if agreement could be reached, the literature is sparse about effective treatments and the characteristics of children most likely to benefit from them. Moreover, to the extent that efficacy is demonstrated in treatment of conduct disordered youth, the services that are most likely to work typically are unavailable.<sup>6</sup> Therefore, even assuming reliability of diagnosis, there is apt to be little basis for determining the match between individual juveniles and available services.

### *Lack of Planfulness*

*Values in Conflict.* The problem is not simply one of limited technology of assessment and treatment. Indeed, this issue arises only after a determination of the standard to be used in deciding whether coercive intervention is justified. In both individual cases and determinations of policy, the law generally has been less than forthright in statement of the values that should be honored in matters pertaining to children and families.

Mnookin (1975) has framed the problem in stark but realistic terms:

Deciding what is best for a child poses a question no less ultimate than the purposes and values of life itself. Should the judge be primarily concerned with the child's happiness? Or with the child's spiritual and religious training? Should the judge be concerned with the economic "productivity" of the child when he grows up? Are the primary values of life in warm interpersonal relationships, or in discipline and self-sacrifice? Is stability and security for a child more desirable than intellectual stimulation? These questions could be elaborated endlessly. And yet, where is the judge to look for the set of values that should inform the choice of what is best for the child? Normally, the custody statutes do not themselves give content or relative weights to the pertinent values. And if the judge looks to

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<sup>6</sup>A comprehensive review of outcome research (Melton, 1987b; see also Melton & Spaulding, in press) showed that no study has demonstrated hospitalization or residential treatment to be more effective than less restrictive alternatives for mentally disordered children and youth. Moreover, traditional office-based psychotherapy appears to have limited usefulness for the behavior disordered youth who are most likely to be involved with the juvenile court and other youth service systems. On the other hand, "alternative" treatments (e.g., intensive home-based services; clinical advocacy; day treatment) have shown promising results, but such programs are least likely to be available.

society at large, he finds neither a clear consensus as to the best child rearing strategies nor an appropriate hierarchy of ultimate values. (pp. 260-261)

In general, child and family issues present a clash of values and interests. At a minimum, legislatures and judges must decide how to allocate decision-making responsibility among child, parents, and state. Unfortunately, however, the case law is filled with examples of opinions that left unclear whose interests were vindicated or even what interests were at stake (see, e.g., *Pierce v. Society of Sisters*, 1925; *Meyer v. Nebraska*, 1923; *Tinker v. Des Moines Independent School District*, 1969). Along the way, the Supreme Court frequently has rendered incongruous holdings based on inconsistent assumptions about the nature of childhood and family life (for a list of several especially blatant contradictions, see Melton, 1984, p. 454, note 34).

There are several possible explanations for the lack of forthright decision making. First, the nature of the interests at stake often is unclear in children's cases. In particular, both the state and the parents are apt to argue that the child's interests are coextensive with their own, and the child—or various purported agents of the child—may claim an independence of interests. In such a context, the court may not recognize the complexity of the interests before it. The child advocacy movement itself often overlooks the fact that its adherents have markedly divergent perspectives on the nature of childhood, children's rights, and family privacy (Melton, 1983).

Second, courts (and other decision makers) may avoid the hard choices that are inherent in clashes among the autonomy of youth, the privacy of families, and the welfare of youth.<sup>7</sup> Rather than reach a determination that has a clear winner, courts may tend to find a compromise that minimizes the need to make choices among legitimate interests, particularly when the conflicts are emotion-laden and involve moral dilemmas (see Melton, 1986; Mnookin, 1985).

Third, courts often seem to overlook the realities of the children's cases before them in order to reach symbolic decisions about the ordering of child, family, and state (see generally Melton, 1987a). As I will discuss in more detail later, the actual social facts may be obscured by mythical discussions of the family and other institutions that may be involved in a particular issue.

**Trends in Conflict.** Regardless of the actual reason(s) for failure to analyze the choices involved in child and family policy, it is clear that response to the various issues is largely unthoughtful and unplanned. Indeed, one of the most curious aspects of child mental health policy is that several apparently mutually exclusive trends have arisen more or less independently. Followed to their logical conclusions, these trends appear to be on a collision course with each other, but commentators and advocates rarely juxtapose them.

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<sup>7</sup>Of course, actual policy questions present still more complex problems. As suggested in the quote from Mnookin, a decision to give primary weight to the state's interest in the healthy socialization of youth still leaves the difficult questions about the aspects of human life that are most important to promote and, regardless of the ranking of values, whether short-term or long-term effects are more important. As already noted, the matter is complicated still further by the fact that the state of knowledge is such that underlying empirical assumptions may have to go untested (Melton, 1984).

First, with the recognition of minors' personhood by the Supreme Court in the late 1960s, greater deference is being paid to minors' self-determination and privacy than ever before. This movement is particularly acute in regard to access to treatment, given evidence for adolescents' competence to make such decisions and the benefits to be derived from respect for autonomy and privacy (see Tremper & Kelly, this issue).

Second, *family* has become a political buzzword, and public figures on both the left and the right are competing to see who can be the most "pro-family." With the solidification of the doctrine of the right to privacy, parental rights have been given new meaning. In that regard, legislatures have acted to increase the procedural safeguards preventing undue state intervention in family life and to erect barriers to public schools' intrusion into matters that at least some people believe to be reserved to the family (see, e.g., American Bar Association/Institute of Judicial Administration, 1981; Hatch Amendment, 1978/1982).

Third, the new paternalism has resulted in the definition of a wide variety of disparate behavior—for example, violence, overeating, drinking, dangerous driving—as public health problems (see Bonnie, 1985, for review). Within such a rubric, self-injurious and risky behavior is perceived as warranting state intervention because of the ultimate social and economic costs of such behavior. Given adolescents' tendencies to engage in risky behavior to a disproportionate degree, they are often expected to bear the brunt of new paternalist efforts.

Fourth, with the rise of conservative governments in several major Western democracies, a tendency has arisen to "get tough" on wayward children and families (cf. Gardner, this issue; Parton, 1985). At the same time that a general philosophy of nonintervention is espoused, the state moves toward more severe intrusions when it does decide to intervene in families "deserving" such action. In part as a result, rates of institutionalization have continued to rise in the United States (see, for review, Melton & Spaulding, in press; see also Jackson-Beeck, Schwartz, & Rutherford, this issue), Canada (Corrado & Bala, in press), and the United Kingdom (Rutherford, in press).

To summarize, we currently are confronted with unprecedented child self-determination, family privacy, state intervention to protect children (especially in regard to their health), and state intervention to disrupt families and constrain child autonomy! Each of the major schools of thought about children's rights seem to have identified issues in which it can pursue its agenda with little controversy. On the other hand, the ultimate incompatibility of such perspectives cannot be avoided. If, for example, a school district relies on the new paternalism to provide the ideological foundation for establishment of school health clinics, it eventually will be confronted with the question of who may give (and refuse) consent to the clinics' services. It also eventually will have to decide whether to seek state authority to coerce receipt of services, to require parental involvement, or to enforce confidentiality against parents.

As the example illustrates, a lack of planfulness ultimately may create crises in administration of services. Nonetheless, as indicated by the conflicting trends, little effort has been made in most contexts to reconcile the diverse social movements on behalf of children and youth. For better or worse, overarching policies are essentially nonexistent. Even particular programs are apt not

to have considered the ways in which their services clash with coexistent programs and policies.

*Diffusion of Boundaries.* The lack of planning reflects not only the conflicts of values and social trends; it also results from the overdifferentiation of children's services. For various historical reasons (see Levine, Ewing, & Hager, this issue), child mental health, social service, juvenile justice, and special education programs have grown up separately but with a common mission of treatment for wayward youth. With professionalization, bureaucratization, and corporatization of therapeutic services (see, e.g., Jackson-Beeck, Schwartz, & Rutherford, this issue), whatever differences may once have existed among the agencies providing services to youth and their families have largely disappeared. The various systems provide essentially the same services to essentially the same clients (principally, conduct disordered male adolescents from troubled families), often in the same programs (see, for a review, Melton & Spaulding, in press). To a large extent, as Lerman (1980) has pointed out, we are left with a single "youth-in-trouble institutional system."

Lerman's insight is important because it suggests a hypothesis that experience has confirmed: If increased regulation renders the doors to an agency more difficult to open, youth simply will be shuttled through another door to the institution. For example, tightening of status offense jurisdiction resulted in increased rates of placement in mental health and social service programs (see, e.g., Costello & Worthington, 1981; Hinckley & Ellis, 1985; Krisberg, Schwartz, Litsky, & Austin, 1986; Van Dusen, 1981; Warren, 1981).

Noting this problem and the underlying, unstated assumption that youth must be in custody somewhere, Melton and Spaulding (in press) have argued that the debate over allocation of responsibility for admissions to mental hospitals is largely symbolic. The more important policy question—and the question that is largely ignored—is how to ensure that youth in *all* of the treatment systems are guaranteed service in the least restrictive alternative possible. Pursuit of such a policy goal would serve to protect the privacy of *both* children and families.

*Assumptions as Axioms.* As implied above, when attention has been given to the conflicts of values that arise in child and family policy, such analyses have neglected the actual social realities. Unfortunately, the debates have been less on the basis of abstract principles than fictional realities. Thus, rather than forthright emphasis on family integrity and parental autonomy, the Supreme Court has tended ostensibly to recognize the independent rights of children but then to ascribe such incompetency and vulnerability to them as to justify (falsely) their dependent status (see generally Melton, 1987a). Such mythological discussions often are so lengthy as to obscure the actual holdings.

Equally important, such statements of social fact (more precisely, of legal fiction) tend to take on a life of their own. Even when they know the social reality to be variant from the vision of the Supreme Court, courts feel bound to adopt the high court's view of youth and their families (Perry & Melton, 1984; see, e.g., *Hodgson v. Minnesota*, 1986). Although perhaps following from the doctrine of stare decisis (see Monahan & Walker, 1986), such behavior is a

curious way of determining empirical fact. The result is consciously and persistently irrational policy making.

### Science and Symbols

The general theme of this article may appear strange to readers schooled in the belief that juvenile and family law is especially "scientific." The juvenile court and related agencies historically have viewed themselves as based heavily on the social sciences (see Levine, Ewing, & Hager, this issue).

Nonetheless, the "science" that has entered juvenile and family law typically has been clinical opinion that was based on a very slender foundation (see Aber & Reppucci, this issue). Similarly, the research base for child mental health services is remarkably thin (Melton, 1987c). Historically, little attention has been given to the assumptions underlying the juvenile court and other treatment-oriented programs for children.

Still, in children's class litigation, a common phenomenon has been the wide use of social science experts, but without the full development of relevant questions of social fact (Melton, 1986; Mnookin, 1985). With the indeterminacy in children's law, the emphasis on prediction, and the rampant psychological assumptions (regarding competency, for example), discussion of social science may be expected in children's cases. Nonetheless, there is evidence that judges are especially unlikely to pay attention to social science evidence in children's cases (Melton, Weithorn, & Slobogin, 1985). I have previously suggested some reasons why so little care is taken in consideration of social facts in children's cases:

. . . [A]ttention to psychological assumptions may be intended to affirm a priori concepts of the proper ordering among child, family, and state — not to evaluate those assumptions critically. Moreover, the level of indeterminacy may be so great that neither the court nor the parties are sure what social science evidence is relevant — just that some is. Even if consensus exists, directly relevant information is often unavailable. (Melton, 1986, p. 349, citation omitted)

Nonetheless, in view of the forward-looking nature of children's policy, judges and other decision-makers may seek the counsel of social scientists in order to appear to be making rational, planful policy:

. . . [S]ociology was called into "The Nation's Service" almost before sociology existed as a scientific discipline, and . . . it was invited to participate in councils of government even though it knew nothing about the problems being deliberated. To us, this highlights a very significant feature of social science use in public affairs: its ceremonial function. In the past, and . . . today as well, government sometimes [would] invite sociologists to join in helping to make policy as a way of *appearing* rational, a way of trying to create the impression that it is efficient, rational and foresightful in conducting the affairs of state. (Scott & Shore, 1979, p. 129)

In conclusion, I should make clear that I am not arguing for dominance of social scientists in children's policy. Rather, my point is that insufficient care has been taken in formulating such policy. A planful approach is needed with serious consideration of *both* normative and empirical factors. Indeed, part of the problem has been the presentation of normative values in empirical guise (e.g., children ought to be dependent; therefore, they must be incompetent and vulnerable). In approaching problems of child mental health policy, we should not try to convert fictions into reality. At the same time, though, we must attend to the symbols of justice to ensure that children and their families have a say in the development and application of policy.

I am willing, as are Tremper and Kelly (this issue), to acknowledge children's personhood. Human dignity demands preservation of privacy under most circumstances. However, I also recognize that minors and the society as a whole have an interest in the protection of family integrity. Nonetheless, a planful approach to child mental health policy can accommodate both of these values. For too long, children's services have resulted in unnecessarily restrictive treatment that intruded on minors and disrupted families. Although the task is undoubtedly complex and the state of knowledge about treatment alternatives is less than it should be, I am optimistic that careful interdisciplinary consideration of child mental health policy will result in a system of services that is more effective and more just.

In that regard, this special issue reflects salutary developments in the academic study of children's issues. Such study has been given increasingly greater status in law schools. The leading scholars on children's law generally and child mental health policy in particular are committed to careful consideration of both normative and social-scientific considerations. Our society's interests in preservation of the family and socialization of children demand no less.

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# NEBRASKA LAW REVIEW



TAKING *GAULT* SERIOUSLY: TOWARD A NEW  
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## Taking *Gault* Seriously: Toward a New Juvenile Court

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## I. INTRODUCTION

*Non-culpable children faced with the criminal process must be protected, not by the state, but from the state. There is nothing unique in the juvenile process, including the concept of lesser culpability, that excludes it from this conclusion. This, in sum, is the received wisdom of the last twenty-five years of juvenile sociological and jurisprudential study.<sup>1</sup>*

More than two decades have passed since the Supreme Court rendered its landmark decision in *In re Gault*.<sup>2</sup> The appellant, Gerald Gault, had been committed at age fifteen to the Arizona State Industrial School "for the period of his minority [to age twenty-one], unless sooner discharged by due process of law."<sup>3</sup> Gerald lost his liberty for up to six years because he had made a phone call of the "irritatingly offensive, adolescent, sex variety."<sup>4</sup> Had he been an adult convicted of making an obscene phone call, he could have been sentenced only to a fine of five to fifty dollars or imprisonment of up to two months.<sup>5</sup> The apparent injustice of the disposition was magnified by several facts: Gerald's parents were not notified of his arrest; neither Gerald nor his parents were notified of the charge; Gerald was not provided access to counsel or the opportunity to summon and cross-examine witnesses; and the judge interrogated Gerald during the hearing and compelled him to testify against himself.

The egregious facts of Gerald's case unfortunately were common in juvenile courts before *Gault* was decided. In *Gault*, though, the Supreme Court majority joined in Justice Fortas's scathing critique of the juvenile court as a "kangaroo court."<sup>6</sup> The Court added meaning to this assessment by its proclamation for the first time that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."<sup>7</sup> Accordingly, the Court held that the fact that Gerald had been tried in juvenile rather than criminal court did not abrogate his constitutional right to counsel,<sup>8</sup> confrontation of witnesses,<sup>9</sup> notice of the charges,<sup>10</sup>

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1. Walkover, *The Infancy Defense in the New Juvenile Court*, 31 UCLA L. REV. 503, 562 (1984) (emphasis added).

2. 387 U.S. 1 (1967).

3. *Id.* at 7-8.

4. *Id.* at 4.

5. *Id.* at 8-9.

6. *Id.* at 28.

7. *Id.* at 13.

8. *Id.* at 35.

9. *Id.* at 56.

10. *Id.* at 33.

and exercise of the privilege against self-incrimination.<sup>11</sup>

*Gault* promised radical change in juvenile justice. Founded on the principle that rehabilitation should be the hallmark of the law's response to wayward youth,<sup>12</sup> juvenile courts rarely had recognized the rights that were denied Gerald Gault by the Arizona trial court. In fact, failure to provide the rudiments of due process was believed to be consistent with the therapeutic aim of juvenile courts.<sup>13</sup> As a result, and because many juvenile judges had received no legal training at all, juvenile justice was essentially lawless.<sup>14</sup> Although the Supreme Court stopped short of asserting that the juvenile court was a legal innovation<sup>15</sup> that had completely failed,<sup>16</sup> the Court left little doubt that, as a matter of both law<sup>17</sup> and policy,<sup>18</sup> juvenile justice would have to change radically if it was to survive scrutiny. As the Court noted in a case subsequent to *Gault*:

[I]t is simply too late in the day to conclude . . . that a juvenile is not put in jeopardy at a proceeding whose object is to determine whether he has commit-

11. *Id.* at 55.

12. See Levine, Ewing & Hager, *Juvenile and Family Mental Health Law in Sociohistorical Context*, 10 INT'L J. L. & PSYCHIATRY 91, 100-02 (1987).

13. See *infra* note 97 and accompanying text.

14. *In re Gault*, 387 U.S. 1, 14 n.14 (1967).

15. The juvenile court is a relatively youthful jurisprudential invention. Juvenile codes were adopted in virtually every American jurisdiction in the first two decades of the twentieth century. See Levine, Ewing & Hager, *supra* note 12, at 100-01.

16. The Court's opinion in *Gault* suggested that the juvenile court's failure to remediate delinquents was the result, at least in part, of a lack of adequate resources, rather than inherent flaws. *In re Gault*, 387 U.S. 1 (1967). This view was emphasized four years later in the Court's holding that the Constitution does not entitle respondents in delinquency proceedings to a jury trial:

The juvenile concept held high promise. We are reluctant to say that, despite disappointments of grave dimensions, it still does not hold promise, and we are particularly reluctant to say . . . that the system cannot accomplish its rehabilitative goals. So much depends on the availability of resources, on the interest and commitment of the public, on willingness to learn, and on understanding as to cause and effect and cure. In this field, as in so many others, one perhaps learns best by doing. We are reluctant to disallow the States to experiment further and to seek in new and different ways the elusive answers to the problems of the young . . .

*McKeiver v. Pennsylvania*, 403 U.S. 528, 547 (1971).

17. *Gault* was a landmark case in many ways. Perhaps the most far-reaching was its "constitutionalizing" children's issues. See *supra* notes 7-11. Accordingly, *Gault* gave a clear message that juvenile courts would have to begin taking the rudiments of due process seriously.

18. In a statutory case that presaged *Gault*, the Court had concluded that a juvenile respondent "receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children." *Kent v. United States*, 383 U.S. 541, 556 (1966). In *Gault* itself, the Court made unmistakably clear its view that the juvenile court had failed to accomplish its stated purposes and, indeed, that it had often operated in countertherapeutic ways. *In re Gault*, 387 U.S. 1, 22 (1967).

ted acts that violate a criminal law and whose potential consequences include both the stigma inherent in such a determination and the deprivation of liberty for many years.<sup>19</sup>

With the abrogation of the myth that juvenile court proceedings were on behalf of, rather than against, the respondents, it was reasonable to expect that juvenile procedure after *Gault* and its progeny<sup>20</sup> would differ little from criminal procedure.

However, the logic of *Gault* never was followed to its conclusion. Although it is indisputable that *Gault* led to significant change in juvenile law,<sup>21</sup> it is also clear that many juvenile courts have failed to implement its mandate fully. Many juvenile courts persist in the illusion that they are therapeutic instruments<sup>22</sup> and, accordingly, neglect the due process rights basic to an adversary system.<sup>23</sup> Still more fundamentally, little attention has been given to the question of whether a separate juvenile court can be justified at all when juvenile respondents are entitled to most of the procedural rights owed criminal defendants.<sup>24</sup>

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19. *Breed v. Jones*, 421 U.S. 519, 529 (1975).

20. Strictly speaking, *Gault* applied only to adjudicatory delinquency proceedings leading to possible incarceration. See Rosenberg, *The Constitutional Rights of Children Charged with Crime: Proposal for a Return to the Not So Distant Past*, 27 UCLA L. REV. 656, 662 nn.32-34 and citations therein. In subsequent cases, the logic of *Gault* was applied to the standard of proof, *In re Winship*, 397 U.S. 358 (1970); double jeopardy, *Breed v. Jones*, 421 U.S. 519 (1975); and retroactivity, *Ivan V. v. City of New York*, 407 U.S. 203 (1972) (per curiam).

21. *Gault* led to major revisions in juvenile codes to "legalize" juvenile courts with subsequent major revisions to increase punitive responses to serious juvenile crime. Prior to *Gault*, procedures were so minimally lawful that many juvenile courts lacked law-trained judges. W. WADLINGTON, C. WHITEHEAD & S. DAVIS, *CHILDREN IN THE LEGAL SYSTEM* 229 (1983).

22. See, e.g., IDAHO CODE § 16-1801 (Supp. 1988):

The policy of the state of Idaho is hereby declared to be the establishment of a legal framework conducive to the constructive judicial processing of children's cases where the child's conduct is in conflict with the law; and the providing of professional assistance to courts handling children's cases, through a coordinated program of rehabilitation, thereby insuring integrated treatment and assistance to communities throughout the state in their programs of prevention and control of juvenile delinquency . . . .

23. Several studies conducted in the late 1960s and early 1970s showed that *Gault* had little effect on many juvenile courts. See, e.g., W. STAPLETON & L. TEITELBAUM, *IN DEFENSE OF YOUTH* (1972); Duffee & Siegel, *The Organization Man: Legal Counsel in the Juvenile Court*, 7 CRIM. L. BULL. 544 (1971); Platt, Schechter & Tiffany, *In Defense of Youth: A Case Study of the Public Defender in Juvenile Court*, 43 IND. L.J. 619 (1968). Although directly comparable recent research is not available, studies showing the frequency of an absence of defense counsel in juvenile court, see *infra* note 132, raise questions about the court's continuing unlawfulness in many jurisdictions.

24. Because of its adoption of a just deserts approach to juvenile disposition and its application of the full panoply of criminal procedure to juvenile hearings, the Juvenile Justice Standards Project is often characterized as having taken a radi-

With more than two decades of post-*Gault* hindsight, this Article is intended to stimulate new discussion of this issue. Perhaps the time has come to follow *Gault* to its logical conclusion and to "put an effective end to what has been the idealistic prospect of an intimate, informal protective proceeding" and "once again to place the juvenile squarely in the routine of the criminal process."<sup>25</sup> Although I will not go quite so far, I will argue that *Gault* and its progeny, when examined in the light of empirical evidence, require a truly new juvenile court that relies on knowledge of psychosocial development in order not to treat juveniles, but to ensure protection of their right to due process.

## II. HISTORIC RATIONALES FOR THE JUVENILE COURT

In consideration of the social utility of the juvenile court and its present and future mission and form, a useful starting point is analysis of the validity of the historic rationales for a separate juvenile court.<sup>26</sup> Social historians now doubt that the founding of the juvenile court is largely or even wholly explained by the stated motives of the turn-of-the-century child savers.<sup>27</sup> However, examination of the ostensible rationales is most likely to provide an answer to the question of whether any coherent justification exists for a separate juvenile court.

Judge Julian Mack's oft-cited contemporary discussion of the nature and goals of the early juvenile court<sup>28</sup> provides a snapshot of the

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cal approach to juvenile justice. Besides the fact that a series of recommendations that could win the endorsement of the American Bar Association must not be that radical, the commentary to the 23 volumes of Juvenile Justice Standards is remarkable for its lack of attention to the question of whether a juvenile court can be justified at all. The closest it comes to such a discussion is a footnote excerpting a conclusory statement from a position paper prepared for the Project: "Juveniles may be viewed as incomplete adults, lacking in full moral and experiential development, extended unique jural status in other contexts, and deserving of the social moratorium extended by this and all other societies of which I am aware." ABA JOINT COMMISSION ON JUVENILE JUSTICE STANDARDS, JUVENILE JUSTICE STANDARDS RELATING TO DISPOSITIONS 19 n.5 (1980).

25. *McKeiver v. Pennsylvania*, 403 U.S. 528, 545 (1971).

26. The *Gault* Court itself noted that *parens patriae* doctrine had been distorted substantially from its early purpose of protection of state interests in the estates of dependent persons. *In re Gault*, 387 U.S. 1, 16-17 (1967).

27. See generally J. KETT, *rites of passage* (1977); A. PLATT, *THE CHILD SAVERS: THE INVENTION OF DELINQUENCY* (2d ed. 1977).

28. Mack, *The Juvenile Court*, 23 HARV. L. REV. 104 (1909). Judge Mack's rather romanticized account of the juvenile court itself bears some indicia of the sociopolitical determinants of the founding of the court, as identified by modern scholars. Judge Mack provided this description of the clientele of the early juvenile court:

Most of the children who come before the court are, naturally, the children of the poor. In many cases the parents are foreigners, frequently unable to speak English, and without an understanding of American methods and views. What they need, more than anything else, is kindly assistance; and the aim of the court, in appointing a probation officer for the child, is to have the child and the parents feel, not so much

idealized court:

[The juvenile judge] must be a student of and deeply interested in the problems of philanthropy and child life, as well as a lover of children. He must be able to understand the boys' point of view and ideas of justice; he must be willing and patient enough to search out the underlying causes of the trouble and to formulate the plan by which, through the cooperation, oftentimes, of many agencies, the cure may be effected. . . .

The problem for determination by the judge is not, Has this boy or girl committed a specific wrong, but What is he, how has he become what he is, and what had best be done in his interest and in the interest of the state to save him from a downward career. It is apparent at once that the ordinary legal evidence in a criminal court is not the sort of evidence to be heard in such a proceeding . . . .<sup>29</sup>

#### A. Juveniles Are Not Responsible

##### 1. *The Legal Framework*

At its deepest roots, this paternalistic vision of the juvenile court was based on the moral premise that youth do not deserve punishment for their violations of law. Rather, in Judge Mack's words, offenders should be "protected" by the state, acting as would "a wise and merciful father" when he learns that his child has erred.<sup>30</sup> To pursue that course, the court must concern itself not with the question of whether a given disposition is a juvenile's just desert, but instead whether the dispositional plan is responsive to his needs. Indeed, the court need not worry about whether the juvenile deserves state intervention at all, because the intervention is for his own good, regardless of whether he has broken the law:

[It is] the duty of the state, instead of asking merely whether a boy or girl has committed a specific offense, to find out what he is, physically, mentally, morally, and then if it learns that he is treading the path that leads to criminality, to take him in charge, not so much to punish as to reform, not to degrade but to uplift, not to crush but to develop, not to make him a criminal but a worthy citizen.<sup>31</sup>

It is easy to approach Judge Mack's assertion cynically and to focus solely on the adequacy of the juvenile court in delivering the promised rehabilitation. Although the failings of the court in that regard now

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the power, as the friendly interest of the state: to show them that the object of the court is to help them to train the child right . . . .

Mack, *supra*, at 116-17.

29. Mack, *supra* note 28, at 119-20. In his dissenting opinion in *Gault*, Justice Stewart summarized the import of the offender- rather than offense-based dispositional inquiry in juvenile justice: "[A] juvenile proceeding's whole purpose and mission is the very opposite of the mission and purpose of a prosecution in a criminal court. The object of one is correction of a condition. The object of the other is conviction and punishment for a criminal act." *In re Gault*, 387 U.S. 1, 79 (1967) (Stewart, J., dissenting).

30. Mack, *supra* note 28, at 107.

31. *Id.*

are well known<sup>32</sup>, it is important to consider the validity of the underlying assumption that it is unjust to brand a juvenile as a criminal.<sup>33</sup> Even if the juvenile court has not matched the rehabilitative ideal, a special system of justice may be defensible if retribution cannot be morally applied to a juvenile.

Indeed, such a line of argument may require merely a showing that youthfulness is a mitigating, even if not an excusing, factor. For example, in a "modest defense" of the juvenile court, my colleague Martin Gardner has contended that the court can be justified by the discrepancy in level of stigma that may exist between *delinquent* and *criminal*.<sup>34</sup> If, as he argues, most juvenile offenders are sufficiently mature that they are culpable for their conduct but sufficiently immature that they do not deserve the same level of punishment as adult offenders, then an intermediate level of punishment is just. Given that labeling by the community as a criminal is a part of the punishment meted out by the criminal justice system, a label with less stigma would be appropriate for juvenile offenders. Therefore, Professor Gardner favors retention of the juvenile court even though he accepts a retributive response to most juvenile crime. Consistent with the general principle that punishment should be proportionate to the offense, he would reduce both the sentence (disposition) and the opprobrium imposed on juveniles convicted of a crime, relative to the sanctions to which adult offenders are subject. Although the first object of his partial responsibility theory could be accommodated in the criminal justice system,<sup>35</sup> the latter may require that a special status be maintained for juvenile offenders.<sup>36</sup>

Still, the existence of a juvenile court clearly does not exclude punishment of juveniles, and the absence of a juvenile court does not eliminate the possibility of fully or partially exculpating juveniles on the basis of their immaturity. Even at the zenith of the rehabilitative ideal, some juveniles were expressly the objects of punishment,<sup>37</sup> and most juvenile offenders were subject to de facto punishment.<sup>38</sup> On the other hand, for centuries prior to the invention of the juvenile court, the defense of infancy operated in criminal courts to excuse the criminal conduct of all children under age seven and of those children be-

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32. See *infra* Section II(B).

33. See Mack, *supra* note 28, at 109.

34. Gardner, *Punitive Juvenile Justice: Some Observations on a Recent Trend*, 10 INT'L J. L. & PSYCHIATRY 129, 148-50 (1987).

35. See generally Morse, *Undiminished Confusion in Diminished Capacity*, 75 J. CRIM. L. & CRIMINOLOGY 1 (1984).

36. Professor Gardner's argument rests on an empirical assumption about the relative social consequences of the *criminal* and *delinquent* labels. He acknowledges that the assumption is speculative. Gardner, *supra* note 34, at 149-50.

37. See Gardner, *supra* note 34, at 130 n.8.

38. *In re Gault*, 387 U.S. 1, 16 (1967).

tween the ages of seven and fourteen who failed to appreciate the wrongfulness of their conduct.<sup>39</sup>

In short, the desirability of a juvenile court is not perfectly related to the question of the criminal responsibility of juvenile offenders. Nonetheless, it is undeniable that some relationship exists between the modal level of responsibility of juvenile offenders and the age-graded applicability of the usual strictures of criminal law. If most juvenile offenders are not worthy of punishment but the state has a compelling interest, as it undeniably does, in the prevention of continuing antisocial behavior, then a nonretributive justice system is needed to respond to the problem of juvenile delinquency. Therefore, before conclusions are reached about the wisdom of a separate system of juvenile justice, careful consideration is needed of the level of responsibility that may be justly expected of most juveniles.

## 2. *The Psychological Evidence*

### a. *Changing Views of Children's Competence*

Such questions are especially acute because of a large body of recent psycholegal scholarship that indicates juveniles, especially adolescents, commonly are more competent decisionmakers than the law historically has presumed.<sup>40</sup> Piagetian theory implied that adolescents, at least by age fourteen, would not differ from adults on average in their ability to comprehend and weigh risks and benefits of personal decisions.<sup>41</sup> That general proposition now has been supported by numerous laboratory<sup>42</sup> and field studies<sup>43</sup> of decisionmaking by youth in various legally relevant contexts.

In fact, if research contradicts the Piagetian hypotheses at all, it generally is in the direction of competence of even younger minors to make personal decisions. For example, some studies have shown elementary-school-age children able to identify material risks of psycho-

39. See generally Kean, *The History of the Criminal Liability of Children*, 53 LAW Q. REV. 364 (1937); Ludwig, *Rationale of Responsibility for Young Offenders*, 29 NEB. L. REV. 521 (1950); Walkover, *supra* note 1.

40. See generally Melton, *Developmental Psychology and the Law: The State of the Art*, 22 J. FAM. L. 445, 452-56 (1983).

41. See Grisso & Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOLOGY 412 (1978).

42. E.g., Belter & Grisso, *Children's Recognition of Rights Violations in Counseling*, 15 PROF. PSYCHOLOGY: RES. & PRAC. 899 (1984); Weithorn & Campbell, *The Competency of Children and Adults to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982).

43. E.g., Day & Reznikoff, *Social Class, The Treatment Process, and Parents' and Children's Expectations about Psychotherapy*, 9 J. CLIN. CHILD PSYCHOLOGY 195 (1980); Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 AM. J. ORTHOPSYCHIATRY 446 (1980).



therapy.<sup>44</sup> Other research has indicated that children in the intermediate grades make adult-like decisions about routine therapeutic and educational matters, even if they are not as competent as adolescents and adults in comprehending and weighing the risks and benefits of the various alternatives.<sup>45</sup> Stated somewhat differently, children can imitate adult models in making decisions for themselves, even when they are not prepared cognitively to explain the merits of those decisions.

Although such studies of actual decisionmaking are most germane to legal concerns, it should be noted that changes in psychologists' perceptions of children's general competence also have occurred among basic developmental psychologists. Recent research has shown children to be capable of sociocentric moral reasoning and behavior at earlier ages than most developmental psychologists (at least those with a cognitive-developmental bent) had believed possible. Although the attribution of subjective responsibility<sup>46</sup> has proven to be one of the most strikingly developmental aspects of moral judgment,<sup>47</sup> researchers who have adjusted their methods to account for young children's poor verbal and free-recall skills have found even preschoolers to apply perceptions of intentionality of behavior to their moral judgments.<sup>48</sup> Observations of empathy and sympathetic distress among children in day care centers are also illustrative of the sociomoral competence of young children, sometimes including toddlers.<sup>49</sup> Indeed, preschoolers refer to others' needs as the basis for their own naturally occurring prosocial behavior.<sup>50</sup>

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44. Kaser-Boyd, Adelman, Taylor & Neison, *Children's Understanding of Risks and Benefits of Psychotherapy*, 15 J. CLIN. CHILD PSYCHOLOGY 165 (1986).

45. See, e.g., Lewis, *Decision Making Related to Health: When Could/Should Children Act Responsibly?*, in CHILDREN'S COMPETENCE TO CONSENT (G. Melton, G. Koocher & M. Saks eds. 1983); Weithorn & Campbell, *supra* note 42.

46. In Piaget's seminal theory of moral development, attribution of responsibility on the basis of intention rather than objective consequences requires sufficient cognitive development that the child is able to comprehend motives of others. Piaget believed this diminution of egocentricity in moral judgment did not occur until the child reached middle childhood. See generally J. PIAGET, *THE MORAL JUDGMENT OF THE CHILD* (1965) (originally published in 1932).

47. Lickona, *Research on Piaget's Theory of Moral Development*, in MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES 219, 229 (T. Lickona ed. 1976).

48. See, e.g., Austin, Ruble & Trabasso, *Recall and Order Effects as Factors in Children's Moral Judgments*, 48 CHILD DEV. 470 (1970); Darley, Klosson & Zanna, *Intentions and Their Contexts in the Moral Judgments of Children and Adults*, 49 CHILD DEV. 66 (1978). See generally ALTERNATIVES TO PIAGET: CRITICAL ESSAYS ON THE THEORY (L. Siegel & C. Brainerd eds. 1978).

49. See generally Hoffman, *Empathy, Role Taking, Guilt, and Development of Altruistic Motives*, in MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES 124 (T. Lickona ed. 1976).

50. Eisenberg-Berg & Neal, *Children's Moral Reasoning about their Own Spontaneous Prosocial Behavior*, 15 DEV. PSYCHOLOGY 228 (1979).

Similarly, comprehension of physical causality occurs much earlier than children are able to articulate their understanding of causality and, therefore, earlier than Piaget believed was possible. "Adult-like" causal reasoning is well established by age four or five and sometimes observable even among two- and three-year-old children.<sup>51</sup> Thus, concepts of agency and intentionality are within the repertoire even of young children.

Although such bodies of research cast doubt on the historic presumption of irresponsibility among juveniles, it is important not to oversell their significance. The capacity to perceive and evaluate the intentionality of behavior does not translate directly into the capacity to form criminal intent.<sup>52</sup> Moreover, some of the research by Piagetian critics that shows children capable of higher-level reasoning than cognitive-developmental theorists typically assumed requires unusual conditions. That children may be able to demonstrate higher-level reasoning when the task is presented nonverbally or the demands on memory are minimized probably has little relevance to the law's view of children's maturity.

Similarly, research on juveniles' competence in decisionmaking is not completely apposite to questions of their responsibility. On the one hand, the cognitive requirements for compliance with the criminal law probably are generally less advanced than the information-processing skills needed to make rational decisions about one's physical and economic welfare. On the other hand, the threshold for personal responsibility should be higher than the threshold for exercise of self-determination. Thus, in considering questions of responsibility, we should be sensitive to developmental trends in judgment that we may find irrelevant to the question of whether interests in liberty are to be recognized and protected in nonpunitive situations. I shall consider these points in turn.

*b. The Low Expectations of the Criminal Law*

As Stephen Morse has argued in his discussions of the relationship between mental disability and personal responsibility, the expecta-

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51. Bullock, *Causal Reasoning and Developmental Change over the Preschool Years*, 28 HUM. DEV. 169 (1985); Bullock, *Preschool Children's Understanding of Causal Connections*, 2 BRIT. J. DEV. PSYCHOLOGY 139 (1984).

52. Some psycholegal commentators on children's responsibility have failed to make this distinction clearly. See, e.g., Keasey & Sales, *An Empirical Investigation of Young Children's Awareness and Usage of Intentionality in Criminal Situations*, 1 LAW & HUM. BEHAV. 45 (1977). Besides the fact that different levels and perhaps even different types of intent are relevant in the domains of psychology and law, the equation of capacity to form criminal intent and laboratory demonstrations of understanding of intentionality ignores the additional moral elements in the former. Attribution of responsibility surely rests on more than an ability to consider subjective factors in assessing blame.

tions of moral behavior that are established in the criminal law generally are quite low.<sup>53</sup> The foundation for this conclusion is especially clear when one considers the lack of obvious legal significance of infantile moral reasoning. The lowest level of moral development often is said to be an evaluation of the morality of conduct in terms of its personal consequences.<sup>54</sup> Although few would seek a society in which citizens refrained from *mala in se* only because of the threat of punishment, such a perspective is deeply embedded in the deterrent purpose of the criminal law.<sup>55</sup>

In a classic essay, Justice Holmes even argued that such a purpose is the *sine qua non* of law:

If you want to know the law and nothing else, you must look at it as a bad man, who cares only for the material consequences which such knowledge enables him to predict, not as a good one, who finds his reasons for conduct, whether inside the law or outside of it, in the vaguer sanctions of conscience.<sup>56</sup>

To a large extent, as a society, we do not care that prospective criminals obey the law for reasons that are not morally praiseworthy. We do not punish unethical states of mind absent illegal conduct. Similarly, we probably would be satisfied if all citizens obeyed the law, even if they did so because they expected the approbation of their peers.<sup>57</sup>

At the same time, we have few qualms about punishing those who break the law because they have calculated that the risk of punishment is insufficient to warrant foregoing the short-term personal gains often associated with antisocial behavior. Most of us feel little guilt about punishing offenders who are so egocentric that they appear insensitive to the effects of their crimes on the victims, but who are not so socially inept that they are unaware of the community's condemnation of their behavior.<sup>58</sup> Indeed, our moral intuition tells us that such "cold-blooded" behavior is especially blameworthy.

Our intuition is confirmed to some extent by the fact that most elementary-school-age children and even some preschool children are

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53. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978); Morse, *supra* note 35.

54. See, e.g., Kohlberg, *Moral Stages and Moralization: The Cognitive-Developmental Approach*, in MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES 31 (T. Lickona ed. 1976).

55. See generally Gibbs, *Deterrence Theory and Research*, in 33 NEB. SYMP. ON MOTIVATION: THE LAW AS A BEHAVIORAL INSTRUMENT (G. Melton ed. 1985).

56. Holmes, *The Path of the Law*, 10 HARV. L. REV. 457, 459 (1897).

57. Evaluation of the morality of an event based on the positive consequences and resulting positive emotion associated with it occurs even in early childhood. Hoffman, *supra* note 49; Kohlberg, *supra* note 54.

58. Many sex offenders have little appreciation of the impact of their behavior on the victims, and they often fail to comprehend fully why society is outraged by their behavior. See, e.g., A. GROTH, *MEN WHO RAPE: THE PSYCHOLOGY OF THE OFFENDER* (1979).

capable of reaching the same conclusion.<sup>59</sup> Consideration of intent, including hedonistic or exploitive motives, does not require high levels of cognitive development or educational achievement. For that matter, actual conformity to the primary behavioral norms of the community requires even less sociomoral development. Even young children are not inclined to adopt physically dangerous means of responding to slights by their peers. Similarly, the lack of a substantial relationship between age and honesty<sup>60</sup> demonstrates that children understand the rules of an orderly society at a very young age and are capable of responding accordingly, whatever their motive for doing so. From an early age, children can imitate normative social behavior.<sup>61</sup>

*c. The Lack of Congruence Between Competence  
and Responsibility*

Although the preceding discussion shows that the social expectations embedded in the criminal law generally do not rest on advanced developmental levels, the fact that juveniles appear more competent decisionmakers than the law historically has presumed does not imply that youth generally should be held fully accountable by the state for their misdeeds. I reach that conclusion even though I have argued elsewhere that the new research and theory on minors' competence should be used to establish lower age thresholds for legal recognition of the validity of their decisions.<sup>62</sup>

The age thresholds for recognition of autonomy and privacy, cessation of special age-based entitlements, and establishment of criminal responsibility need not be, indeed should not be, the same.<sup>63</sup> Respect for personhood demands that we err on the side of promotion of autonomy. Therefore, the presumption should be in favor of self-determination and those special entitlements that assist youth in developing the capacity for full exercise of autonomy, but doubt about criminal (or quasicriminal) responsibility should be resolved in the direction of nonresponsibility.

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59. L. Sametz, A Child's Use of Distributive Justice as a Function of the Child's Cognitive Level (paper presented at the meeting of the Society for Research in Child Development, Apr. 1981).

60. Burton, *Honesty and Dishonesty*, in *MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES* 173, 179-80 (T. Lickona ed. 1976).

61. See generally Mischel & Mischel, *A Cognitive Social-Learning Approach to Morality and Self-Regulation*, in *MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES* 84 (T. Lickona ed. 1976).

62. See, e.g., Melton, *Toward "Personhood" for Adolescents: Autonomy and Privacy as Values in Public Policy*, 38 *AM. PSYCHOLOGIST* 99 (1983).

63. This point is developed in substantially more detail in Melton, *Are Adolescents People? Problems of Liberty, Entitlement, and Responsibility*, in *THE ADOLESCENT AS DECISION-MAKER: APPLICATIONS TO DEVELOPMENT AND EDUCATION* (J. Worell & F. Danner eds. 1989).

Advocating a "jurisprudence of semi-autonomy" that treats adolescence "as a learner's permit," Franklin Zimring has reached the same conclusion.<sup>64</sup> He has argued convincingly that it is unfair to hold adolescents accountable for their behavior at the same level that we hold adults. When the state systematically has denied adolescents experience in decisionmaking, it is unreasonable for society to expect the same quality of decisionmaking from adolescents that it expects from adults, even if adolescents typically have the same capacity to assess and weigh the risks and benefits of various alternatives.

Professor Zimring's point is rendered more acute by evidence that there may be subtle differences between adolescents' and adults' appraisal of social situations. David Elkind's description of residual egocentrism in adolescence is illustrative.<sup>65</sup> Adolescents typically are unrealistically sensitive to others' reactions (what Professor Elkind terms the "imaginary audience") and insensitive to their own vulnerability (the "personal fable"). Although such differences are insufficient to form legally relevant differences in regard to adolescents' ability to comprehend and weigh risks and benefits, they may be sufficient to cast some doubt about their level of culpability for illegal behavior.

#### *d. Some Preliminary Conclusions*

As Thomas Lickona has summarized, "[m]oral judgment, as depicted by Piaget, is indisputably developmental; it changes with age and experience."<sup>66</sup> Nonetheless, the level of moral reasoning expected within the criminal law is achieved by most juveniles at an early age. At a minimum, the several lines of research showing children and youth to be more competent cognitively and socially than the law has presumed cast doubt on the assumption that most juveniles cannot fairly be held accountable for their behavior.

The qualifier to this conclusion, though, is the evidence suggesting that adolescents may be in a transition stage in terms of criminal responsibility. This qualifier is given special credence by research showing that juvenile delinquents are especially immature. Delinquents usually are less competent socially and cognitively than their peers.<sup>67</sup> As a result, age may be sufficiently mitigating to support a theory of only partial responsibility for many adolescents, a point to which I shall return.

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64. F. ZIMRING, *THE CHANGING LEGAL WORLD OF ADOLESCENCE* (1982).

65. Elkind, *Egocentrism in Adolescence*, 38 *CHILD DEV.* 1025 (1967).

66. Lickona, *supra* note 47.

67. See *infra* notes 118-32 and accompanying text.

### B. Juveniles Are Especially Amenable to Treatment

Even if juveniles can reasonably be presumed to be responsible for their behavior, a separate system of justice may be a wise policy if juveniles are especially amenable to treatment. The founders of the juvenile court certainly assumed such amenability. Using a social construct that continues to creep into public policy,<sup>68</sup> the early child savers presumed juvenile offenders to be particularly malleable and, therefore, predictably responsive to treatment to prevent their future antisocial conduct. Juvenile crime was perceived as posing relatively little threat to society, and juveniles were believed to be essentially innocent in a Rousseauian sense.<sup>69</sup> If youth were placed in a benign, "natural" setting away from the temptations of the modern city, they could be expected to be restored to their state of innocence and then to be "civilized" appropriately.<sup>70</sup>

The idyllic view of the therapeutic programs planned by the founders of the juvenile justice system is illustrated by Judge Mack's description:

What is needed is a large area, preferably in the country,—because these children require the fresh air and contact with the soil even more than does the normal child.—laid out on the cottage plan, giving opportunity for family life, and in each cottage some good man and woman who will live with and for the children.<sup>71</sup>

The perception of delinquents as innocent creatures led astray by the realities of urban immigrant culture is exemplified by Judge Mack's reference to the purported therapeutic effects of sending wayward youth to the country. This view is further illustrated by the ease with which the judge believed that therapeutic change would occur:

A thorough investigation, usually made by the probation officer, will give the court much information bearing on the heredity and environment of the child. This, of course, will be supplemented in every possible way; but this alone is not enough. The physical and mental condition of the child must be known, for the relation between physical defects and criminality is very close. It is, therefore, of the utmost importance that there be attached to the court, as has been done in a few cities, a child study department, where every child, before hearing, shall be subjected to a thorough psycho-physical examination. In hundreds of cases the discovery and remedy of defective eyesight or hearing or some slight surgical operation will effectuate a complete change in the character of the lad.<sup>72</sup>

In such a view, the traditional strictures of the legal process were inapposite, because delinquency was at root a medical problem that demanded expert diagnosis and treatment, not a moral/social problem

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68. See Melton, *The Clashing of Symbols: Prelude to Child and Family Policy*, 42 AM. PSYCHOLOGIST 345, 350 (1987).

69. See J. ROUSSEAU, EMILE (Dutton ed. 1955) (originally published in 1762).

70. See J. KETT, *supra* note 27, at 100.

71. Mack, *supra* note 28, at 114.

72. *Id.* at 120.

that required just resolution. In such a context, social workers, doctors, and even "wise and merciful" substitute fathers<sup>73</sup> were legitimately more at home than were lawyers intent on using the skills of their profession. The guts of the juvenile court were to be in its ancillary clinics and training schools, not in the trappings of due process and legal authority.

In *Kent*<sup>74</sup> and *Gault*,<sup>75</sup> the Supreme Court refused to accept the fiction that such good intentions had necessarily—or even often—resulted in therapeutic procedures and effects. Juvenile offenders were subjected to the "worst of both worlds,"<sup>76</sup> a deprivation of due process based on the promise of a treatment that often was harshly punitive.

Unfortunately, the reality noticed in *Kent* and *Gault* is not radically different today. The "treatment" available through the juvenile justice system often remains little more than brutal punishment.<sup>77</sup> Class action suits in the 1970s and 1980s have illuminated inhumane conditions in numerous juvenile correctional facilities and in many adult jails where juveniles also are held.<sup>78</sup> In fact, substantial change is only beginning to occur in many communities where the threat of personal liability now looms for state and local officials who fail to comply with the Juvenile Justice and Delinquency Prevention Act's mandate to remove juveniles from adult jails.<sup>79</sup>

Too often, in fact, the situation at the time of *Gault* has been exacerbated by the growth of the child mental health and social service professions. The child mental health system has become an increasingly misused instrument of state intrusion into the lives of youth and

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73. See *supra* notes 30-31 and accompanying text.

74. *Kent v. United States*, 383 U.S. 541 (1966).

75. *In re Gault*, 387 U.S. 1 (1967).

76. *Kent v. United States*, 383 U.S. 541, 566 (1966).

77. See, e.g., K. WOODEN, *WEeping IN THE PLAYTIME OF OTHERS* (1976).

78. See Soler, *Litigation on Behalf of Children in Adult Jails*, 34 CRIME & DELINQ. 190 (1988), and cases cited therein.

79. *Hendrickson v. Griggs*, 672 F. Supp. 1126 (N.D. Iowa 1987); Swanger, *Hendrickson v. Griggs: A Review of the Legal and Policy Implications for Juvenile Justice Policymakers*, 34 CRIME & DELINQ. 209 (1988).

The Juvenile Justice and Delinquency Prevention Act and the *Hendrickson* case present new opportunities for reform of the juvenile justice system, if not of the juvenile court itself. It remains to be seen, though, whether the response to such opportunities will be more of the same (i.e., construction of juvenile detention centers instead of housing in adult jails) or new, less restrictive approaches to the prevention and remediation of juvenile delinquency. The raft of juvenile justice bills introduced in the 1989 session of the Nebraska Legislature was illustrative. Compare, e.g., LB 493 (a proposal by Sen. Arlene Nelson and five other senators to authorize the Department of Corrections to operate juvenile detention facilities) with LB 663 (proposed Juvenile Services Act, introduced by Sen. Sandy Scofield and 10 other senators, to provide an array of family- and community-based services for juvenile offenders).

their families.<sup>80</sup> Without doubt, the scope of the juvenile justice system has expanded as private therapeutic facilities have become available for placement.<sup>81</sup> Indeed, some of the most egregious abuse of juveniles placed as a result of their misbehavior has been as part of purported treatment.<sup>82</sup> For example, one high-priced, highly professionalized center that received youth from juvenile courts all over the country subjected them to lie detectors to determine whether their thinking was "correct," forced them to stand or sit at attention when it was not, and engaged in rather innovative physically abusive procedures supposedly intended to quiet upset youth.<sup>83</sup>

The problem with the implementation of the rehabilitative ideal, though, is not simply a matter of perversion of the juvenile court's purported purpose. Even when the court's therapeutic purpose has been taken seriously, its efficacy has not been demonstrated. As a panel of the National Academy of Sciences concluded, the assertion that "nothing works" in juvenile (and adult) corrections still has not been persuasively refuted.<sup>84</sup> The most well-validated treatment for

80. See generally Morse & Whitebread, *Mental Health Implications of the Juvenile Justice Standards*, in LEGAL REFORMS AFFECTING CHILD AND YOUTH SERVICE (G. Melton ed. 1982).

81. See, e.g., G. MELTON & W. SPAULDING, NO PLACE TO GO: CIVIL COMMITMENT OF MINORS (in press); Jackson-Beeck, Schwartz & Rutherford, *Trends and Issues in Juvenile Confinement for Psychiatric and Chemical Dependency Treatment*, 10 INT'L J. L. & PSYCHIATRY 153 (1987); Krisberg, Schwartz, Litsky & Austin, *The Watershed of Juvenile Justice Reform*, 32 CRIME & DELINQ. 5 (1986); Lerman, *Trends and Issues in the Deinstitutionalization of Youths in Trouble*, 26 CRIME & DELINQ. 281 (1980); Rutherford, *The Boundaries of Child Welfare in England*, in RETHINKING CHILD WELFARE (J. Gilgun, I. Schwartz, G. Melton & Z. Eisikovits eds.) (in press).

82. See Melton & Davidson, *Child Protection and Society: When Should the State Intervene?*, 42 AM. PSYCHOLOGIST 172 (1987).

83. *Milonas v. Williams*, 691 F.2d 931 (10th Cir. 1982).

84. THE REHABILITATION OF CRIMINAL OFFENDERS: PROBLEMS AND PROSPECTS (L. Sechrest, S. White & E. Brown eds. 1979). See also NEW DIRECTIONS IN THE REHABILITATION OF CRIMINAL OFFENDERS (S. Martin, L. Sechrest & R. Redner eds. 1981) (examining directions for rehabilitation programs that theory suggests may be most profitable). The National Academy task panel saw no reason for belief that juvenile delinquents would be especially amenable to treatment:

It may be implicitly assumed by many that age is an important element in classification because it is, or should be, easier to rehabilitate youthful offenders. That seems a dubious prospect at best. By any measure currently available, rates of involvement in criminal activity subsequent to adjudication are at least as high for juveniles as for adults with similar offense histories. It could be argued that given the same circumstances it might be more difficult to rehabilitate juveniles than adults because their very youth is indicative that they have no prolonged periods of satisfactory behavior patterns to which they might be restored by proper treatment. In fact, however, very little is known about differential treatment or potential for rehabilitation of juveniles and adults. Certainly when the treatment methods that have been employed are examined, there do not appear to have been any startling differences between what



delinquent behavior remains getting older!<sup>85</sup>

It may be argued that this dismal picture reflects inadequate resources, poorly conceptualized treatment programs, and failure to protect program integrity in evaluation studies, rather than intrinsic ineffectiveness of treatment. To a large extent, I agree. Some of the most highly touted negative evaluation studies have focused on programs so poorly developed and staffed that no one reasonably could have expected them to work.<sup>86</sup> Most serious juvenile offenders have a multiplicity of significant, persistent problems—educational delays, family disorganization, a lack of community support, economic poverty, poor social skills, and aberrant social perceptions and expectancies.<sup>87</sup> Some small experimental programs that have incorporated an intensive, integrated response to such problems have shown success.<sup>88</sup>

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has been tried with juveniles and adults. The one exception is temporary foster home placement of juveniles, but that tactic has never been subjected to a controlled test of its efficacy.

THE REHABILITATION OF CRIMINAL OFFENDERS: PROBLEMS AND PROSPECTS, *supra* at 50-51.

A background paper commissioned by the panel concluded that early exercise of punitive sanctions through the juvenile justice system also was likely to have little deterrent effect. Klein, *A Judicious Slap on the Wrist: Thoughts on Early Sanctions for Juvenile Offenders*, in NEW DIRECTIONS IN THE REHABILITATION OF CRIMINAL OFFENDERS 376, 392 (S. Martin, S. Sechrest & R. Redner eds. 1981).

Partly as a result of such dismal analyses, Congress, with the apparent blessing of the Supreme Court, has rejected rehabilitation outright as a goal for adult corrections, at least when institutionally based. *Mistretta v. United States*, 109 S. Ct. 647 (1989). In the absence of evidence of efficacy, treatment planning as a base for sentencing decisions was found to be "a serious impediment to an even-handed and effective operation of the criminal justice system." *Id.* at 656. In the current state of the art, such an argument applies with equal force to juvenile corrections.

85. See, e.g., G. MELTON & D. HARGROVE, PLANNING MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH ch. 2 (in press) (conduct disorders tend to be persistent across time and pervasive across situations); J. MONAHAN, PREDICTING VIOLENT BEHAVIOR 72-73 (1981); L. ROBINS, DEVIANT CHILDREN GROWN UP: A SOCIOLOGICAL AND PSYCHIATRIC STUDY OF SOCIOPATHIC PERSONALITY (1966).

86. Quay, *The Three Faces of Evaluation: What Can Be Expected to Work*, 4 CRIM. JUST. & BEHAV. 341 (1977).

87. For reviews of the relevant epidemiological literature, see G. MELTON & D. HARGROVE, *supra* note 85; M. RUTTER & H. GILLER, JUVENILE DELINQUENCY: TRENDS AND PERSPECTIVES (1984).

88. For a comprehensive review of the treatment outcome literature, see G. MELTON & D. HARGROVE, *supra* note 85, at ch. 3. For examples of promising programs, see I. GOLDENBERG, BUILD ME A MOUNTAIN: YOUTH, POVERTY, AND THE CREATION OF NEW SETTINGS (1971); Hengeier, Rodick, Borduin, Hanson, Watson & Urey, *Multisystemic Treatment of Juvenile Offenders: Effects on Adolescent Behavior and Family Interaction*, 22 DEV. PSYCHOLOGY 132 (1986); Shore & Massimo, *Fifteen Years after Treatment: A Follow-up Study of Comprehensive Vocationally Oriented Psychotherapy*, 49 AM. J. ORTHOPSYCHIATRY 240 (1979).

All of the programs that have demonstrated lasting success in treating youth with persistent and pervasive behavior problems have been small and intensive.

Recent studies of youth who have spontaneously ended delinquent careers also have provided new directions for experimentation in services for delinquents.<sup>89</sup>

Even if treatment is potentially effective for some delinquents, though, the argument that the juvenile court's failure really is just a matter of inadequate investment or careless conceptualization misses the point. First, even if juvenile justice programs are potentially effective in preventing further crime, at least by some youth, rehabilitation programs are not differentially effective for juvenile delinquents to a degree that justifies a separate justice system. Although the claim by some that adolescence is too late for significant change is simply wrong,<sup>90</sup> the historic view that youth is a time of great malleability was equally naive.<sup>91</sup> Most juvenile offenders do not recidivate, no matter what intervention is provided.<sup>92</sup> Insofar as rehabilitation is the goal, it is hard to justify *any* court involvement for such youth. Among those juveniles who are repeat offenders, there is little reason to expect special amenability to treatment, relative to adult offenders.<sup>93</sup>

Second, it must be remembered that the court's primary purpose is to administer justice. Even an effective rehabilitation system fails in

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It is unclear whether they could be adopted on a large scale. No state has yet tried.

89. A key to cessation of delinquency appears to be sense of personal efficacy. Mulvey, *Cessation of Delinquency as a Worthwhile Research Topic*, in 11(1) DIVISION OF CHILD, YOUTH, & FAMILY SERVICES NEWSLETTER 4, 14 (1988). An implication would be that treatment is most likely to be effective when it induces or restores some measure of personal control by youth, a conclusion that also can be derived from other areas of psychological research and theory. See, e.g., Melton, *Decision Making by Children: Psychological Risks and Benefits*, in CHILDREN'S COMPETENCE TO CONSENT (1983); Tremper & Kelly, *The Mental Health Rationale for Policies Fostering Minors' Autonomy*, 10 INT'L J. L. & PSYCHIATRY 111 (1987). Such a process of involvement of youth themselves in making decisions about their treatment can hardly be said to be endemic to youth corrections.

90. See Hobbs & Robinson, *Adolescent Development and Public Policy*, 37 AM. PSYCHOLOGIST 212 (1982).

91. See *supra* note 85. See also K. Federle, *The Abolition of the Juvenile Court: A Proposal for the Preservation of Children's Legal Rights*, at 9-11 (paper presented at the meeting of the American Society of Criminology, Chicago, Nov. 11, 1988)(serious crime is committed disproportionately by juveniles).

92. After an exhaustive review of the literature, Professors Rutter and Giller concluded:

[D]elinquent behavior is very pervasive among children and adolescents, most delinquency is minor, most youths who commit minor delinquent acts are not particularly distinctive in their personal characteristics or family background, and in most cases the delinquency constitutes a passing phase that will come to an end without the need for rigorous intervention.

M. RUTTER & H. GILLER, *supra* note 87, at 350-51.

93. See, e.g., *id.* at 361 (noting that antisocial behavior typically begins during adolescence and ceases in young adulthood).

the end if it undermines due process. The traditional quid pro quo theory of juvenile law<sup>94</sup> denigrates the fundamental interests lost in the name of treatment.<sup>95</sup> The legal system should be supported in its preservation of the reality and appearance of justice, no matter what the consequences are for treatment.<sup>96</sup> The fact that the "treatment" often has been ineffective or even harmful simply compounds the insult to the integrity of juvenile respondents and their families.

### C. Formal, Adversary Procedures Are Not Conducive to Rehabilitation

The notion that criminal procedure is ill-suited to resolution of matters pertaining to children, youth, and families is deeply embedded in the traditions of the juvenile court. Indeed, in the pre-*Gault* years, it was easy for juveniles to be committed to a training school without ever realizing that they had been in court. The image painted by the words of Judge Mack is illustrative:

The child who must be brought into court should, of course, be made to know that he is face to face with the power of the state, but he should at the same time, and more emphatically, be made to feel that he is the object of its care and solicitude. The ordinary trappings of the court-room are out of place in such hearings. The judge on a bench, looking down upon the boy standing at the bar, can never evoke a proper sympathetic spirit. Seated at a desk, with the child at his side, where he can on occasion put his arm around his shoulder and draw the lad to him, the judge, while losing none of his judicial dignity, will gain immensely in the effectiveness of his work.<sup>97</sup>

Even today, juvenile courtrooms often more closely correspond to the conference rooms of child guidance centers than the courtrooms in which other matters are heard. The notion persists among professionals and the general public that formal adversary procedures are inconsistent with the psychological well-being of children and youth, a belief that has been given credence by the Supreme Court.<sup>98</sup>

In keeping with the historic, still prevalent belief in the innocence

94. *Gault* repudiated the idea that juveniles' right to due process is properly sacrificed in the name of treatment. *In re Gault*, 387 U.S. 1, 13 (1967).

95. *Cf. O'Connor v. Donaldson*, 422 U.S. 563, 578 (1975) (Burger, C.J., concurring).

96. Of course, those systems that have a legitimate purpose of personal and social change should not neglect the treatment of troubled and troublesome youth. The emphasis on pursuit of justice in the legal system need not diminish the commitment of the mental health and child welfare systems to assistance to troubled youth. Such an emphasis also need not prevent juvenile justice authorities' provision of needed treatment as an element of humane care of those juveniles desiring such services.

97. Mack, *supra* note 28, at 120.

98. See *Parham v. J. R.*, 442 U.S. 584, 610 (1979). It is not mere coincidence that the alternative dispute resolution movement has had its greatest success in legal matters pertaining to children and families. But see Melton, *Family and Mental Hospital as Myths: Civil Commitment of Minors*, in *CHILDREN, MENTAL HEALTH, AND THE LAW* (N. Reppucci, L. Weithorn, E. Mulvey & J. Monahan eds. 1984); Melton & Lind, *Procedural Justice in Family Court: Does the Adversary Model*

and vulnerability of youth, the intuition of many adults is that children and youth develop most fully when they are shielded from conflict—hence, from adversariness. That view is overly simple. Although chronic exposure to *uncontrollable* conflict may impair children's development,<sup>99</sup> the opportunity to *resolve* conflict actually may enhance psychological growth, especially in older children and youth who may experience a sense of accomplishment.<sup>100</sup> Experience in decisionmaking also may foster a greater appreciation of diverse points of view and, therefore, may stimulate legal and moral socialization.<sup>101</sup> Regardless, the reality is that juveniles accused of delinquent or status offenses already are in a state of conflict with the state and specific adverse parties, often including their parents. Otherwise, there would be no reason for court involvement. The question is not whether to foster conflict in juvenile court, but how to resolve the conflict already present most fairly.

In that regard, psychological research and theory support the *Gault* assumption that the "fundamental requirements of due process" are also the requisites for a psychologically satisfying resolution of the juvenile's predicament: "[T]he appearance as well as the actuality of fairness, impartiality and orderliness—in short, the essentials of due process—may be a more impressive and more therapeutic attitude so far as the juvenile is concerned."<sup>102</sup>

Indeed, benefit to the family as a whole may accrue from due attention to procedural protections. Even when the parents' and juveniles' interests are ostensibly in conflict, a structure to assure that less restrictive alternatives are considered is apt to promote family integrity and parental satisfaction by avoiding unnecessary fractionation of the family.<sup>103</sup> By the same token, affirmative efforts to ensure that minors have a say in what happens to them increase the likelihood that treatment will be successful.<sup>104</sup> Thus, even if the Constitution did

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*Make Sense?*, in LEGAL REFORMS AFFECTING CHILDREN AND YOUTH SERVICES (G. Melton ed. 1982).

99. See, e.g., Emery, *Interpersonal Conflict and the Children of Discord and Divorce*, 92 PSYCHOLOGICAL BULL. 310 (1982).

100. See, e.g., DeCharms, *Personal Causation and Perceived Control*, in CHOICE AND PERCEIVED CONTROL (1979). See generally STRESS, COPING AND DEVELOPMENT IN CHILDREN (N. Garmezy & M. Rutter eds. 1983).

101. See generally Melton, *supra* note 89.

102. *In re Gault*, 387 U.S. 1, 26 (1967). The psychological evidence on the significance of due process for children and youth is discussed in Section III(A) *infra*.

103. See G. MELTON & W. SPAULDING, *supra* note 81; Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's "Time-Consuming Procedural Minuets" Theory in Parham v. J. R.*, 9 BULL. AM. ACAD. PSYCHIATRY & L. 149 (1981).

104. See, e.g., Adelman, Lusk, Alvarez & Acosta, *Competence of Minors to Understand, Evaluate, and Communicate about Their Psychoeducational Problems*, 16 PROF. PSYCHOLOGY: RES. & PRAC. 426 (1985); Brigham, *Some Effects of Choice on*

not demand recognition of the due process rights of juvenile respondents, preservation of adversary process in juvenile court would be consonant with the state's interests and therefore justifiable on utilitarian grounds.

#### D. Summary: A Bankrupt Legal Theory

A review of the assumptions underlying the juvenile court shows it to be a bankrupt legal institution. The theories that have guided juvenile law through the twentieth century are without foundation. Adolescents are neither so irresponsible nor so responsive to treatment as to justify a separate juvenile court. Even if the Constitution permits an incomplete application of adversary procedures to juvenile court,<sup>105</sup> neither common sense nor psychological research supports the premise that a nonadversary approach to delinquency adjudications would foster more effective treatment.

In short, the juvenile court cannot rest on its historic rationales. If *Gault* itself did not result in an outright abolition of the juvenile court, its logic appears to push toward that end. As the Supreme Court recognized, the traditional juvenile court was inconsistent with constitutional mandates for due protection of the liberty interests of juvenile respondents. Post-*Gault* developments give no reason to believe that public policy is consistent with maintenance of the residue of the historic juvenile court, because the philosophical and empirical foundations for the court have been shattered.

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*Academic Performance*, in CHOICE AND PERCEIVED CONTROL (1979); Holmes & Urie, *Effects of Preparing Children for Psychotherapy*, 43 J. CONSULTING & CLINICAL PSYCHOLOGY 311 (1975); Lewis, *supra* note 45; Lewis & Lewis, *Improving the Health of Children: Must the Children Be Involved?*, 4 ANN. REV. PUB. HEALTH 259 (1983); Melton, *supra* note 89; Taylor, Adelman & Kaser-Boyd, *Exploring Minors' Reluctance and Dissatisfaction with Psychotherapy*, 16 PROF. PSYCHOLOGY: RES. & PRAC. 418 (1985); Taylor, Adelman & Kaser-Boyd, *Minors' Attitudes and Competence Toward Participation in Psychoeducational Decisions*, 16 PROF. PSYCHOLOGY: RES. & PRAC. 226 (1985).

The importance of ensuring a voice for juveniles even in emotion-laden decisions is illustrated by the fact that children's participation in decisions about foster placements increases the likelihood that the placements will be successful. Bush & Gordon, *Client Choice and Bureaucratic Accountability: Possibilities for Responsiveness in a Social Welfare Bureaucracy*, 34(4) J. SOC. ISSUES 22 (1978); Bush, Gordon & LeBailly, *Evaluating Child Welfare Services: A Contribution from the Clients*, 51 SOC. SERV. REV. 491 (1977).

105. *In re Gault*, 387 U.S. 1 (1967), made clear that juveniles accused of delinquent offenses are entitled to the rudiments of an adversary system: e.g., representation by counsel, confrontation of one's accusers, and the privilege against self-incrimination. However, subsequent cases have suggested that some constitutionally mandated elements of criminal procedure may not be required in juvenile court. See, e.g., *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971). Also, the Supreme Court has approved of nonadversary procedures in decisionmaking about mental treatment involving minors. *Parham v. J. R.*, 442 U.S. 584 (1979).

Nonetheless, I do believe that a juvenile court is desirable, but only if it is a truly new juvenile court fully consistent with the spirit of *Gault*. I advocate a juvenile court that has more, rather than fewer, procedural protections available than in criminal courts. Such a new court would be based on acceptance of the *Gault* respect for the personhood of juveniles, combined with a psychological understanding of children's and adolescents' comprehension of fundamental legal rights and their (lack of) access to procedures necessary to vindicate those rights.

### III. WHY DUE PROCESS REQUIRES A NEW JUVENILE COURT

#### A. The Developmental Psychology of Procedure

##### 1. *The Salience of Freedom*

In constructing a new juvenile court, the most fundamental point that must be recognized is that liberty and privacy are important to children and youth, just as they are to adults. Attempts to deny the moral personhood of children must take into account the fact that the attributes associated with concern for human dignity are displayed at a quite young age. Courts cannot legitimately deny rigorous protection of minors' liberty on the ground that it is unimportant.<sup>106</sup>

Even very young children find choice to be reinforcing and meaningful.<sup>107</sup> More directly germane to the circumstances in which juveniles' liberty is threatened by the state, even the best residential treatment programs are experienced as aversive by the children and youth placed in them.<sup>108</sup> The more "institutional" and less normalized a placement outside the natural family is, the more intense the resulting anger and sense of degradation are.<sup>109</sup>

106. *But see* Schall v. Martin, 467 U.S. 253, 265 (1984) ("The juvenile's countervailing interest in freedom from institutional constraints, even for the brief time involved here, is undoubtedly substantial . . . [b]ut that interest must be qualified by the recognition that juveniles, unlike adults, are always in some form of custody.").

107. *See, e.g.,* Brehm, *The Effect of Adult Influence on Children's Preferences: Compliance versus Opposition*, 5 J. ABNORMAL CHILD PSYCHOLOGY 31 (1977); Brehm & Weinraub, *Physical Barriers and Psychological Reactance: 2-Year-Olds' Responses to Threats to Freedom*, 35 J. PERSONALITY & SOC. PSYCHOLOGY 830 (1977).

108. *See, e.g.,* E. Roth & L. Roth, *Children's Feelings about Psychiatric Hospitalization: Legal and Ethical Implications* (paper presented at the meeting of the Am. Orthopsychiatric Ass'n, Toronto, Apr. 1984).

109. *See* Bush, *Institutions for Dependent and Neglected Children: Therapeutic Option of Choice or Last Resort?*, 50 AM. J. ORTHOPSYCHIATRY 239 (1980). *See generally* L. RIVLIN & M. WOLFE, *INSTITUTIONAL SETTINGS IN CHILDREN'S LIVES* (1985) (discussing the relationship between institutional invasions of privacy and children's self-esteem).

## 2. *The Social Psychology of Procedural Justice*

If maintenance of liberty and privacy is important to juveniles, then it should come as no surprise when they desire procedures that provide the level of care due in a matter as serious as the potential diminution of such primary goods. In that regard, the large body of research and theory on perceived procedural justice should be informative.<sup>110</sup> Encompassing scores of studies, such research has produced findings that have proven robust across settings, populations, and methods. To summarize, studies of perceived justice have shown that perceptions of the fairness of procedures for dispute resolution provide much of the foundation for individuals' overall level of satisfaction with the legal and political systems. Indeed, perceptions of procedural justice color perceptions of distributive justice (the fairness of the outcome), especially when the outcome is negative.

Process control—the opportunity for each disputant to have a say and to present one's case as one sees fit—is the strongest element in procedural justice. Consequently, both disputants and observers express greater satisfaction with adversary procedures than inquisitorial ones, even in societies in which the latter predominate in the legal system. Care in ensuring that underdogs are heard enhances the evaluation of authorities and the institutions they represent.

The second most important element in perceived procedural justice is ethical appropriateness—treating the parties with respect for their personal dignity.<sup>111</sup> The legal process is viewed more positively when disputants are treated politely and their rights are protected.

The two remaining factors known to affect perceptions of procedural justice are ones that are well known to legal policymakers: honesty and consistency. People desire to be treated forthrightly; dishonest behavior, especially by those in authority, violates the rudiments of respect for persons and fidelity to social contracts. By the same token, the most basic considerations of equity demand that parties in like circumstances be treated alike. Decisions should be predictable rather than arbitrary, and they should not be based on irrelevant personal or social characteristics. An unreliable legal system administers justice ineffectively.

## 3. *Developmental Factors in Use of Procedural Protections*

Whether the conclusions of social psychological studies of proce-

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110. See, e.g., Leventhal, *What Should Be Done with Equity Theory?*, in SOCIAL EXCHANGE: ADVANCES IN THEORY AND RESEARCH (1980); Thibaut & Walker, *A Theory of Procedure*, 66 CALIF. L. REV. 541 (1978). A lucid comprehensive review of empirical research on procedural justice is provided in E. A. LIND & T. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* (1988).

111. See Tremper, *Respect for the Dignity of Minors: What the Constitution Requires*, 39 SYRACUSE L. REV. 1293 (1988).

dural justice can be generalized to children and youth is an empirical question. Unfortunately, few studies have addressed that question. Nonetheless, the empirical evidence that is available suggests that the same principles underlie adults' and children's responses to the legal system.<sup>112</sup> As already noted, even young children appreciate personal control, and a close corollary would be a desire for a voice in disputes involving them. Even first graders evaluate the fairness of dispute resolution at least in part in terms of the procedures used,<sup>113</sup> and older elementary-school-age children generally understand the basic elements of the adversary process and the reasons for them.<sup>114</sup> Those children who understand the process best are also those who are most likely to perceive it as fair.<sup>115</sup>

Taken together, the various lines of research on procedural justice give ample reason for care in the means by which complaints against juveniles are investigated and adjudicated.<sup>116</sup> Just as for adults, the degree of control that juveniles have in the presentation of their cases and the courtesy with which they are treated by legal authorities are apt to shape their response to the legal system. Consequently, even if not mandated by ethics and the Constitution, the preservation of due process in juvenile court would be important in order to socialize respect for the law as an institution. The appearance of fairness is at least as important in juvenile court as in other legal contexts.

At the same time, though, research suggests that due process for juveniles may be different from that for adults. Evidence from Thomas Grisso's program of research on juveniles' waivers of rights is

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112. For more extensive discussions of the usefulness of social psychological theory and research in juvenile and family law, see Melton & Limber, *Psychologists' Involvement in Cases of Child Maltreatment: Limits of Role and Expertise*, 44 AM. PSYCHOLOGIST— (1989)(in press); Melton & Lind, *supra* note 98.

113. Gold, Darley, Hilton & Zanna, *Children's Perceptions of Procedural Justice*, 55 CHILD DEV. 1752 (1984).

114. In a project I am directing that is nearing completion (National Center on Child Abuse and Neglect Grant No. 90-CA-1274), studies of children in sexual abuse cases and children in general are showing substantial knowledge of the legal process by the mid-elementary grades, sometimes with greater knowledge of the nature of the adversary process than of relevant legal vocabulary. The notion that fairness accrues when both parties in a dispute have a say apparently develops quite early.

115. Perceptions of fairness of the legal process are positively correlated with level of knowledge about it. *Id.*

116. Such research has special meaning, given normative presumptions in favor of respect for the dignity of all persons, regardless of age, and corollary concern for the just resolution of disputes, especially when primary goods like liberty and privacy are at stake. In such an ethical and legal framework, hypotheses from relevant research about the means of enhancing justice should be given serious consideration, even when they have not been conclusively demonstrated. In any event, as discussed *infra*, there is a solid theoretical and empirical foundation for such hypotheses in regard to procedural justice in childhood and adolescence.



especially persuasive in that regard.<sup>117</sup> In brief, such studies have shown that juvenile respondents rarely assert their fifth and sixth amendment rights; their parents are typically ineffective advocates or even adversaries; they often do not understand key words in the *Miranda* warning; they often do not comprehend critical phrases in such warnings; and experience in the legal system, by itself, does not alleviate such deficiencies.

Such findings stand in contrast to research on adolescents' decisions in other legally relevant contexts, which almost uniformly has shown youth to be substantially more competent in decisionmaking than the law presumes.<sup>118</sup> The reason for the inconsistency of findings in research on waivers of rights in delinquency proceedings with those in studies of decisionmaking by adolescents in other situations is not entirely clear.<sup>119</sup> Such a discrepancy probably reflects social class differences to some extent.<sup>120</sup> However, the hypothesis that social class accounts for most of the variability is rendered less plausible by the relatively greater displays of competence in some other settings that involve disadvantaged youth in serious decisions.<sup>121</sup>

Particular institutional variables may make adolescents appear to be poor decisionmakers in juvenile court. There is a strong cultural belief that "talking" mitigates children's responsibility for misdeeds, whether minor infractions of home or school rules or serious violations of the law. In a survey of middle-class parents of adolescents,

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117. Grisso, *Juveniles' Capacities to Waive Miranda Rights: An Empirical Analysis*, 68 CALIF. L. REV. 1134 (1980); Grisso, *Juveniles' Consent in Delinquency Proceedings*, in CHILDREN'S COMPETENCE TO CONSENT (1983); Grisso & Lovinguth, *Lawyers and Child Clients: A Call for Research*, in THE RIGHTS OF CHILDREN: LEGAL AND PSYCHOLOGICAL PERSPECTIVES (J. Henning ed. 1982). Professor Grisso's work is summarized and its significance analyzed in detail in Melton, *Making Room for Psychology in Miranda Doctrine: Juveniles' Waiver of Rights*, 7 LAW & HUM. BEHAV. 67 (1983).

118. See *supra* notes 40-45 and accompanying text. Ironically, the law has presumed greater competence of adolescents involved in delinquency investigations and adjudications than of adolescents making decisions in other contexts in which research has shown them to be as competent as adults. Compare, e.g., *Fare v. Michael C.*, 442 U.S. 707, *reh'g denied*, 444 U.S. 887 (1979) (waiver of *Miranda* rights by a 16-year-old defendant held valid), and *Parham v. J. R.*, 442 U.S. 584 (1979) (minors, including adolescents, presumed generally unable to make good decisions about mental health treatment). *Fare* and *Parham* were decided the same day.

119. See Melton, *supra* note 117, at 81-82.

120. Research has shown children's level of reasoning about their rights and their willingness to assert a right to be related to social class. See, e.g., Melton, *Children's Concepts of their Rights*, 9 J. CLINICAL CHILD PSYCHOLOGY 186 (1980). Such group differences are probably related to class differences in the degree that entitlement is actually experienced. See R. COLES, *PRIVILEGED ONES* (1977).

121. Lois Weithorn's work, currently in preparation for publication, shows adolescents in psychiatric facilities to be at least as competent as adult patients in decision-making about treatment.

Professor Grisso found that about one-third would advise their children to confess to police, and about one-half of the remainder said that youth should remain silent *temporarily* until things "cool down" so that the story could be related in a calm atmosphere.<sup>122</sup> In actual interrogations, parents of juvenile respondents rarely advised their children to remain silent; in fact, the majority did not give *any* advice or counsel to their children involved in an undeniably difficult situation.<sup>123</sup> The picture of the outcome is consistent: juveniles rarely invoke their constitutional rights, and younger juveniles (those under age 16) almost never do.<sup>124</sup>

Professor Grisso's studies suggest that juveniles' difficulties in applying their rights in delinquency proceedings emanate most directly from a belief that those rights are not rights at all, but instead are privileges revocable by people in authority.<sup>125</sup> This "immature" belief may be the product of true age differences in reasoning,<sup>126</sup> but it also may reflect an accurate perception of reality in many juvenile courts<sup>127</sup> and within many relationships between juvenile respondents and their attorneys.<sup>128</sup>

Still another explanation for the apparent incompetency of many juveniles in asserting their rights in delinquency proceedings is that many respondents may lack the cognitive skills of most of their peers. Two specific findings lend credence to this interpretation. First, even the oldest juveniles appeared less competent than adults in Professor Grisso's study when the juveniles had IQs less than eighty. Second, there is a high prevalence of learning disabilities among adjudicated juvenile delinquents, despite the fact that learning disabled youth are not disproportionately prone to delinquent behavior, as measured by both self-report and police contacts.<sup>129</sup> The latter finding suggests that juveniles who are less cognitively and socially adept are also less able to take advantage of options for diversion, whether because of

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122. T. GRISSE, JUVENILES' WAIVER OF RIGHTS: LEGAL AND PSYCHOLOGICAL COMPETENCE 180-82 (1981).

123. *Id.* at 185-86.

124. *Id.* at 34-37.

125. *Id.* at 129-30.

126. See Melton, *supra* note 120.

127. See, e.g., I. SCHWARTZ, (IN)JUSTICE FOR JUVENILES: RETHINKING THE BEST INTERESTS OF THE CHILD, 148-66 (1989).

128. Despite the fact that *In re Gault*, 387 U.S. 1 (1967), leaves no question that the juvenile court should be an adversary institution, the proper role of attorneys in juvenile court continues to be a matter of controversy and ambiguity. See generally INSTITUTE OF JUDICIAL ADMINISTRATION AND AMERICAN BAR ASSOCIATION, STANDARDS RELATING TO COUNSEL FOR PRIVATE PARTIES (1976).

129. N. DUNIVANT, A CAUSAL ANALYSIS OF THE RELATIONSHIP BETWEEN LEARNING DISABILITIES AND JUVENILE DELINQUENCY (1984); N. DUNIVANT, IMPROVING ACADEMIC SKILLS AND PREVENTING DELINQUENCY OF LEARNING-DISABLED JUVENILE DELINQUENTS: EVALUATION OF THE ACLD REMEDIAL PROGRAM (1984).

their own lack of adroitness in maneuvering through the juvenile justice system or the appearance (perhaps accurate) that they will be relatively unamenable to treatment.

Whatever the reasons for the apparent incompetence of many youth in the juvenile justice system in exercising their rights, there can be no question of its adverse consequences. Not only do juveniles often waive their rights to silence and counsel during interrogation, they often are not represented by counsel at *any* stage of the proceeding.<sup>130</sup>

## B. A Psychological Approach to Due Process

### 1. *Dual-Maximal Doctrine*

After *Gault*, it is indisputable that the state's position is adverse to juvenile respondents in delinquency proceedings and that minors' liberty is protected by the Constitution. In such a context, defenders of the juvenile court can offer no coherent justification in response to Irene Merker Rosenberg's plaintive "question why, in view of age and competency differentials, the child is given less [procedural] protection rather than more."<sup>131</sup>

As Professor Rosenberg persuasively argued, the logic of *Gault* implies a "dual-maximal approach" that combines "fundamental fairness" and "functional equivalence" in determining the procedures constitutionally necessary to protect the interests of juvenile respondents.<sup>132</sup> In other words, in recognition of the obligation to provide due process, juveniles accused of delinquent offenses should be provided those rights that are necessary to fundamental fairness, even when such rights exceed those possessed by criminal defendants. At the same time, though, juvenile respondents should have all of the rights available to adult defendants, even those not necessarily a part of fundamental fairness as applied to adults, because juvenile proceedings are functionally equivalent to criminal trials. The dual-maximal approach is desirable because "it applies to children all the guarantees already applicable to adult criminal defendants, while also permitting enhanced protection of children because of their vulnerability and im-

130. I. SCHWARTZ, *supra* note 127, at 153-57. Case law originating in criminal cases shows unmistakably that the requisites for competency to waive the right to counsel are stringent, indeed higher than for any other competency in the criminal process. See G. MELTON, J. PETRILLA, N. POYTHRESS & C. SLOGOBIN, *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 99-100 (1987) and cases cited therein. Therefore, it is hard to believe that juvenile courts are exercising due care in accepting waivers of respondents' right to counsel.

131. Rosenberg, *supra* note 20, at 659.

132. *Id.* at 661-73. See also Feld, *Criminalizing Juvenile Justice: Rules of Procedure for the Juvenile Court*, 69 MINN. L. REV. 141 (1984).

maturity without making the additional protection automatically available to adults."<sup>133</sup>

## 2. *An Example: The Privilege Against Self-Incrimination*

The implications of Professor Rosenberg's theory, to which I also subscribe, can be demonstrated by analysis of the Supreme Court's decision in *Fare v. Michael C.*<sup>134</sup> In *Fare*, the Supreme Court held that a juvenile's request for his probation officer during police interrogation was not per se an invocation of *Miranda*<sup>135</sup> rights. Further, applying a totality-of-the-circumstances test, the Court held that Michael C. had made a competent waiver of his rights. The Court did so despite the facts that Michael C. had suspected that any attorney provided by the police would in fact be an undercover police officer,<sup>136</sup> that he trusted and asked for his probation officer,<sup>137</sup> and that he was immature, emotional, and uneducated.<sup>138</sup> Michael C.'s request for the assistance of a trusted adult was functionally equivalent to an adult's request for an attorney and should have been regarded as an invocation of the right to silence and the corollary right to counsel under *Miranda*.<sup>139</sup> Indeed, Professor Grisso's findings about the misunderstanding of fifth

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133. Rosenberg, *supra* note 20, at 671.

134. 442 U.S. 707, *reh'g denied*, 444 U.S. 887 (1979).

135. *Miranda v. Arizona*, 384 U.S. 436 (1966).

136. *Fare v. Michael C.*, 442 U.S. 707, 710-11, *reh'g denied*, 444 U.S. 887 (1979).

137. Michael's probation officer had advised Michael to contact him whenever he had a police contact. *Id.* at 712.

138. This description of Michael was provided by Justice Powell, *id.* at 733, who concurred that a request for a probation officer is not per se an invocation of *Miranda* rights, but who dissented from the holding that Michael had made a competent waiver of his rights.

139. See Melton, *supra* note 117, at 74-76. The Court was concerned that recognition of a juvenile's request for a probation officer as an invocation of the right to silence would open the door to similar rules regarding "one's football coach, music teacher or clergyman." *Fare v. Michael C.*, 442 U.S. 707, 714, *reh'g denied*, 444 U.S. 887 (1979). However, such an expansion is a logical corollary to the fifth amendment-based right to counsel under *Miranda*. After all, when an adolescent has never been permitted independently to contract for professional services before, why should he be expected to call an attorney when he is in the unusual and difficult situation of interrogation for a serious crime?

If the assistance of counsel is needed to render the privilege against self-incrimination meaningful for competent adults, surely such protection should also be available to juvenile suspects. See *In re Gault*, 387 U.S. 1, 47 (1967) ("It would indeed be surprising if the privilege against self-incrimination were available to hardened criminals but not to children."). As a practical matter, to achieve such protection absent automatic provision of counsel during interrogation, a court should treat a juvenile's request for a trusted adult in terms of both its plain meaning (i.e., access to the adult friend or relative should be provided) and its implicit meaning of a request for legal assistance (i.e., interrogation should be halted until the juvenile's attorney is present and advises his or her client to "talk").

and sixth amendment rights that is endemic among juvenile respondents logically lead further: confessions of juveniles should not be admitted unless counsel was present during interrogation.<sup>140</sup>

Although the privilege against self-incrimination may be unnecessary to fundamental fairness,<sup>141</sup> the doctrine of functional equivalence ensures that juveniles are provided at least those rights that are owed criminal defendants. Once the right has been applied, the doctrine of fundamental fairness requires that its application is meaningful. The latter doctrine leads in some circumstances to rights that are broader for juveniles than for similarly situated adults.

Therefore, not only should the right to silence be unwaivable by juveniles without the advice of counsel, but the right to counsel itself should not be waivable by juveniles except in extraordinary cases, if at all.<sup>142</sup> Indeed, the policy of promotion of the appearance and fairness of adjudication of charges of delinquency implies the need for a juvenile court, but the court should be a "super-court" rather than a quasi-social-service agency dispensing a watered-down form of justice.

### 3. *The Need for Empirical Data*

In designing the new juvenile court, the overarching question should be the nature and scope of procedures needed to ensure both that respondents *are* treated fairly and that they *feel* they are being treated fairly. In other words, legal policymakers should explore the procedural forms necessary to make justice *meaningful*, in all senses of that word.

For example, the Supreme Court has refused to extend the right to a jury trial to juveniles.<sup>143</sup> It has done so because of a nostalgic desire to save a court whose time has passed.<sup>144</sup> If *Gault* were to be taken

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140. Grisso, *supra* note 117, at 1161-63.

141. Rosenberg, *supra* note 20, at 668-71. See, e.g., *In re Gault*, 387 U.S. 1, 65-78 (1967) (Harlan, J., concurring in part and dissenting in part).

142. As already noted, *supra* note 130, fair application of existing law affecting criminal defendants should result in few, if any, valid waivers of counsel by juvenile respondents. Nonetheless, data on the frequency of waivers permitted by juvenile courts, *supra* note 130, indicate the need for a stronger standard therein.

I recognize that such an approach would result, in a sense, in fewer rights for juveniles. See *Faretta v. California*, 422 U.S. 806 (1975) (when the waiver of counsel is knowing, intelligent, and voluntary, the sixth amendment requires courts to permit defendants to proceed *pro se*). However, research on juveniles' waiver of the right to counsel shows that extraordinary care is necessary if such a waiver is to be executed competently by a juvenile. The assistance of counsel is so important to an adequate defense that some abrogation of the right to self-representation is likely in most cases to ensure greater protection of juveniles' rights.

143. *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

144. Consider the following quote from *McKeiver* in the light of the *Gault* attack on the juvenile court as a "kangaroo court": "There is a possibility, at least, that the jury trial, if required as a matter of constitutional precept, will remake the juve-

seriously, there should be no question of the applicability of the sixth amendment to juveniles under the doctrine of functional equivalence. Nonetheless, the need to preserve fundamental fairness leaves open the question whether the jury must be reshaped to fulfill its purposes when applied to juveniles.<sup>145</sup> If the sense of equity that the jury embodies<sup>146</sup> is to be preserved for juveniles, then its form may require some alteration, while not negating the right itself.<sup>147</sup>

The example of the possible application of the right to trial by jury raises the broad need for psychological research on juvenile procedure, because evidence now is lacking about the meaningfulness of particular procedures when applied in juvenile court. Perhaps under the auspices of the State Justice Institute, the National Center for State Courts, or a similar organization, a large research program is needed to test the effects of various procedures; to determine the symbolism of the procedures; and to identify the specific procedures that are most likely to help juveniles take an active role in their defense, but that still provide due protection of their interests. The initial attempts to establish a new juvenile court in the spirit of *Gault* should be accompanied by appropriate evaluation research and should be modified in keeping with the results of such studies.<sup>148</sup>

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nile proceeding into a fully adversary process and will put an effective end to what has been the idealistic prospect of an intimate, informal protective proceeding." *McKeiver v. Pennsylvania*, 403 U.S. 528, 545 (1971).

145. In *Williams v. Florida*, 399 U.S. 78 (1970), the Supreme Court identified the primary purpose of the jury as being the prevention of state oppression, a purpose that is met through "the interposition between the accused and his accuser of the commonsense judgment of a group of laymen, and in the community participation and shared responsibility that results from that group's determination of guilt or innocence." *Id.* at 100. It is at least plausible that such "community participation and shared responsibility" is experienced differently when juveniles are judged.
146. *Id.* See also Melton, *Introduction: The Law and Motivation*, in 33 NEB. SYMP. ON MOTIVATION: THE LAW AS A BEHAVIORAL INSTRUMENT xvii-xviii (G. Melton ed. 1985) (the significance of the jury may rest primarily in the symbolism entailed in "the expression of the community conscience" and the resulting effects on perceived justice).
147. An underlying issue in *McKeiver* may have been the conceptual difficulties in constituting a jury of a juvenile's peers. *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).
148. A general need in psycholegal research is for analysis of the effects of various innovations ("natural experiments") by legislatures and courts by comparing trends across jurisdictions. Steadman, *Mental Health Law and the Criminal Offender: Research Directions for the 1990's*, 39 RUTGERS L. REV. 323, 328 (1987). The University of Nebraska's Center on Children, Families, and the Law is the hub of a consortium combining the efforts of similar centers at six universities and in several professional organizations and policy centers. Such a multistate consortium is especially well situated to evaluate the impact of significant juvenile reform when some states do begin to take *Gault* more seriously.

#### 4. *The Role of Counsel*

As should be obvious by now, I expect that the range of procedures necessary to fundamental fairness in juvenile court is sufficiently disparate from criminal court to merit the existence of the former. I do not expect, though, that a specialized bench is necessary to such a court.<sup>149</sup> The more lawful the court is, presumably the less need there is for a specialized judiciary.<sup>150</sup> The sorts of decisions that a judge must make in the new juvenile court should be similar to those in criminal courts and, therefore, well within the expertise of general-jurisdiction judges.

On the other hand, there may be a need for a specialized bar in the new juvenile court. By stating this conclusion I do not mean to imply that attorneys for juveniles should depart from the role of zealous advocate. It is exceedingly rare that children appear in delinquency proceedings when they are so young that they cannot reasonably instruct legal counsel,<sup>151</sup> an event that is likely to be even more uncommon when the defense of infancy is restored.

Given the just presumption that litigating parties should have the opportunity to have their say,<sup>152</sup> ascription of a lesser role to juvenile clients establishes an untenably high threshold for assistance in one's defense, as the drafters of the Juvenile Justice Standards recognized:

It has sometimes been suggested that all or most of a juvenile court lawyer's clientele is not sufficiently mature to instruct counsel in any usual sense and that counsel must, therefore, usually act as guardian or *amicus curiae*. The proponents of this view often tend, however, to equate competence with capacity to weigh accurately all immediate and remote benefits or costs associated with the available options. In representing adults, wisdom of this kind is not required; it is ordinarily sufficient that clients understand the nature and purposes of the proceedings, and its general consequences, and be able to formulate their desires concerning the proceeding with some degree of clarity. Most adolescents can meet this standard, and more ought not to be required of them. To do so would, in effect, reintroduce the identification of state and child by imposing on respondents an "objective" definition of their interests.<sup>153</sup>

In the instances in which juvenile respondents do not meet such a

149. Even under existing juvenile procedure, the necessity of a specialized bench is questionable. For example, Nebraska has a traditional juvenile code; see, e.g., NEB. REV. STAT. § 43-245 (1988). Nonetheless, only three Nebraska counties have separate juvenile courts with specialized judges. NEB. REV. STAT. § 43-2,111 (1988).

150. The American Bar Association has favored rotation of general-jurisdiction judges through the juvenile or family court. A.B.A. JUVENILE JUSTICE STANDARDS RELATING TO COURT ORGANIZATION AND ADMINISTRATION §§ 1.1 & 2.1 (1980).

151. See A.B.A. JUVENILE JUSTICE STANDARDS RELATING TO COUNSEL FOR PRIVATE PARTIES pt. III & commentary (1980) [hereinafter A.B.A.].

152. See *supra* notes 111-17 and accompanying text.

153. A.B.A., *supra* note 151, commentary at 8.

low standard, they should be declared incompetent to proceed.<sup>154</sup> That possibility negates any possible question about cases in which an attorney might need to move away from an advocate's role.

Attorneys' ethical duty to represent their clients' interests as defined by the client does not mean, of course, that they should abandon any counseling role.<sup>155</sup> Indeed, effective representation requires substantial investment of time and effort in educating clients about their rights and the options available to the court and the clients themselves. When significant misunderstanding or ignorance about such matters is present, as it often is with juvenile clients, that investment should increase proportionately.

Effective representation of juveniles does not imply simply an increased allotment of time to counseling. The nature of the counseling also may be qualitatively different. Attorneys representing juveniles should be knowledgeable about the nature of common gaps or errors in juveniles' information about the legal process; the kinds of interventions that are necessary to persuade juveniles that their rights are indeed entitlements; the range of dispositional alternatives (especially those that are relatively unrestrictive) available to the court; and the formal and informal procedural innovations that are useful in promoting juveniles' active involvement in their defense and in ensuring that they are treated fairly and perceive that they have been so treated.

Beyond such specialized knowledge, obviously including knowledge about the law that is specific to juvenile procedure, attorneys representing juveniles should have skills in relating to young clients. Specialized clinical courses and clerkships would be desirable.

Whether such expertise can be easily acquired by practicing lawyers who occasionally handle juvenile cases is an empirical question that ultimately should be answered through empirical research. However, I am skeptical. It is at least plausible that lawyering in the juvenile court—ensuring that juvenile respondents are full adversaries—will require development of a specialized bar.

#### IV. THE PROBLEM OF RESPONSIBILITY: A RETURN TO THE PAST IN THE NEW JUVENILE COURT

If the juvenile court is to be based primarily on protection of the process due children and youth in an adverse relation to the state, some consideration still must be given to the problem of responsibility. Even if the general presumption of irresponsibility that has guided the juvenile court cannot be justified, surely there are children who are so

154. *In re Causey*, 363 So. 2d 472 (La. 1979); *In re S. W. T.*, 277 N.W.2d 507 (Minn. 1979). See Grisso, Miller & Sales, *Competency to Stand Trial in Juvenile Court*, 10 INT'L J. L. & PSYCHIATRY 1 (1987).

155. A.B.A., *supra* note 151, commentary at 8-9.



immature that their behavior would be properly excused. Although prosecution in such an instance is unlikely to say the least, a two-year-old accused of assault and battery on a playmate in the sandbox surely does not deserve criminal punishment, regardless of the malicious, premeditated manner in which sand was thrown.

As the rehabilitative underpinnings of the juvenile court have withered away, courts have increasingly been faced with the problem of determining individual juveniles' responsibility, especially in those jurisdictions in which punitive purposes have been expressly recognized in juvenile codes.<sup>156</sup> In such cases, the question is whether the existence of a juvenile court, even a punitive juvenile court, obliterates the need to resurrect the defense of infancy that applied in criminal law prior to the invention of an ostensibly benevolent court for wayward youth.

In the same manner that pre-*Gault* courts conclusorily rejected criminal procedural protections in a "civil" juvenile court, some courts have summarily rejected the application of the defense of infancy when the juvenile court still exists. For example, the Rhode Island Supreme Court upheld the finding of delinquency of a twelve-year-old boy accused of raping a five-year-old girl, despite the respondent's attempt to assert an infancy defense:

Once one accepts the principle that a finding of delinquency or waywardness in a juvenile proceeding is not the equivalent of a finding that the juvenile has committed a crime, there is no necessity of a finding that the juvenile had such maturity that he or she knew what he or she was doing was wrong.<sup>157</sup>

Dissenting Justice Feldman understood the critical issue, though. Recalling the United States Supreme Court's insights in *Gault*, he concluded that failure to provide criminal defenses like the defense of infancy in juvenile court was necessarily dependent on a ruse:

What the State cannot do is impose criminal sanctions upon a juvenile under the guise of treatment or rehabilitation, when confinement and incarceration is the likely or possible result. Allowing criminal prosecution and punishment . . . by the simple expedient of calling such prosecution "civil" or "rehabilitative" confers too much dignity on juvenile court euphemisms. It is only to the love-struck poet that stone walls do not a prison make, nor iron bars a cage. To the rest of mankind, to be "awarded" to the department of corrections and put behind stone walls or iron bars is to be in prison, even if it is called "juve-

156. See Gardner, *supra* note 34, at 132 n.17, and authorities cited therein.

157. *In re Michael*, 423 A.2d 1180, 1183 (R.I. 1981). Accord *Gammmons v. Berlat*, 144 Ariz. 148, 696 P.2d 700 (1985). Similar logic was used by a New York family court that found a nine-year-old boy to be delinquent for having robbed a bank. *In re Robert M.*, 110 Misc. 2d 113, 441 N.Y.S.2d 860 (Fam. Ct. 1981). The court rejected the defense's argument that Robert was merely playing, found that he possessed the relevant *mens rea*, and refused to consider an infancy defense. See also *Jennings v. State*, 384 So. 2d 104 (Ala. 1980) (scope of juvenile jurisdiction is a matter of legislative discretion).

nile rehabilitation."<sup>158</sup>

Those courts that have found the defense of infancy to apply in juvenile court often have seemed to take a result-oriented approach that may have satisfied the court's sense of justice in the particular case but failed to address fully the principle at issue. For example, in finding that the New York Family Court Act does not obliterate common-law presumptions in regard to the defense of infancy, a family court judge gave a colorful account of the adjudication of an eight-year-old boy charged with burglary and possession of stolen property:<sup>159</sup>

Standing at full height, the top of Andrew's head barely clears the counsel table in the courtroom.

One look at this respondent is sufficient to prompt the conclusion that the juvenile justice system clearly was not designed for his level of maturity and development. Despite the fact that he meets the technical definition of the jurisdictional statute [regarding age] . . . the court has serious doubts that he is capable of understanding concepts of criminal liability or any facets of the judicial process in which he finds himself.<sup>160</sup>

Similarly, even though faced with a specific statutory disavowal of the defense of infancy,<sup>161</sup> a New Jersey court dismissed charges of aggravated sexual assault against three boys, aged six through nine, who had forcibly penetrated the vagina of a six-year-old girl with their fingers.<sup>162</sup> The court found that the boys were incapable of understanding the "intangible elements" and "symbolic knowledge" required for a "knowing sexual penetration."<sup>163</sup> The court concluded that the state's interests would not be harmed by a failure to assume jurisdiction over "juveniles who are simply too young to be capable of behavior needful of state oversight."<sup>164</sup>

One state supreme court has given forthright attention to the implications of *Gault* for consideration of juveniles' responsibility for delinquent behavior. In the state with a juvenile justice system most closely tailored to fit a retributive model,<sup>165</sup> the Washington Supreme

158. *Gammons v. Berlat*, 144 Ariz. 148, 154, 696 P.2d 700, 705 (1985) (Feldman, J., dissenting).

159. *In re Andrew M.*, 91 Misc. 2d 813, 398 N.Y.S.2d 824 (Fam. Ct. 1977).

160. *Id.* at 814, 398 N.Y.S.2d at 825. The court's opinion was not purely result oriented. Noting the compatibility between post-*Gault* conceptions of the juvenile court and recognition of the defense of infancy, the court concluded that the idea that the juvenile court is "almost criminal" is "a historical vestige with roots in pre-*Gault* philosophy which falls in the face of the reality of minimum periods of secure incarceration" required under recent legislation. *Id.* at 815, 398 N.Y.S.2d at 826.

161. N.J. STAT. ANN. § 2C:14-5(b) (West 1982).

162. *State ex rel. C.P. & R.D.*, 212 N.J. Super. 222, 514 A.2d 850 (Super. Ct. Ch. Div. 1986).

163. *Id.* at 233, 514 A.2d at 856.

164. *Id.*

165. See WASH. REV. CODE ANN. §§ 13.04-13.06.010 (Supp. 1988).

Court unanimously held that the newly defined "criminal nature" of juvenile proceedings made the infancy defense applicable.<sup>166</sup>

Assuming, as *Gault* makes clear, that juvenile proceedings are quasicriminal, the defense of infancy should be available to those children who fall within its historic bounds. Complete exoneration of some children does not mean, though, that those youth who are responsible for their misdeeds should be subject to the full force of the criminal law. As I have already discussed, recognition that juveniles are responsible still leaves room for mitigation because of immaturity.<sup>167</sup> Although such a partial responsibility theory could be accommodated within criminal courts by an age-graded sentencing scheme,<sup>168</sup> it also is consistent with the model of a new juvenile court which I am proposing.<sup>169</sup> If juveniles are to be subjected to *any* punishment, then they should be provided the protections embedded within criminal procedure, modified as necessary to ensure that such procedures meet the special demands of fundamental fairness as applied to youth.

## V. CONCLUSIONS

Despite the fact that the juvenile court is a relatively recent development in Anglo-American jurisprudence, it has seemed firmly established as a stable legal institution. It has remained so even though its underlying assumptions have been discredited, many of its unique features were eliminated by *Gault* and its progeny, and the court's remaining special aspects have been the object of criticism from both the left and the right.

The time has come to take seriously the message of *Gault* and to institute procedures designed to facilitate justice for juveniles accused of delinquent behavior. Mental health professionals long have been misused in juvenile court to sustain the illusion of a therapeutic institution operating in youth's behalf. Perhaps through critical examination of the court's assumptions and the perceived justice of its procedures (current and potential), psychologists and other behavioral scientists can begin to be used in the service of a more just institution

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166. *State v. Q.D.*, 102 Wash. 2d 19, 22, 685 P.2d 557, 560 (1984). The Washington Supreme Court has not been consistent in its recognition of the implications of an overtly punitive juvenile justice system in that state. See, e.g., *State v. Schaff*, 109 Wash. 2d 1, 743 P.2d 240 (1987) (right to jury trial does not apply).

167. See *Thompson v. Oklahoma*, 108 S. Ct. 2687 (1988).

168. Such an approach was taken under the Youthful Offenders Act that formerly guided sentencing of young adults in federal criminal courts.

169. Although I am arguing on other grounds for maintenance of the juvenile court (albeit in substantially altered form), my proposal also would satisfy the need that Professor Gardner has articulated for a separate juvenile court in order to preserve the appearance of reduced culpability of juvenile offenders. See *supra* notes 34-36 and accompanying text.

affecting children and youth. For example, psychologists can assist in developing and applying the knowledge necessary to teach youth how to use their rights. Similarly, they can evaluate procedures to determine those that enable youth really to have their say and to feel that they were treated fairly.

At the same time, withdrawal of reliance on the juvenile court is likely to make the child mental health and social service systems more protective of the privacy and autonomy of child clients and thus more humane and just. Not only have juvenile courts misused mental health professionals; mental health professionals also have misused juvenile courts as a coercive "therapeutic" instrument.<sup>170</sup> With a truly new juvenile court, the integrity of both the justice system and the human service system is likely to prosper.

In reaching such conclusions, I am mindful of the difficulty of the task. As Professor Feld noted, "[t]he juvenile court has demonstrated a remarkable ability to deflect, co-opt, and absorb ameliorative reform virtually without institutional change."<sup>171</sup> Nonetheless, the interests at stake are fundamental. More than twenty years after *Gault*, it is certainly time to consider carefully its implications and to design, evaluate, and implement procedures consistent with meaningful justice for youth.

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170. An example of such an abuse of the juvenile justice system is the practice that I have observed occasionally of a mental health or social service professional's filing a status offense petition in order to attempt to force another agency to provide services, pursuant to a court order. Given the statutory label of "children in need of services" ("CHINS kids") for status offenders in many jurisdictions, what could be a better example than a child who apparently needs court jurisdiction in order to receive services? Such a strategy is obviously flawed, though, by its imposition of a *de facto* punitive sanction against an individual child when "the system" is the culprit. Similar problems are present when agencies attempt to compensate for their own understaffing by use of the court's "hammer" and staff resources to ensure that juvenile clients comply with treatment plans.

171. Feld, *supra* note 132, at 276.

# **Psychologists' Involvement in Cases of Child Maltreatment**

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# Psychologists' Involvement in Cases of Child Maltreatment

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## *Limits of Role and Expertise*

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**ABSTRACT:** *As psychologists have become increasingly involved in the investigatory and adjudicative phases of child maltreatment cases and as criminal prosecutions have become increasingly common in such cases, the ethical problems facing psychologists have become more acute. Psychologists involved in cases of child maltreatment should remember their primary duty to promote human dignity. In that regard, care must be taken to protect the rights of the various parties, assist the parties to make use of the legal process, and keep implicit or express promises, including those emanating from professional roles. Psychologists must be careful to avoid intruding into the province of legitimate decision-making authorities.*

With the dramatic increase in reporting and criminal prosecution of child maltreatment, especially sexual abuse, the roles of psychologists and other mental health professionals in the process have changed. Historically, psychologists' roles in cases of child maltreatment have been limited to the beginning and end of the legal process. Although psychologists might initiate an investigation through a report of suspected maltreatment, until recently, the investigation itself usually was exclusively in the hands of child protective workers and law enforcement officers. Psychologists were likely to be involved minimally, if at all, in the investigation. Similarly, if a case was believed by investigators to be substantiated, psychologists also were rarely involved in any civil or criminal adjudicatory hearing (trial) to determine whether abuse had occurred.

Only after such a finding of fact did psychologists typically enter the case. As clinical evaluators, psychologists might then assess a child's or family's need for services. A report might be provided to the court, or the psychologist might testify as an expert in the dispositional phase of the proceedings. Finally, psychologists might be involved as therapists in implementing the court's dispositional orders.

Recently, however, psychologists have become increasingly involved in the investigatory process, especially in sexual abuse cases. In some jurisdictions, psychologists and other mental health professionals are the primary

interviewers of the child victim and sometimes other key informants. In short, psychologists often now are used to gather evidence for the prosecution and, substantially less frequently, the defense.

The use of psychologists as experts in the adjudicatory phase of child maltreatment cases also appears to be growing steadily, as evidenced by numerous scholarly articles and appellate judicial opinions discussing the practice (almost all of them since 1980; see, e.g., Bulkley, 1987, and McCord, 1986, and citations therein). Most commonly, psychologists' testimony at adjudication is intended to assist the fact finder (the judge or the jury) in determining whether abuse occurred. As a practical matter, such testimony typically is used to bolster the credibility of prosecution child witnesses.

This new role of psychological experts raises substantially more difficult problems than the traditional use of mental health experts at disposition or sentencing because the answers to the questions posed in the latter proceedings are predictive and therefore inherently probabilistic (Mnookin, 1975; Monahan & Walker, 1985; Walker & Monahan, 1987). Because the event has not yet occurred, no better, more case-specific evidence is available in determining the relative merits of various possible dispositions.

By contrast, use of behavioral science at adjudication is aimed at proving that an individual did (or did not) commit a particular act at a particular point in time through group-probability data about the characteristics of abusers or abused children. The conceptual leap is obvious. Even if it is acknowledged that the degree of certainty attached to the judgment about whether the event occurred is itself probabilistic, more case-specific evidence is potentially available. Whether the defendant shares characteristics of abusers or the victim shares characteristics of abused children tells little about whether the defendant perpetrated the specific offense of which he or she is accused. For that matter, even the proven fact that the defendant previously has committed abusive acts does not in itself justify the conclusion that he or she is guilty of a current charge. Such evidence generally is excluded as unduly prejudicial (Federal Rule of Evidence 404).

Beyond these fundamental philosophical problems about the limits of inference from scientific data, questions

have been raised about the level of scientific foundation for the opinions that experts do give. Moreover, some have contended that mental health professionals often contaminate the investigatory process through suggestion.

Amid these controversies, psychologists must exercise special care to avoid inadvertently overstepping the bounds of their professional role (American Psychological Association [APA], 1981, Principle 1f). The interests at stake—child welfare, family privacy, and personal liberty—are all weighty ones demanding the utmost respect. At the same time, a minefield of ethical problems is created by the legal and factual complexity of many maltreatment cases and by the emotional response that such cases engender in the parties themselves as well as the investigators, other professionals, and the community as a whole. Recognizing the profound personal and social significance of cases of child maltreatment and the charged atmosphere that often surrounds such allegations, in this article we intend to present some guidelines for psychologists' involvement, based on ethical and legal considerations and the current state of knowledge.

We will emphasize sexual abuse in our discussion because most current controversies about the proper role of psychologists and other mental health professionals have arisen in such a context. However, with a few obvious exceptions (e.g., use of sexually anatomically correct [SAC] dolls), the guidelines that we offer are applicable to child maltreatment cases in general.

## **The Duty to Treat People with Dignity**

### ***General Principles***

The metaprinciple underlying the Ethical Principles of Psychologists (APA, 1981) is stated in the opening sentence of the Preamble: "Psychologists respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights." Consistent with this metaprinciple of respect for persons, psychologists are obligated to respect and promote individual autonomy (APA, 1981, Principle 6) and privacy (APA, 1981, Principle 5).

Although it is fashionable in some quarters to assert differences in goals between the legal and mental health professions, it is clear that the overarching ethical principles governing the conduct of psychological research and practice are highly consistent with the fundamental

values underlying the American legal system. Indeed, the Ethical Principles expressly obligate psychologists to "avoid any action that will violate or diminish the legal and civil rights of clients or of others who may be affected by their actions" (APA, 1981, Principle 3c). In keeping with this principle, psychologists involved professionally in cases of alleged maltreatment have a primary duty to facilitate justice, the principal purpose of the legal process (see Thibaut & Walker, 1978).

Therefore, psychologists must be careful to avoid intrusions on the due process rights of defendants. For example, in criminal cases, psychologists should not evaluate defendants before they have had an opportunity to consult with counsel, and they should avoid being used unwittingly to gather prosecutorial leads in such evaluations, contrary at least to the spirit of the fifth and sixth amendments (see Melton, Petrila, Poythress, & Slobogin, 1987, chap. 3.) At the same time, psychologists should be sensitive to the ethical interests of victims. For example, intrusions on the privacy of victims should be no greater than is necessary to meet the demands of justice (APA, 1981, Principle 5a).

### ***The Promotion of Perceived Justice***

A useful general approach to identifying the behavioral requirements of these principles is to frame the goal in terms of enhancement of perceived justice. Whatever the outcome of the case, the parties should be able to look at the psychologist's involvement with confidence that they were treated fairly, with respect for their personal dignity and the other fundamental values embedded in the legal process. In that regard, it is important to note that satisfaction with legal processes (and interaction with authorities generally) is highly dependent on perceived procedural justice (Lind & Tyler, 1988). Although victim advocates generally have emphasized the stress engendered by the legal process, the longer term effects may be related primarily to beliefs about whether justice was done, and those beliefs are more highly related to procedure than to distribution of rewards and punishments. Even first graders are highly attuned to procedural justice in their perception of the fairness of the outcome of a dispute (Gold, Darley, & Hilton, 1984).

The major positive attribute of the adversary system is that it gives interested parties, including victims, an opportunity to have a say. In that regard, promotion of the feeling of control is consistent with the humanization of the legal process and of professionals' involvement with the various parties (Katz, 1984; Thibaut & Walker, 1978). Perceived control also is positively related to psychological adjustment and enhancement of feelings of self-esteem (see generally Perlmutter & Monty, 1979). This general behavioral principle is true for children as well as adults, and it extends even to difficult decisions from which many would protect children (e.g., placement in foster homes; see Bush & Gordon, 1978, and Bush, Gordon, & LeBailly, 1977).

Several general guidelines follow from an examination of the large body of research on procedural justice,

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viewed in the light of fundamental ethical principles. In their involvement in the legal process, psychologists should endeavor to maximize the strength of the factors known to affect perceptions of justice: representation ("voice"), ethical appropriateness (i.e., politeness and concern for the rights of others), honesty, and consistency (Lind & Tyler, 1988).

Specifically, psychologists and others involved in work with child victims<sup>1</sup> should seek to increase victims' satisfaction with the legal process and, in so doing, enhance their sense of personal dignity. In that regard, the general strategy should be to make children partners in the pursuit of justice.

Using age-appropriate concepts and vocabulary, psychologists and other professionals involved in the legal process should keep child victims informed of the progress of the case. It is well known that ambiguity fosters anxiety (Dibner, 1954), but this principle is often ignored in the name of protection of children. To use a blatant but common example, when children find themselves moved from home to home mysteriously, seemingly for no reason and without notice, it should be unsurprising when their anxiety level increases, and their behavior appears to be less well controlled (see Bush et al., 1977). Similarly, initial studies of the effects of testimony on children suggest that the experience of being in limbo while proceedings are pending has far more deleterious effects than testifying itself, which can even have positive effects (*Kentucky v. Stincer*, 1987, brief of amicus curiae APA; Runyan, Everson, Edelsohn, Hunter, & Coulter, 1987).

Informing children about the progress of the case and the alternatives for the future is important not only because of its potential significance in managing anxiety. Systematic and ongoing education and counseling about the process signal a belief that children's experience is important and, in so doing, may enhance children's perceived control, at least in regard to the legal system itself. More directly, care in teaching child victims about the legal process may help children to make use of the process to vindicate their interests. By increasing children's understanding of the process, their confidence in interacting with the legal system also may increase, making them "good" (credible) witnesses (see Lind & O'Barr, 1978). Such understanding also may help children to express themselves in ways that make it more probable that they will have a say and, therefore, that they will feel that they have been treated fairly.

Accomplishment of such an understanding typically will require care in explaining the legal process. Legal authorities often believe, erroneously, that mere involvement in the process will result in children's fully com-

prehending their rights and those of others, an assumption that is known to be untrue even for adolescents and adults (Grisso, 1981). Children commonly are unfamiliar with having their views taken seriously, and the belief that children should be heard is not one that children in lower class communities usually embrace until the intermediate grades (Melton, 1980). Although research useful in preparing children for involvement in the legal process is just beginning, there is reason to believe that professionals often fail to explain the process to children in terms and concepts that are comprehensible to them.

In that regard, it should be remembered that interviews are interactive processes. Besides obtaining information about the concepts and knowledge that children have about the legal process and about their memory for specific events, research should be conducted to determine ways of increasing the quality of interviews and the validity of inferences drawn by investigators from what children do and do not tell them (Melton & Thompson, 1987). Research is needed on decision making by the various authorities in the legal system (e.g., child protection workers, prosecutors, and juries). Policy-capturing methods and ethnographic research about the process of substantiation of child maltreatment cases would provide information about practices that currently are being followed by authorities and about directions for research or intervention to improve the legal process, in regard to both accuracy and perceived justice.

Attention to and clarification of children's concerns (and related research) should be an emphasis throughout the legal process, not just in preparation for testimony. Relatively few child victims testify, but many are left in limbo or have a substantial change in their lives (e.g., out-of-home placement) as a result of legal proceedings. Besides providing regular feedback about the status of cases in which they are involved, authorities should use the provisions for victim involvement (e.g., solicitation of opinions at disposition or sentencing) that are present in the victim protection statutes of many American jurisdictions but that rarely are applied to child victims.

### *The Fulfillment of Promises*

If children and others involved in the legal process are to be treated with respect, then psychologists working with them must be honest about the limits of their role and expertise (APA, 1981, Principles 2a, 4, 5g, 6, 6a, and 6b). In that regard, the expectations of both participants in and observers of the legal process may be violated as a result of the complexity of roles of the various actors in the process, incomplete or misleading disclosure of the actors' agenda, or the actors' naiveté about the roles that they might be required to assume involuntarily.

Child maltreatment cases invite such violations of implicit promises because of the inherent ambiguity of the responsibilities and allegiances associated with some roles (e.g., guardian ad litem) and the fact that multiple investigations (e.g., police and child protective services) and proceedings often are pending or potentially will be initiated. When the same allegations result in a child pro-

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<sup>1</sup> The principles outlined here actually are applicable to interaction with most of the parties in a child maltreatment case. However, we will emphasize work with victims because such work is the primary vantage point from which psychologists view the legal process and because the professional norms for such work are less developed than the analogous norms for evaluations of criminal defendants (see Melton et al., 1987, chap. 3).



tection proceeding in juvenile or family court, a custody battle in a divorce proceeding in the civil division of a court of general jurisdiction, a tort action in a separate civil proceeding, and a trial in the criminal division (all of which may occur at the same or different points in time), ample opportunity exists for inadvertent or involuntary breaches of promise or simply confusion about what expectations are reasonable.

A particularly egregious example of mixture of roles in a manner that violates fidelity and privacy is when psychotherapy is used as a prosecutorial investigative tool. For example, in *State v. R. H.* (1984), an Alaska case that APA entered as amicus curiae, a father entered therapy pursuant to a dispositional order after an uncontested juvenile-court finding of child abuse. Thereafter, the prosecutor subpoenaed the treating psychologist's records in an attempt to gather evidence on which to build criminal charges. The appellate court properly ordered the subpoena quashed as contravened by both statutory psychologist-client privilege and the constitutional privilege against self-incrimination. The latter privilege was applicable because the statements in therapy were, in effect, government-compelled, given that the treatment itself was ordered by the court.

An expansive reading of reporting laws to abrogate any privilege in child maltreatment cases works against state interests, as the Alaska court recognized. A breach of confidentiality to make a report of suspected maltreatment may be justified, but the report should be no more inclusive than necessary to provide a basis for investigation. Abrogation of privilege altogether may frustrate the family court's attempts to promote therapeutic services in the child's welfare (Melton, 1987b; *State v. Andring*, 1984).

Beyond these considerations of purpose and efficacy, the principles of fidelity and respect for persons demand that "every effort is made to avoid undue invasion of privacy" (APA, 1981, Principle 5a). When a client enters therapy with a promise of confidentiality and his or her statements are then used as the basis of criminal charges (or termination of parental rights), the therapist's behavior is deceitful (if purposeful) or inadvertently misleading (if involuntary).

A more subtle but no less regrettable example of the unethical mixture of roles occurs when a psychologist behaves like an investigating detective who, as a ruse by which to obtain a confession, assures a suspect that the police are there to help him or her. When the interviewer is gathering information to be used to remove children from their parents' home or to be presented to the grand jury to support a criminal indictment, his or her assurance is just as hollow and dishonest, even if meant to be supportive. A child protective worker rarely can function effectively and ethically as both law enforcement officer and therapist.

In short, psychologists should be certain that those with whom they are working understand their role in the process. If material from an interview may be admitted into evidence in court or used by the prosecutor in making

a decision whether to file criminal charges, that fact should be made totally clear to the interviewee. To avoid any misunderstanding resulting from expectations attached to roles and resulting diminution in actual or perceived justice, psychologists should limit their role, whenever possible, to one of the following: investigator, evaluator (for disposition), or therapist.

## The Duty to Respect Legitimate Authority

### *Ethical Considerations*

Issues of role do not end with clarification of the nature and limits of a psychologist's involvement in the legal process and identification of the interests that the psychologist intends or may be compelled to serve. Questions remain regarding the limits of psychologists' expertise. When the bounds of competence are exceeded, misrepresentation implicitly occurs, the risk of societal harm increases, and justice is infringed (APA, 1981, Principles 2 and 4). Overreaching by experts also adversely affects the integrity of the judicial process by usurping authority from democratically designated decision makers (cf. APA, 1981, Principles 1 and 6). Therefore, when experts become involved in the legal process and give opinions unjustified by specialized knowledge, the canons of professional ethics as well as the rules of evidence are violated.

### *Evidentiary Rules*

To understand the application of the general injunction to avoid overstepping the bounds of the professional role, some knowledge of the rules governing expert testimony is helpful (see Melton et al., 1987). As a general rule, witnesses are barred from offering any opinions or inferences in their testimony. It is the proper province of the trier of fact (the judge or the jury) to determine the meaning of the evidence presented by the witness. However, the opinion of an expert witness is admissible if the witness is "qualified as an expert by knowledge, skill, experience, training, or education" and if the opinion is based on "scientific, technical, or other specialized knowledge [that] will assist the trier of fact to understand the evidence or to determine a fact at issue" (Federal Rule of Evidence 702).

Like any other type of evidence, the expert's testimony must satisfy two further requirements. First, the expert's opinion must be relevant (Federal Rule of Evidence 402). Second, the probative value of the opinion testimony must outweigh its prejudicial value (Federal Rule of Evidence 403). Indeed, if the empirical foundation of an expert's opinion is weaker than the "aura of special reliability and trustworthiness" (*State v. Saldana*, 1982, p. 230) of expert testimony, the trier of fact will not be assisted by it.

Courts in some jurisdictions use additional standards to guide them in determining the probative value of expert testimony that involves novel scientific evidence. Most of these jurisdictions follow a variant of the test enunciated in *Frye v. United States* (1923), which requires that the scientific basis for the testimony "be sufficiently estab-

lished to have gained general acceptance in the particular field in which it belongs" (p. 1014).

### **Expert Testimony in Abuse Cases**

**Abuser characteristics.** In the adjudicatory phase of child maltreatment cases, several types of opinions may be sought. Although the admissibility of each is controversial, the point that attracts the least debate is the admissibility of opinions about the characteristics of child abusers. By proffering such opinions, the prosecution seeks to create the inference that the defendant is similar to people who abuse children and, therefore, must be guilty. Such evidence is character evidence and therefore is clearly inadmissible unless the defendant puts forth such evidence first (Federal Rule of Evidence 404).

**Abused-child characteristics.** Mental health experts also may be asked to testify about the characteristics of maltreated children in order to buttress or attack the credibility of the prosecuting witness. The least objectionable testimony of this sort concerns aspects of the victim's behavior that might otherwise be confusing to the fact finder. Most frequently, such testimony is offered by the prosecution to explain delays in the child's reporting of sexual abuse. Testimony also may be sought to explain a child's conflicting, confusing, or vague accounts of abuse or to account for a child's retraction of an accusation of abuse (Bulkley, 1987).

Whether such testimony actually will assist the fact finder depends on the knowledge of the lay public. If the average juror is cognizant of these common behaviors of maltreated children, then expert testimony is an undue intrusion into the fact-finding process. Although recent studies have indicated that laypersons are not knowledgeable about typical reactions of rape victims (Frazier & Borgida, 1988) or battered women (Ewing & Aubrey, 1987), little is known about the degree that laypersons possess such knowledge about sexually abused children.

However, a study by Finkelhor (1984) indicated that, at the very least, jurors may be aware of child victims' propensity to delay reporting of sexual abuse. In a general-population survey in metropolitan Boston, parents estimated that only 33% of victimized boys and 39% of victimized girls would tell their parents soon after an abusive incident. These estimates were very similar to figures found in population surveys that have examined the frequency of children's delays in reporting sexual abuse (see Finkelhor, 1979).

Thus far, at least when the defense has challenged the child witness's credibility, most courts have admitted expert testimony about the specific behaviors at issue (e.g., retractions or vague accounts). Testimony about "sex abuse syndromes" is more problematic. Experts have testified about a variety of "typical" emotional and behavioral effects of sexual abuse on children, including fear of men, nightmares, anxiety, sleep disorders, unusual sexual knowledge or behaviors, a poor relationship with the mother, and precocious behavior and appearance (see, e.g., *State v. Kim*, 1982; *State v. Myers*, 1984). Generally, such testimony is presented by the prosecution to prove

that a child fits the profile of a sexual abuse victim and was therefore abused, although occasionally the defense will attempt to prove that a child does not fit such a profile and therefore has not been abused.

Although judicial opinions on admissibility of such testimony are far from unanimous and the trend is toward exclusion (Bulkley, 1987), the majority of appellate courts that have considered the issue have approved of admission of opinions about the nature of an abuse syndrome, provided that the expert stops short of an opinion about the credibility of a particular child. In our view, however, testimony about syndromes should not be admitted because it is inherently misleading on several grounds (see Melton, 1987a). First, that a child honestly *feels* abused (the matter of primary clinical significance) does not necessarily indicate that the legal offense of child abuse has been committed against him or her (the converse, of course, is also true). The use of the same terminology may imply a congruence that may not be present.

Second, a determination that a child was abused at some point in time does not prove that the child was abused by the defendant at the particular point in question. Profile evidence is apt to prejudice the trier of fact in making the relevant finding.

Third, the extant syndromes (e.g., Summit, 1983) lack a firm scientific foundation. Rather than hard data, they are based on clinical intuition, which, in the present state of the art, may be useful for treatment planning but which connotes a certainty that goes well beyond current knowledge and misleads the fact finder in a legal proceeding (see *In re Amber B.*, 1987; *People v. Bledsoe*, 1984).

Fourth, where statistical data are available, they indicate that although sexual abuse, for example, has observable deleterious initial effects on many victims, many other abused children do not show identifiable syndromes (Browne & Finkelhor, 1986). Some purported indicators (e.g., nightmares) are quite common among children in other clinical populations and indeed among children generally (Melton & Hargrove, in press; Schroeder, Gordon, & Hawk, 1983). Therefore, the probability is that children showing behaviors said to be indicative of abuse have *not* been abused. Given evidence that even psychologists who have had substantial statistical training often fail to appreciate the significance of base rates (Kahneman & Tversky, 1973), it is unrealistic to expect judges and jurors to show such sophistication in considering testimony about syndromes.

Finally, although the argument is not germane to the question of whether testimony about characteristics of abused children is so misleading as to be inadmissible, another consideration may raise questions in the minds of child advocates about the wisdom of encouraging expert testimony on victim characteristics. In effect, such testimony, even if intended to be supportive of the child witness, puts the victim "on trial" and often leads to unnecessary intrusions on the victim's privacy by opening the door to extensive evaluations, testimony, and arguments about the victim's reliability and credibility.

Although our preference is for outright exclusion of syndrome testimony on legal policy grounds, we recognize that many courts will continue to admit such opinions. We also recognize that skillful cross-examination (in regard, for example, to the proportion of young children in the general population who have nightmares) may vitiate some of our arguments. The degree to which syndrome testimony is inherently misleading is at least partially susceptible to empirical test.

In any event, the critical issue for psychologists is not the determination of admissibility, although psychological data may assist in the resolution of that question. Rather, as expert witnesses, psychologists' first concern must be the monitoring of their expertise and the careful delineation of the limits of their specialized knowledge. Psychologists who answer questions about characteristics of abused children are not violating ethical principles, *provided* that they are cognizant of the limits of knowledge and take steps to ensure that the trier of fact is aware of such limits, including the application of base rates and the degree of scientific validity of the findings presented (see APA, 1981, Principles 1a, 2, and 4; Bazelon, 1982; Weithorn, 1987a). Testimony should be limited to hard data whenever possible (for examples, see Grisso, 1986; Melton et al., 1987).

Some measure of overconfidence may be a necessary part of the clinical enterprise when clients are in distress and the scientific literature is scant. As already noted, theory and clinical impressions regarding syndromes may provide a useful starting point for development of hypotheses relevant to treatment planning in a particular case. However, when the clinician enters the courtroom, he or she should don a scientist's hat. Presentation of greater certainty than is scientifically warranted does not assist the fact finder. Rather, it misleads the fact finder and, in so doing, undermines the pursuit of justice and the exercise of legitimate legal authority.

**Credibility of the victim.** Another form of expert testimony at the adjudicatory phase of abuse proceedings has been virtually unanimously recognized by legal authorities to be inadmissible and by scholarly commentators to be unethical. Whenever experts render opinions on the *ultimate issue* (the question to be decided by the trier of fact; e.g., whether the defendant is guilty of abuse), they move beyond their specialized knowledge as psychologists to determinations of matters that are legal and moral (for a comprehensive discussion of commentary on ultimate-issue testimony, see Melton et al., 1987). Therefore, experts should not give ultimate-issue opinions, and lawyers and judges should not seek them (see, e.g., American Bar Association, 1984; American Psychiatric Association, 1982; Bazelon, 1982; Bonnie & Sloboin, 1980; Grisso, 1986; Melton et al., 1987; Morse, 1978a, 1978b; Task Force on the Role of Psychology in the Criminal Justice System, 1978; Weithorn, 1987b; Weithorn & Grisso, 1987).

To be specific, under no circumstances should a court admit the opinion of an expert about whether a particular child has been abused or has told the truth,

and most courts that have considered the issue have properly excluded such evidence, as a matter of law (see, e.g., *People v. Bledsoe*, 1984; *People v. Izzo*, 1979; *People v. Parks*, 1976; *People v. Roscoe*, 1985; *State v. Holloway*, 1986; *State v. Keen*, 1983; *State v. Maule*, 1985; *State v. Mueller*, 1983; *State v. Myers*, 1984; *United States v. Azure*, 1986). By the same token, as a matter of ethics, the opinion should not be offered in expert testimony or a report to the court.

The ethical violation occurs because of the implicit misrepresentation of a commonsense moral and legal judgment as a clinical or scientific decision. Whether a child is telling the truth is not a judgment based on specialized knowledge. Indeed, the counterexamples that are often given (i.e., cases in which children have given graphic descriptions of sexual acts) prove the point. The inference that such descriptions are credible is a matter of common sense. Even if the expert is correct in his or her judgment, the presentation of the judgment as based on specialized knowledge is deceptive, and the result is usurpation of the role of the trier of fact with concomitant diminution of the appearance of justice.

Of particular note in consideration of admissibility of ultimate-issue opinions by mental health professionals is the fact that clinicians are substantially more likely than legal professionals to view vignettes of parent-child interaction as indicative of sexual abuse and warranting state intervention (Atteberry-Bennett & Reppucci, 1986; Haugaard & Reppucci, 1988). These differences in perception extend to specific situations. For example, mental health and social service workers are more likely than law enforcement officials to find children's manipulations of sexually anatomically correct (SAC) dolls to be suggestive of a history of abuse (Boat & Everson, 1987a). Even if it were not disrespectful of the law for clinicians to offer essentially legal conclusions as psychological experts, it must be acknowledged that, as a matter of fact, clinicians' judgments cannot substitute for those of legal authorities. When clinicians usurp the role of the fact finder, they not only exceed the boundaries of specialized knowledge, but they also are likely to suggest legal conclusions that are different from those of legal authorities. In that sense, presentation of ultimate-issue opinions not only violates the rules of evidence and the Ethical Principles of Psychologists, but it also increases the risk of erroneous application of the law by the trier of fact.

## The Technology of Investigation: Special Problems

### SAC Dolls

Adherence to a prohibition of ultimate-issue testimony alleviates, if not totally eliminates, many of the more controversial aspects of mental health and social service professionals' involvement in investigations of child maltreatment. For example, use of SAC dolls has been mischaracterized as a "test" for sexual abuse, rather than a means for children to clarify their verbalizations through demonstration. The former conceptualization, which is

based on a misunderstanding of the proper role of clinicians in the fact-finding process, leads to exclusion of interview material altogether because of reliance on a scientifically unproven technique (see, e.g., *In re Amber B.*, 1987).

*There is no behavioral test for child abuse.*<sup>2</sup> When it is recognized that the goal is not to reach a clinical judgment on the basis of doll play about whether abuse has occurred but instead to assist in gathering information, arguments about the purported psychometric properties of dolls become moot. Rather, the critical question in regard to SAC dolls is whether they assist in interviewing children when sexual abuse is suspected. Specifically, do SAC dolls in fact serve as stimulus support to children in describing an incident in which abuse allegedly occurred?

On the other hand, do the dolls actually interfere with children's ability to recall and describe a possible incident of maltreatment? Such interference might occur in two ways. First, the dolls might be so distracting that they make it more rather than less difficult for some children to relate the details of an incident. Second, the dolls might have such strong demand characteristics that they elicit distorted accounts presenting more highly sexualized events than actually occurred.

In the only investigation that has examined each of these issues, Goodman and Aman (1987) compared three- and five-year-old children's responses in interviews in which no dolls, regular dolls, or SAC dolls were present. At least in response to questions (rather than free recall), the dolls did not serve as stimulus support. The SAC dolls did adversely affect three-year-olds' ability to answer objective questions, although they did not increase their suggestibility or frequency of false alarm errors.

Goodman and Aman's (1987) investigation and other studies of preschool children's responses to SAC dolls (Boat & Everson, 1987b; Jampole & Weber, 1987; Sivan & Schor, 1987; White, Strom, Santilli, & Halpin, 1986) all lead to the conclusion that the dolls do not "demand" sexualized responses. When children are given a choice, SAC dolls are not at the top of priorities for play, especially among boys. In an interview using the dolls, young children frequently do explore the dolls' genitalia visually and manually. However, young children not known to have been sexually abused infrequently engage in simulations of sexual activity with the dolls, although such play does occur occasionally, especially among older preschoolers (Boat & Everson, 1987b).

In summary, data to support the use of SAC dolls as cues in interviews of young children still are scant, and there is some initial evidence suggesting that a distraction effect may occur in very young children. On the other hand, the dolls do not appear to have highly suggestive effects that would distort children's reports.

<sup>2</sup> This point was consensually recognized by the audience of invited experts when the paper on which this article is based was presented at a symposium organized by the National Center on Child Abuse and Neglect.

### *Child Abuse Screening Instruments*

Although SAC dolls are not accurately classified as tests, several psychometric instruments have been developed for use in screening parents at particular risk for child maltreatment, although not for "diagnosing" abuse (for a review, see Grisso, 1986). Great care must be taken to avoid misuse of such instruments. For example, in some validity studies the Child Abuse Potential (CAP) Inventory (Milner, 1986) has demonstrated an uncanny hit rate (about 90%) in discriminating abusers from non-abusers. If that fact alone were presented to a court, it certainly would diminish doubt about the guilt of an alleged abuser who scored above the cutoff on the Abuse scale of the CAP. A judge or jury (or child protective worker) probably would conclude—erroneously—that the odds are 9 in 10 that the defendant is an abuser.

Even if the high hit rate could be sustained in samples drawn from the general population, it must be remembered that 10% of a large proportion (i.e., nonabusers) is apt to exceed 90% of a small proportion (i.e., abusers). However, the 90% hit rate is limited to studies in which the base rate for abuse is 50%, far higher than in the general population. When the CAP is administered to samples with lower base rates for abuse, the false positive rate increases substantially. Moreover, even among high-risk parents, predictions of abuse (a matter of substantial concern in the dispositional phase of child protective proceedings) may yield a very high false positive rate (Milner, Gold, Ayoub, & Jacewitz, 1984). Misclassification on the basis of CAP Abuse scale scores also increases when children have disabilities necessitating special care (Milner, 1986), although less so than for some similar instruments (Grisso, 1986).

Given the difficulties that most people have in processing base rates, psychologists using the CAP and similar instruments should be especially careful to ensure that legal and social service authorities do not substantiate abuse allegations merely on the basis of such tests. At the same time, psychologists themselves should avoid drawing even more tenuous conclusions from standard instruments that are unvalidated for assessments of parental capacity and that sometimes even bear little face validity for measurement of constructs related to parental behavior.

### *When Is Involvement Useful?*

In this article, we have focused largely on psychologists' involvement in maltreatment investigations and adjudications, and we have indicated the need for great caution in that context. However, we also do not intend to discourage psychologists from all professional involvement in child maltreatment cases. Psychologists are experienced in talking with children and families about sensitive matters, and they are often expert in identifying factors that may enhance or diminish the quality of communication with a child. Thus, they may participate in investigations by actually conducting interviews or consulting in regard to them. When such a role is taken, however, psychologists

should be clear that their job is to assist in gathering information, not to determine the result of the case.

Psychologists also may assist in the dispositional phase, the historic point of entry for experts in child maltreatment cases (see Melton et al., 1987, chap. 12, for a review). The conceptual problems in forward-looking opinions about possible interventions to remediate a dysfunctional family situation and prevent further harm to the child are substantially less than in the opinions sought of experts at adjudication. Sufficient knowledge is available about the antecedents of child maltreatment, especially physical abuse, to assist judges and child protective workers in developing dispositional plans based on specialized knowledge. However, it also should be acknowledged that outcome research on interventions in maltreating families—and, therefore, on matches between clients and programs—is negative or unavailable in most instances. Therefore, the previous warnings about staying within bounds of competence, indicating points of uncertainty, and refraining from legal conclusions (e.g., whether a home is sufficiently dangerous to warrant compelled removal of a child) are germane in dispositional as well as adjudicatory proceedings.

Finally, psychologists may contribute to maltreatment investigations through use of their skills as researchers. Little is known, for example, about the decision-making process of law enforcement or social service investigators in substantiating a case or prosecutors in determining whether to file criminal or civil charges or no complaint at all. Evaluation research can help to increase the validity of the process and to enhance the perception of justice as it proceeds. Basic social-developmental research also can be useful in identifying aspects of adult-child communication that affect the quality of an investigation and the validity of inferences drawn.

No matter what the role, though, psychologists must keep in mind the compelling purposes of the legal process. They must show respect for the participants in the process and the authorities charged with decision making. Doing so is fully consistent with the high professional and personal duties of psychologists to promote human dignity.

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# **Justice and Mental Health Systems Interactions: A Search for the Holy Grail?**

Clarence J. Sundram  
Chairman  
New York State Commission on Quality of Care  
for the Mentally Disabled

## **Outline of Presentation**

Thursday, 2:40 - 3:30 pm, November 8, 1990

### **I. Premises Requiring Careful Examination**

- A. There is a coherent mental health system or criminal justice system whose interactions can be managed or controlled
- B. There are systemic interactions rather than *ad hoc* arrangements influenced by such factors as personalities of court/mental health actors, locations, client relationships, nature of the crime, and publicity
- C. More attention to the problem will improve results

### **II. Factors That Affect The Handling Of The Mentally Disordered Offender**

- A. They are a minority population in the mental health and the criminal justice systems, both of which are overwhelmed by their caseloads and service demands
- B. Needs tend to be subordinated to other priorities of each system
- C. Both systems have internal conflicts/ambivalences in dealing with the mentally disordered offender
  - 1. Criminal justice system conflicts
    - a. Punishment (try, conflict, lock up)
    - b. Rehabilitation (divert, place, treat)
  - 2. Mental health system conflicts
    - a. Treat, rehabilitate (divert to treatment facilities)
    - b. Avoid stigma of criminality (let prisons deal with criminals)



3. Clinical conflicts
  - a. Protect the patient
  - b. Therapeutic to let patients face consequences

### III. Search for a Paradigm

- A. Mental health system is comprised of diverse state and local government services, private and non-profit providers, and community mental health centers
  1. Weak central policy-making, leading to a diversity of roles for service providers
  2. Service relationship to the patient is usually episodic, rather than long term
  3. Chronic difficulties in establishing the presence and severity of mental illness and its effect upon competence to stand trial and responsibility for the criminal conduct
- B. Interactions between the criminal justice and other systems
  1. The mental retardation (MR) system tends to be structured differently than the mental health system, with a stronger state role in policy making and greater state responsibility for forensic services
    - a. Diagnosis of mental retardation may be less difficult as well
    - b. MR system tends to have the same problems as mental health system with overall shortage of services but tend to use the arrest as leverage to get priority for service
  2. Family courts are generally regarded as bridging the systems more effectively. Why? Is the role of the judge and the court more consistent with the therapeutic missions of the mental health service providers?
  3. Some courts are more likely to engage in negotiated solutions (e.g., town and village courts). Why? Because of non-lawyers? Lower level crimes?
  4. Do these different characteristics of the MR or family court systems produce any better outcomes in their interactions with the justice system?

## **VI. Tentative Conclusions And Recommendations**

- A. Ultimately an argument about resources
  - 1. Who controls them?
  - 2. Who sets priorities?
  - 3. What values guide decision-makers?
  - 4. To whom are they accountable?
- B. Common education/training for key personnel in both systems
  - 1. Cross system training
  - 2. Attorneys, judges, probation officers, district attorneys, mental health personnel
  - 3. Role clarification

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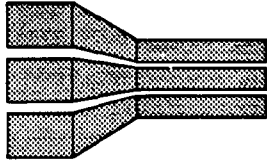
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## *Promoting Systems Change*

"The Commission is a unique agency and change-agent established within government to serve to remind and prod the system to be or become what it is at its roots: an inter-connection of individuals relating with each other in a manner to promote quality of care."

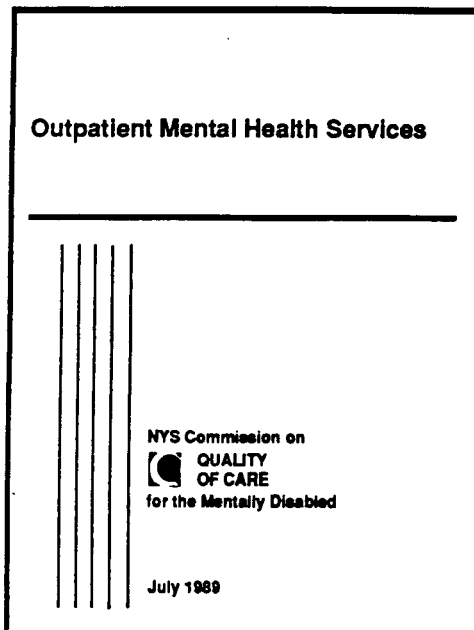
THE MENTAL HYGIENE "SYSTEM" is really a complex of *people*. The system exists for people who have disabilities. Closely allied to these individuals are their families, relatives, and friends, and countless advocates—people who frequently represent the "conscience" of the system, calling for humane care and treatment, justice, and dignity. There are the professional providers of care and treatment, who often must spend long hours in applying their skills to assist and support individuals with disabilities to develop and improve to their fullest potential. Finally, there is government, which, in a democracy, aspires to operate "by the people and for the people," working toward the equality and dignity of all who are governed. The mental hygiene system: at its roots an intertwined organism of human relationships.

New York has a rich array of advocates and advocacy groups actively attempting to change the system, including, recently, forceful and persuasive groups of self-advocates.

The Commission is a unique agency and change-agent established within government to serve to remind and prod the system to be or become what it is at its roots: an inter-connection of individuals relating with each other in a manner to promote quality of care. At the heart of the Commission's mandate and mission is the often difficult task of serving as a catalyst to change the system, to ensure that "the quality of care provided to the mentally disabled in the state is of a uniformly high standard" (*Mental Hygiene Law*, §45.07).

The following pages illustrate the activities and accomplishments of the Commission in its role as "systems change-agent" during the past year.

# Refocusing Mental Health Outpatient Services



In 1988, the State Legislature requested the Commission conduct a study of mental health outpatient services in New York State (Chapter 50 of the Laws of 1988). This request came in the wake of a previous Commission report to the Legislature, *Admission and Discharge Practices of Psychiatric Hospitals*, (1988), which concluded that the problems experienced by the State's inpatient psychiatric system were "symptoms of a system that has not invested sufficiently in developing the quality and types of community-based support services that could appropriately respond to the needs of people who are mentally ill and their families."

The Commission published the study as *Outpatient Mental Health Services* (July 1989).

## Homeless help wanted Report raps outpatient care for the mentally ill

**By David Badger**  
The report, "Outpatient Mental Health Services," released by the NYS Commission on Quality of Care for the Mentally Disabled, says that the state's outpatient mental health system is "grossly inadequate" to meet the needs of the mentally ill. The report says that the state's outpatient mental health system is "grossly inadequate" to meet the needs of the mentally ill. The report says that the state's outpatient mental health system is "grossly inadequate" to meet the needs of the mentally ill.

### Editorial

## Unmet needs of mentally ill

A study of the state's system of outpatient care for the mentally ill reveals what many families of the mentally ill already knew. The system is a hodgepodge of services that are often poorly managed, inadequate to meet the needs of many of the most ill and of every varying quality and cost.

Despite a sizable investment of approximately three-quarters of a billion dollars annually in outpatient mental health services, states the report of the NYS Commission on Quality of Care for the Mentally Disabled, there is presently little assurance that these services are being held accountable for responding to the critical needs of clients and families or the community.

This report is, once again, testament of the failure of the community care system to meet the needs of the hundreds of thousands of mental patients displaced by the state's necessary but poorly executed policy of deinstitutionalization.

While the theory was that many it could be treated better in community settings, the reality was — and is — that many are not getting help.

By following the treatment and discharge from state hospitals, "what was not recovered: 61 percent needed job, 1 percent needed education, 4 percent needed drug and alcohol treatment."

And while the vocational or multiple disability trust, limited program's assistance in other types of services, such as...

### Better planning needed

As if that weren't bad enough, the study found:

① There were staggering variations in cost — for example, from \$82 to \$664 per patient in day treatment.

② There are virtually no performance standards for outpatient mental health services, no clearly defined priority populations to be served, and no measures of the effectiveness of the services provided.

③ The lack of walk-in services and crisis response leads to overcrowding on emergency, overcrowded hospital emergency rooms.

The commission report makes several excellent recommendations to rectify the problems that call out so much for spending more money as for distributing it differently. Among them:

④ There must be better planning, including an assessment of needs and standards for service.

⑤ A memorandum on new programs should be developed except for those targeted to reach people with multiple problems, such as the mentally ill drug abuser.

⑥ Involvement of the community in decision-making — through a formal grievance procedure — is of access to or delivery of services.

Schneidman, Garber

... really have to get the meaningful

## Better oversight for psychiatric care

It may not be entirely — or even close — to suggest that New York state has evolved a ready system for providing care to the mentally ill. Nor is it inaccurate to say the system does not work.

The state Commission on Quality of Care for the Mentally Disabled released a study of outpatient mental health services.

That study was a follow-up to a previous commission report on crowded psychiatric hospitals in New York. That study found patients who...

**Study shows state must improve coordination.**

...in their communities with the help of the re-improving in...

## State Stops Expanding Mental Health Program

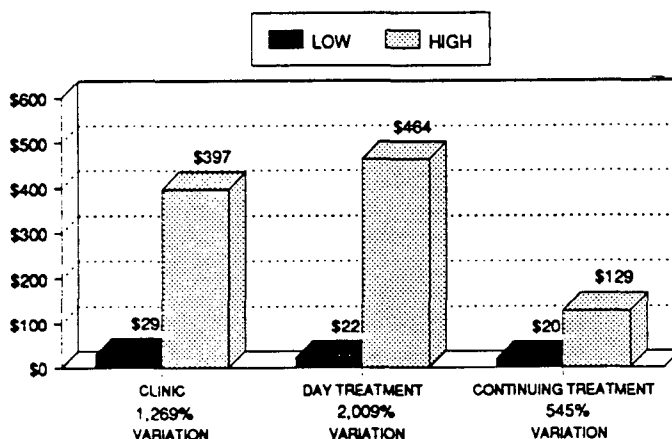
**By David Badger**  
ALBANY, N.Y. — State officials have announced a new report that the state's mental health program is not working as well as hoped. The report says that the state's mental health program is not working as well as hoped.

...and the agency had been of the state's mental health program...

## Findings

- ❑ There are substantial variations in unit-of-service costs for outpatient mental health programs (e.g., from \$29 to \$397 per clinic visit). The costs in excess of the fixed fees for such services are often financed by State and local governments, which annually spend about \$250 million to finance deficits of outpatient programs.
- ❑ Many outpatient programs fail to make reasonable accommodations to serve people with the most serious difficulties, especially individuals who also have drug and alcohol problems. These programs often have restrictive admission criteria, demanding participation requirements, or limited hours of operation, which discourage ready access by seriously ill or difficult-to-treat patients. As a result, many patients go to hospital emergency rooms for services that could be provided by outpatient programs but are not readily available.
- ❑ OMH's monitoring of outpatient programs is inadequate. This permits many programs to operate far below capacity, offer limited outreach services, and provide no crisis or on-call services during evenings or weekends.
- ❑ New York's mental health outpatient system is riddled with planning problems resulting in serious service gaps. For example, 95 percent of New York's certified public mental health outpatient programs have a narrow clinical orientation, which neglects the equally critical needs of persons with mental illness for non-clinical support, such as rehabilitative, educational, vocational, social, and family support services.

Range of Unit Costs of  
Outpatient Services by Program Type  
(1986)



## Outcomes

The Office of Mental Health concurred that major changes are needed to ensure greater programmatic and fiscal accountability for outpatient services, and especially to promote greater access to more services by individuals with serious mental illness. The Office made specific commitments to initiate this change process, including:

- ❑ placing a moratorium on further expansion of outpatient programs, except programs that target children and homeless individuals, to allow a concentrated analysis of new programs from programmatic, legal and fiscal perspectives;
- ❑ developing a performance contracting system for outpatient programs to ensure greater attention to program quality and to reduce duplication of services;
- ❑ developing a dictionary of mental health programs and services to clarify and standardize the planning and reporting functions of outpatient services;
- ❑ integrating and simplifying the local planning process, allowing all State and local service providers within each county to develop a single comprehensive plan for mental health services and promote consumer and family participation in this planning process; and
- ❑ conducting a Consumer Preference Survey in 1990 to determine non-clinical outpatient needs, as well as the clinical mental health needs of individuals with serious mental illness.

[For examples of fiscal outcomes, see page 19].

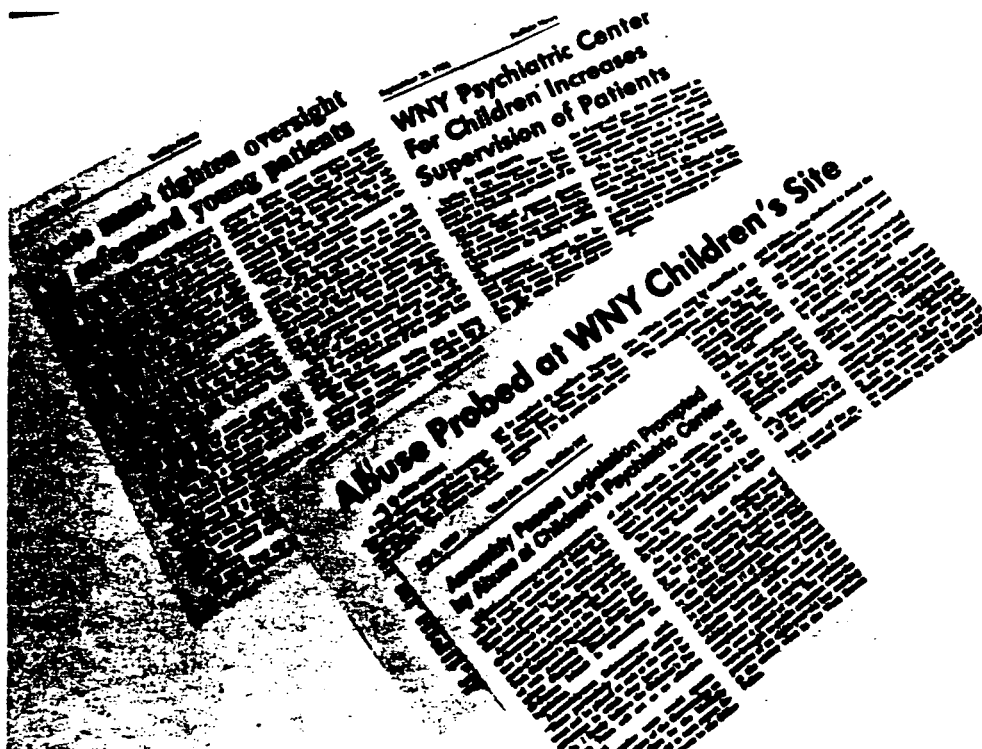
## Curbing Child Abuse: Investigation at Western NY Children's P.C.

Investigation into Allegations of  
Child Abuse and Neglect at  
Western New York Children's Psychiatric Center  
[Interim Report]

NYS Commission on  
 QUALITY  
OF CARE  
for the Mentally Disabled

January 1989

In January 1989, the Commission released a report, *Investigation Into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center [Interim Report]*, based on a nine-month investigation, which concluded that, over a long period, many young children at Western New York Children's Psychiatric Center had engaged in sexual activity with other children, and that many of these incidents occurred and persisted because of deficient management, and improper or inadequate clinical, and supervisory practices at the facility. According to the report, many children had been repeatedly involved in sexual activity with other children, and the highest incidence of this sexual activity occurred on the facility's unit serving the youngest children, age 5-12.



## Summary of Findings

- ❑ Over a long period of time, young children at Western New York Children's Psychiatric Center engaged in sexual activity with other children.
- ❑ The Commission investigation covered 32 allegations of child abuse and neglect involving 36 different children. The Commission recommended to the Department of Social Services that 10 of these cases be "indicated." An additional 11 cases were confirmed as having occurred but recommended to be "unfounded" due to a lack of evidence of culpability of specific staff.
- ❑ Line staff were aware of this sexual activity, and generally reported it appropriately to senior supervisory, administrative, and clinical staff.
- ❑ Senior administrative and clinical staff took little, and often inappropriate, action to intervene to prevent the activity from recurring.
- ❑ Senior management did not seem to recognize the seriousness of the sexual conduct reported, and did not ensure that the children's behavior was addressed in the course of their treatment.
- ❑ Senior management also failed to report the incidents promptly to the State Central Register for Child Abuse and Maltreatment, Office of Mental Health officials, and law enforcement authorities, when warranted.
- ❑ The facility neither addressed the prior physical and sexual abuse histories of many of the children, nor provided the children with appropriate medical examinations following the discovery of their involvement in sexual incidents.

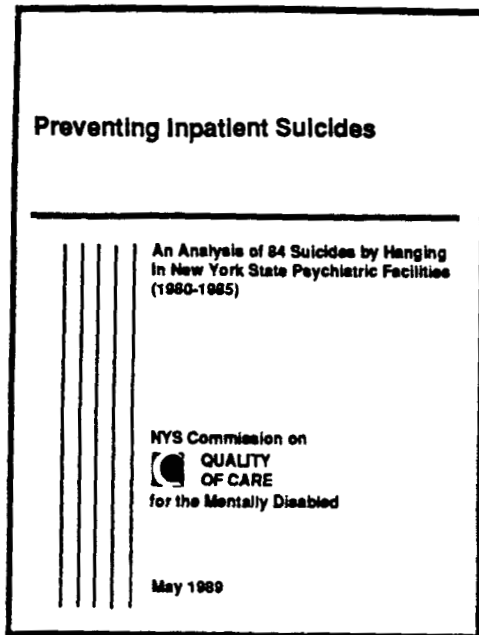
### Western New York Children's P.C. Investigation Early Outcomes

The New York State Office of Mental Health, in responding to the interim report, concurred with the findings and conclusions, and specified immediate and long-term actions.

- ❑ OMH made immediate changes in management and clinical personnel;
- ❑ OMH agreed to develop and implement an on-site peer review system in all State-operated children's inpatient facilities;
- ❑ OMH made a commitment to set up task forces to examine training needs, management and treatment of sexually abused children;
- ❑ OMH stated it would develop policies and procedures for the medical examination of children allegedly sexually abused; and
- ❑ the New York State Legislature established "Child Protection Teams" within the Commission to investigate abuse of children in State-operated children's inpatient facilities where there are serious allegations.



# Preventing Inpatient Suicide



The Commission has completed a study of all inpatient suicides that occurred by hanging in New York State psychiatric facilities during the period 1980-1985. The study, published as *Preventing Inpatient Suicides: An Analysis of 84 Suicides by Hanging in New York State Psychiatric Facilities (1980-1985)*, concluded that such suicides are more than three times as likely to occur among psychiatric inpatients than in the general population. In releasing the findings of the study, the Commission urged greater attention to environmental safeguards and special suicide precautions at these facilities.

May 7, 1989

Poughkeepsie Journal

## Suicide precautions in mental hospitals uneven, says report by watchdog group

By Robert Sullivan  
The Associated Press

ALBANY — Patients in psychiatric centers are three times more likely than others to commit suicide by hanging, a state watchdog commission said in a report Saturday.

But workers in these psychiatric centers carried out special precautions against suicide in only half the cases where those precautions were ordered, the state Commission on Quality of Care for the Mentally Disabled said.

Furthermore, inmates working in identifying potentially suicidal patients were not given enough information about the patients' histories.

The commission also found that workers in psychiatric facilities were often "too vague" for instance, in justifying why they would say "suicide watch, bathroom" instead of saying "no suicide watch, bathroom."

In some cases, workers in psychiatric centers carried out special precautions against suicide in only half the cases where those precautions were ordered.

Workers were more likely to be carried out, the commission said.

The commission said that most of the suicides occurred in relatively enclosed areas of the mental facility, especially hallways and bedrooms. There are areas where patients could easily get to windows, pipes and other things where they could hang themselves.

The panel said that many workers in psychiatric facilities do not receive enough training to be able to identify suicidal patients and to take appropriate action.

enclosed pipes, may help prevent some of these tragedies," said commission chairman Clarence Spivey.

The panel examined all 84 inpatient suicides by hanging at 21 state-operated and 25 state-funded psy-

chiatric facilities from 1980 to 1985. Spivey said hanging was the most common form of suicide among psychiatric inpatients.

According to the commission, the typical hanging victims was a recently admitted, single white male under age 45.

The commission said that half the reported suicides by hanging happened within 30 days of a patient's admission to the facility and that 25 percent of the suicides occurred on a Monday or Friday.

State Mental Health Commissioner Richard Seiden, in a statement included in the commission report, said the findings would be used to improve the mental health system.

## Findings

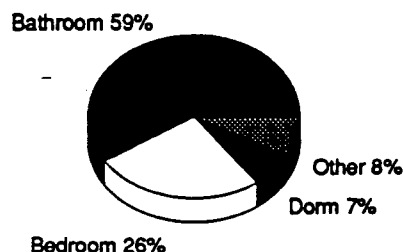
- ❑ The most common form of inpatient suicide is by hanging. The vast majority of these suicides occurred in somewhat secluded areas of the inpatient psychiatric facilities or units, especially bathrooms and private/semi-private bedrooms, where patients had easy access to potential hanging structures.
- ❑ Although 34 percent of the patients studied were on physician-ordered special suicide observations at the time of their death, in half these cases the special precautions were not being carried out by staff.
- ❑ Vaguely written observation orders e.g., "suicide precaution level 1" were less likely to be carried out than more explicit statements, e.g., "observe every 15 minutes."
- ❑ The risk of suicide by hanging is the highest in the first 30 days of hospitalization.

### Ways to Improve Suicide Prevention Safety Net in Inpatient Psychiatric Facilities

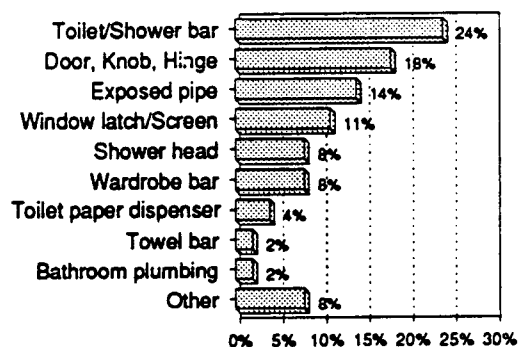
- ❑ remove structural suicide hazards (e.g., exposed sprinkler pipes, non-breakaway shower and closet rods, etc.), especially in patient bedrooms and bathrooms, where patients are more likely to be left unsupervised;
- ❑ pay more diligent clinical attention to suicide precautions in the first 30 days after a patient's admission, during the evening shift, and proximate to holidays and other significant patient anniversaries;
- ❑ evaluate periodically existing practices in ordering and ensuring the full implementation of suicidal precaution orders.

## Location and Structure Used for Inpatient Suicides by Hanging (1980-1985) (N=84)

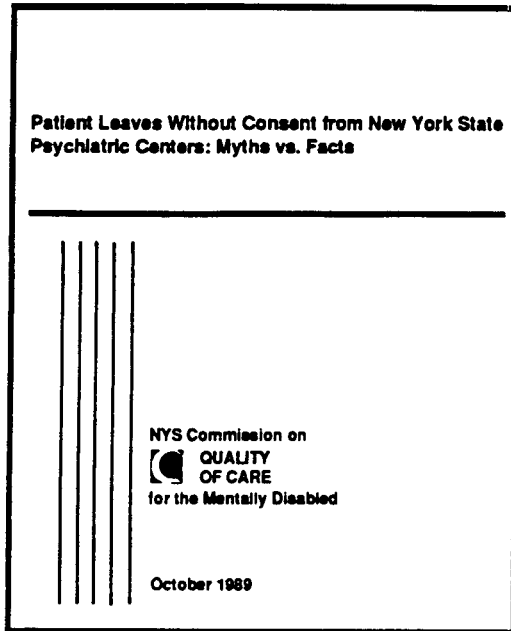
Location



Structure Used



# Preventing Unauthorized Leaves By Psychiatric Center Patients



A Commission study of all patients who went on "leave without consent" (LWOC) from the State's adult psychiatric centers during 1981-1987 concluded that such leaves are common occurrences, especially at larger urban centers. According to the review, from 1981 - 1987, there were an average of 7,242 LWOCs annually out of 26,047 admissions to the State's 25 adult psychiatric centers. Regions varied greatly, with the five non-forensic psychiatric centers in New York City accounting for 44 percent of 1986 LWOCs statewide. The three adult centers on Long Island and four in Albany, Syracuse, Rochester and Buffalo accounted for another 42 percent. A high number were "repeat elopers" who left more than once during the year.

# Better life for mental patients urged

## State report blames hospital escapes on boredom, dissatisfaction

Long cramped, non-private hospital rooms pressure who are voluntarily committed. The report also criticizes the hospital's failure to provide adequate recreation and social activities for the patients.

Despite the high return rate of the patients, the report says, "the majority more than 50 percent of the patients are not satisfied with a year. All but 10 percent of the patients who are voluntarily committed report that they are not satisfied with their care or with their living conditions."

Further, the report says, "the majority of the patients who are voluntarily committed are not satisfied with their care or with their living conditions."

The committee found that the average of 7,342 patients in the state hospitals in 1961 to 1967 was 25 percent of the patients who are voluntarily committed.

Patients who left the public psychiatric hospitals without orders during July 1967 "strongly suggest that patient dissatisfaction with commitment is a major contributor to hospital escapes."

The committee found that the average of 7,342 patients in the state hospitals in 1961 to 1967 was 25 percent of the patients who are voluntarily committed.

**BY BOB COTTA**  
**How the**

By the way, the  
Horse King, Emperor  
of the  
Chinese Empire, has  
just issued a decree  
that all his subjects  
shall be allowed to  
wear the same  
kind of shoes as he  
himself wears. This  
is a very wise  
decision, and it will  
be a great benefit  
to the people. The  
emperor is a very  
kind and generous  
man, and he always  
does what is best  
for his subjects.

A local telephone group has organized the business men to urge the city council to close the city hall to the general public, and to limit the number of people who can enter the building. The group is headed by J. H. Smith, president of the local telephone exchange. Smith has called the council to order to close the city hall to the general public, and to limit the number of people who can enter the building. The group is headed by J. H. Smith, president of the local telephone exchange. Smith has called the council to order to close the city hall to the general public, and to limit the number of people who can enter the building.

An analysis of data for 1980 reveals that 64 percent of the women were from the five counties nearest New York City. An additional 25 percent came from four counties in Albany, Syracuse, Rochester and Buffalo. 17 percent from three counties on Long Island and 13 percent from the 56 counties upstate.

The report called attention to the "overrepresentation" of the 25 metropolitan participants. In 1980, 25 percent of the women had more than 10 years of experience. The metropolitan women had an average of 10 years of experience, while the women from the other counties had an average of 10 years.

[illegible][illegible]

## Findings

- ☐ Patient leaves without consent are quite common, daily occurrences at most State psychiatric centers.
- ☐ The study provided no evidence that centers which locked most or all wards had lower rates of patient leaves without consent.
- ☐ The vast majority of patient elopements result in little harm to the patients or others in the community.
- ☐ Patients left either out of boredom, to take care of an errand in the community, or simply to escape the institution's restrictions.
- ☐ For a few patients, these incidents are high-risk occurrences, and, as the number of elopements increases, the clinician's task of identifying these few high-risk patients becomes increasingly more difficult.
- ☐ Patient elopements are costly to facilities in their demands on staff time to conduct grounds searches, to ensure appropriate internal and external notifications, and to do required paperwork.

## OMH Promised Actions

In its response to the study, the Office of Mental Health agreed to:

- ☐ conduct a review of facility policies and practices regarding the use of locked wards and patient privileges to ensure that patients receive treatment in the least restrictive environment possible, while maintaining a safe ward environment that is consistent with each patient's clinical condition;
- ☐ continue efforts to increase the availability of on-ward and off-ward programming and recreational activities for patients;
- ☐ direct the facilities to review their existing patient grievance procedures and develop a process which will increase consumer and consumer advocate input; and
- ☐ develop a quarterly report on missing patients to monitor patient elopements more closely.

### "I left the facility because...."

- ☐ "I left [the facility] because I didn't like the over-restrictive rules. There is no caffeinated coffee, I can't watch TV, the bedrooms are locked all day, so I can't take a nap and when I'm sleepy from the medication, this is unbearable. Since the rooms are locked during the day, if I want to take a shower, I can't get clean clothes unless I ask the therapy aide, and I don't want to bother the therapy aide."
- ☐ "I'm unhappy with the strict rules, especially in the workshop area. There's not enough coffee breaks, the work is boring [putting colored pieces of cardboard in a box], you get paid very little and staff take points away for any infractions which then limits your privileges."
- ☐ "I was discouraged and upset with the staff and restrictions [on the ward]. The patients and staff get on my nerves. I didn't get a raise at my job and wanted to get out [of the facility]."
- ☐ "I had a craving for Chinese food, but the staff wouldn't let me call for a take-out order, so I left [the facility] to go to the Chinese restaurant."
- ☐ "I wasn't getting any help, the programs in the Rehab Building are boring."
- ☐ "The place [ward] is boring, there's nothing to do but watch TV. I wanted to go to Brooklyn and get an apartment and a job."

# Monitoring Overcrowding in Psychiatric Emergency Rooms

## Psychiatric Emergency Room Overcrowding: A Case Study

NYS Commission on  
 QUALITY  
OF CARE  
for the Mentally Disabled

May 1989

The staggering demands placed on New York City's chronically overcrowded and understaffed hospital psychiatric emergency rooms (PERs) and "gridlocked" inpatient units were factors investigated in a Commission case, published as *Psychiatric Emergency Room Overcrowding: A Case Study*. The report illustrated the effects of heavy dependence on PERs as the main source of psychiatric services in New York City after business hours, when they function under overcrowded and chaotic conditions. In this case, 37-year-old "Armando Peteros" (a pseudonym) allegedly stabbed his parents to death after four visits to psychiatric emergency rooms in a three month period for assaultive behavior and homicidal thoughts.

May 21, 1989

Sunday Record, Middletown

## Slayer of parents sought help, was rejected

ALBANY (AP) — A psychiatric patient who stabbed and killed his parents was himself a victim of a hospital system in New York City that deals poorly with "ragging demands," a state watchdog group said yesterday.

Nicholas Gavrilou, a 37-year-old man charged with killing his parents in Brooklyn in February 1988, went to the King's County Hospital psychiatric emergency room four times in the three months before the stabbings and was discharged each time, according to the Commission on Quality of Care for the Mentally Disabled.

No beds were available each time and overworked doctors admitted later that if they had better records they could have admitted Gavrilou, said the commission. The case "poignantly and comprehensively" illustrates the overcrowded nature of the city's public psychiatric system, the report said.

The problems "have caused incalculable suffering for patients and their families and have frustrated and disoriented hospital staff members who attempt to deliver careful and considered psychiatric treatment," the report said.

One hospital psychiatrist has described it as wartime triage, said Clarence Boudreau, commission chairman. The report criticized the hospital's habit of going on "diversion" status, where they are allowed to transfer patients to other hospitals because beds aren't available.

Patients kept in emergency rooms can stay up to three days without knowing whether a bed will become available, often with no other treatment besides medication and observation, the commission said. It has found that 11 percent of people kept in psychiatric beds should have been elsewhere.

ment program

In effect, psychiatric emergency rooms have become the main "holding area" in New York City at night for refugees from domestic violence and people with drug and alcohol problems, the report said.

In Gavrilou's case, he went to psychiatric emergency rooms four times because he was violent, the panel said. When he was discharged from Kings County Hospital two weeks before the killing, doctors had no records of his earlier visits in the preceding three months, the report said.

After being brought to the hospital again by police after he allegedly killed his parents, Gavrilou said, "are you going to keep me? Please don't let me go this time," the report said.

The report recommended the diversion procedure be phased out, and said the city's Health and Hospitals Corp. should examine staffing needs. The commission said it supports the state Office of Mental Health's plans to add 16,500 psychiatric residence beds within the next 10 years.

Dr. Luis Maron, vice president of mental hygiene services for the Health and Hospitals Corp., said he's been advised not to talk about the Gavrilou case. But in a letter responding to the report, he said the commission's observations and recommendations were consistent with what the city agency has been saying for many years.

State Health Commissioner Dr. David Axelrod said the state has already approved the expansion of bed capacities and many of the department is taking appropriate steps to ensure adequate services for mental health.

"I believe the department is taking appropriate steps to ensure adequate services for mental health," Axelrod said. Gavrilou case, Axelrod

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## Findings

- ❑ Deficiencies due to severe overcrowding:
  - poor follow-up by social work staff due to staffing shortages;
  - incomplete and often unavailable patient records, which contributed to poor treatment decisions; and
  - failure to communicate effectively with the police and family.
- ❑ To deal with the demand for psychiatric inpatient beds, which far exceeded the supply, diversion procedures and "tripwire" agreements were implemented that resulted in the transfer of psychiatric patients from emergency rooms of New York City municipal hospitals to other psychiatric facilities where there were vacant beds.
- ❑ Diversion procedures allowed patients, such as Armando Peteros, to be legally admitted to a hospital, held in the emergency room for up to 72 hours until a bed became available some place in the system, and then transferred to another facility.
- ❑ Essential services, including initial assessment, counseling, medication and referral for continual care, occurred under conditions in a psychiatric emergency room that often bordered on chaos.
- ❑ Support both the OMH plan to expand community residence beds over the next ten years to accommodate an additional 16,000 persons and the OMH intensive case management initiative. In addition, OMH should assure, on a regional basis, the capacity of outpatient programs to provide extended hour clinic services, crisis services both on site and through mobile units, family and in-home support and meaningful follow-up, including home visits to patients who fail to keep appointments and who are likely to decompensate.
- ❑ The Department of Health, in consultation with OMH, should develop specific standards for psychiatric emergency rooms, including staffing standards. The requirement that each PER develop a dependable system for in-house record retrieval should be included in the operating standards.

## Actions

## Commission Recommendations

- ❑ Phase-out the "tripwire" and diversion procedures as soon as possible. To facilitate this goal, the Commission recommended that the Office of Mental Health provide substantial technical assistance to Health and Hospitals Corporation hospitals to ensure that patients who no longer required acute care were placed in more appropriate settings. At the same time, HHC facilities were advised to examine their staffing needs to better comply with the requirements of sound clinical practice, as well as State laws governing discharge planning.
- ❑ In July, 1989, the Office of Mental Health, the New York City Health and Hospitals Corporation and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services signed an agreement "to ensure the effective provision of mental health services in the City of New York." The broad scheme of the agreement will continue the role of City hospitals in providing acute psychiatric services, while the State maintains responsibility primarily for intermediate and extended psychiatric care.
- ❑ The City undertook as a demonstration program, the Coney Island Hospital project aimed at providing managed mental health services to one hundred heavy consumers of services with long histories of recidivism.
- ❑ The Office of Mental Health identified strategies for providing expanded emergency psychiatric services, which include crisis stabilization, crisis outreach, crisis residence, and assessment/referral/diversion.
- ❑ The Office's intensive case management initiative similarly sought to decrease the dependency of the seriously and persistently mentally ill on emergency psychiatric services.

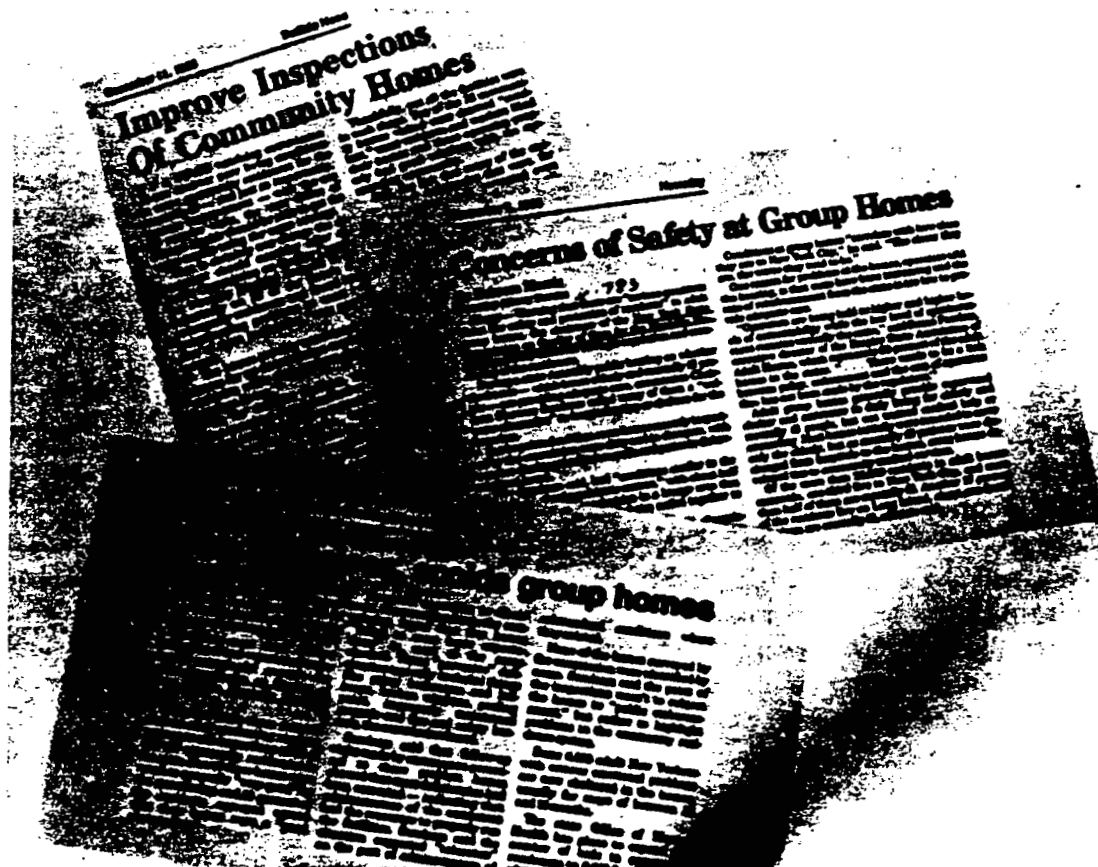
## Fostering Improvements in the Management and Operations of Community Residences

### A Review of 32 Office of Mental Health Supervised Community Residences

NYS Commission on  
 QUALITY  
OF CARE  
for the Mentally Disabled

November 1988

Commission visits and reviews of community residences also serve as catalysts for change. During the reporting period, the Commission published the report, *A Review of 32 Office of Mental Health Supervised Community Residences*, November 1988. The Commission released this study after unannounced reviews of 32 randomly chosen community residences throughout the state which are supervised by the Office of Mental Health. The report details findings in the major areas of environmental conditions, program services, and community integration.



## Findings

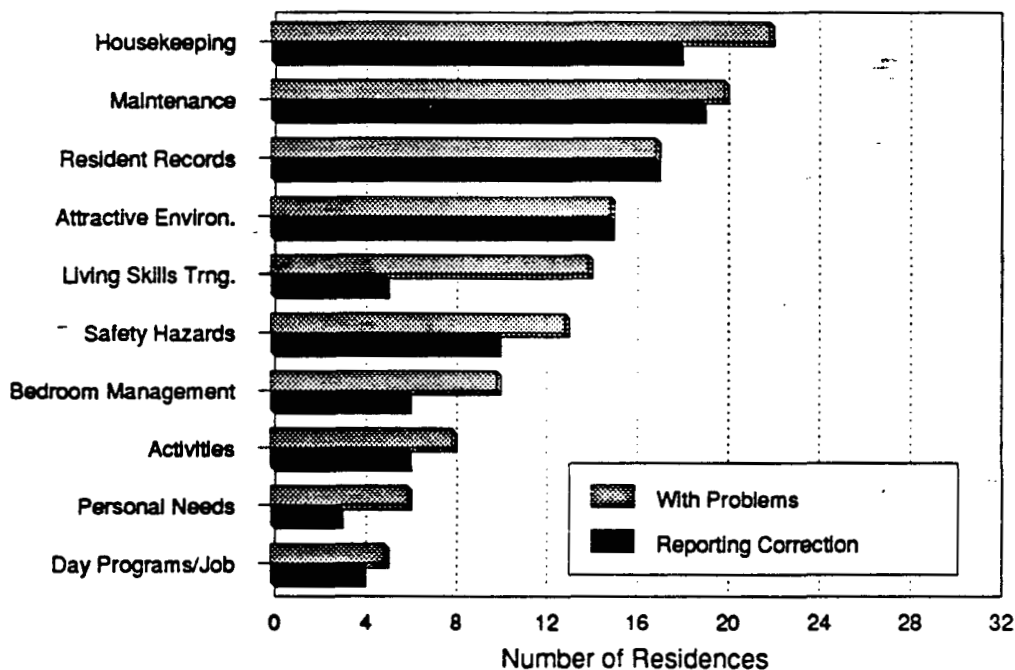
- ❑ 10 of the 32 residences were rated generally as very good in most of the areas examined;
- ❑ most residents (89%) and staff (96%) surveyed were very satisfied with living and working conditions;
- ❑ nearly two-thirds of the community residences, however, had significant problems in several of the areas assessed, with 5 having serious pervasive problems affecting the daily lives of residents;
- ❑ community integration at half the residences surveyed resulted in good relations with neighbors and community organizations. But, other residences made little use of community resources and services, resulting in isolation of residents within their communities; and
- ❑ cited deficiencies at virtually all residences resulted in prompt and substantial corrective action after the Commission's unannounced visits, suggesting that most remedies were well within the reach and budgets of provider agencies.

## Recommendations to OMH to ensure high quality of care and services in all community residences:

- ❑ improve management of residences;
- ❑ strengthen the certification and review process;
- ❑ train residence staff better;
- ❑ develop an independent apartment program; and
- ❑ day programs that respond to residents' needs for vocational and educational services.

The Office of Mental Health substantially endorsed the report's findings and recommendations, and reported that these recommendations are consistent with newly-formulated initiatives and policies at OMH.

## Reported Corrective Actions by the 32 Residences Visited





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## Halting the Diversion of Public Funds

Since its inception, the Commission has found it necessary to use different vehicles to promote change in the fiscal management and delivery of services. Mindful of its mandate to review the cost effectiveness of mental hygiene programs and procedures [N.Y. *Mental Hygiene Law*, §45.07(b)], investigations have been made into the financial practices of facilities where Commission program assessments suggested the need to examine how effectively monies were being spent to produce quality services. These inquiries, many of which have been published as formal reports, found a direct connection between financial abuses by the operators, a weak regulatory system, and the care and conditions at the facilities.

One of the most significant results of these investigations has been the creation and use of new regulatory tools, along with the standard mechanisms (e.g., receivership, license revocation, civil trial, eminent domain condemnation of property, and board member removal proceedings), to deal with significant noncompliance with laws and regulations relating to care and treatment or financial abuse. Throughout this period, the Commission has worked closely, not only with the primary State mental hygiene regulatory and licensing agencies, but also with other government agencies which have collateral jurisdiction over one or more aspects of a case, including: the State Departments of Law, Education, Social Services, State, and Taxation and Finance, and the U.S. Departments of Health and Human Services, Justice, and the Internal Revenue Service.

□ A disturbing pattern of financial abuses through less-than-arm's-length dealings again was found in 1988. The Commission found that the operators of one of the State's largest psychiatric clinic programs improperly billed the Medicaid program for over a million dollars, paid themselves grossly inflated salaries and perks, engaged in self-dealing with family-owned realty enterprises through which they received hundreds of thousands of dollars, and made large unauthorized donations of funds to other charities. Among the specific findings:

- improper Medicaid billings of \$1.4 million by reporting group therapy services at their clinics as individual services for which higher reimbursement is paid, and by operation of an unlicensed clinic;
- the not-for-profit agency, with an annual budget of approximately \$4 million, paid three senior executives in excess of \$150,000/year each, in addition to generous tax-deferred compensation, insurance, and luxury cars for personal and private use; and
- profit-making of \$720,000 over a three-year period through less-than-arm's-length property transactions with family-owned businesses, one of which realized a 4,917 percent return on a \$10,000 investment.

The Commission initially recommended closing one of the loopholes which permitted agency executive self-dealing to remain concealed from the Office of Mental Health. A change was made to the Consolidated Fiscal Report (CFR) system, adding a requirement that related-party transactions by agency administrators and their families be disclosed, and that the CFR be certified by an independent accountant and submitted to the State as a precondition for any future fee increase or contract funding. Furthermore, the Commission will propose legislation to make financial disclosure by agency officials to the State, as well as to agencies' boards of directors, a statutory requirement.

□ Following up on outpatient clinic fees, the Commission found that a proposed across-the-board fee increase of close to \$6 million (\$3.5 million State/local share) for New York City clinics would, in large part, have gone to agencies like this one, which had no demonstrable need for new money. Acting on the Commission's findings and recommendations, the Division of the Budget froze the increase until a methodology could be worked out to prevent windfall profits to Medicaid provid-

ers in the New York City area who didn't need it, while identifying those which did. Projected State/local savings generated from separating the needy agencies from those with apparent surpluses is \$5.7 million for the three years affected by the fee schedule (April 1, 1988 - March 31, 1991).

- The Commission, in 1988-89, also reviewed the cost-effectiveness of a major capital project of the Office of Mental Retardation and Developmental Disabilities to modernize and expand the facilities of a privately run residential school for children and adults with mental retardation. Again, the not-for-profit agency proposed to operate the facility through a non-arm's-length lease with a realty corporation owned by the owner/operator of the school. The proposal called for the renovation and construction of buildings at a cost of \$11.4 million. Upon completion of the project, the lease proposal would raise the cost to \$53.6 million over the next 50 years, and the for-profit realty corporation would fully control the buildings at the expiration of the lease, despite this substantial outlay of public funds.

The Commission's review found windfall profit-making in this proposal which would enrich the owner/operator who was authorized to act on behalf of the not-for-profit agency in negotiating the terms of the lease.

At the recommendation of the Commission, tax-exempt government financing will be proposed to underwrite the direct purchase and renovation of the school by the not-for-profit, which also will assume responsibility for operating the residential school. Use of this approach is estimated to save the State, over the next 50 years, a total of \$26.8 million, consisting of \$16.8 million in owner profits and \$10 million through reduced interest costs. The not-for-profit also would

have benefitted because it would have gained an \$11.4 million equity interest in the property, not including potential equity buildup from property appreciation. Additionally, the devotion of this facility to a public purpose will not necessarily cease due to a lease with the landlord corporation. Legislation to permit the State Dormitory Authority to finance this purchase of the property was passed during the 1989 Legislative Session.

This proposal and other real estate transactions discussed above underscore the need for a uniform policy among State agencies regarding how provider capital projects are financed, what security or other interest the State should retain in such financing, and, most importantly, the character and competence of officials of the corporation who are charged with running it for the public good, not private profit.

"Through a combination of investigative, revenue-maximization, and cost-containment efforts in 1988-89, the Commission estimates annualized savings to the State and local governments of close to \$17 million, or over \$2 million for each analyst in the fiscal bureau."

In Chapter 50, Laws of 1988, the Legislature requested the Commission to undertake a study of outpatient mental health services to assess the programmatic and cost-effectiveness of such services in the mental health system (See above, page 4). Fiscal staff identified some 950 hospital-based and freestanding psychiatric outpatient programs with total expenditures of over \$800 million in 1988.

The analysis disclosed that, despite its significant size and cost, this part of the mental health services was surprisingly lacking in many of the normally expected accountability mechanisms, and those that did exist did not work very well. The Commission concludes that the existing problems, in meeting the needs of the State's citizens with serious mental illness, had less to do with the need for more money than the need for holding existing programs more accountable for providing them with the necessary psychiatric services.

Following a review of the Commission's draft findings, with a recommended morato-

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rium on the issuance of new operating certificates for outpatient services, the OMH Commissioner announced a halt to their further expansion to afford OMH time to thoroughly assess existing regulations, financial mechanisms, and the need for services. The assessment is essential to address the issues of escalating costs and the disparity in the delivery of outpatient services which currently exists.

While gathering cost information for this study, the Commission found that the receipts collected by OMH-operated outpatient programs at State psychiatric centers were substantially less than actual costs because State center outpatient Medicaid reimbursements historically have been based on the fee schedule used to reimburse privately operated mental health agencies. The State's costs to operate its outpatient programs tend to be higher because of State salaries and costs stepped-down from the psychiatric centers. Acting on the Commission's recommendation, the 1989-90 *Executive Budget* made provision that an additional \$30,000,000 for costs currently being incurred should be billed to the Medicaid program. This initiative, which was adopted by the Legislature, will generate an additional \$13,000,000 in reimbursement from the fed-

eral government, and will be a recurring benefit to the State.

- In December 1988, the Chairpersons of the Mental Health, Social Services, and Aging Committees of the State Legislature held a public hearing on adult homes. From testimony presented at the hearing, a study was mandated for adult homes serving individuals discharged from psychiatric facilities. The Legislature specifically designated the Commission to undertake this study, which will include a review of the financial operations of these homes.

Through a combination of investigative, revenue-maximization, and cost-containment efforts in 1988-89, the Commission estimates annualized savings to the State and local governments of close to \$17 million, or over \$2 million for each analyst in the fiscal bureau. Much of the savings are of a recurring nature and do not include potential savings from ongoing recoupment efforts, tighter controls over profit-making abuses by agency executives because of stricter disclosure requirements, and efficiencies from a new rate-setting system which will base rates on analyzed costs and efficiently delivered services.

## Outpatient Mental Health Services Study Catalyst for Fiscal Reform

### Finding

- ❑ While eligibility for federal Medicaid/Medicare reimbursement has reportedly influenced New York's reliance on clinically-oriented outpatient programs, actual federal funding plays a relatively modest role in the financing of outpatient services (13 percent). The State (54 percent) and its local governments (18 percent) pay most of the costs.
- ❑ There are extremely wide variations in the actual per unit cost of providing services, with a range of 545 percent in continuing treatment programs, 1269 percent in clinics, and over 2000 percent in day treatment programs. While these variations are influenced by the auspice of the provider agency (State-operated, hospital-based, or freestanding), there are significant variations within each auspice as well.
- ❑ The availability of close to one-quarter of a billion dollars in deficit funding from the State and local governments to 70 percent of the programs in 1986, has had the perverse effect of removing any incentive for efficient operations or for aggressively seeking third party reimbursement where available.

### Change

- ❑ OMH plans to reconfigure its system by establishing new licensing categories and increasing the range of Medicaid-eligible services. Also, it will move to a pricing system which will base outpatient rates on the estimated costs of efficiently delivered services.
- ❑ A new Consolidated Fiscal Reporting system is being implemented for OMH-funded and non-funded agencies. This major development will greatly enhance OMH's ability to determine the type and volume of services provided in each county, while providing a complete analysis of elements which comprise the costs of delivering each service.
- ❑ Use of performance contracts will provide a tool to reduce duplication of outpatient services, examine deficit funding arrangements, and, if appropriate, remove the State from directly funding programs.

## Strengthening Protective Services for Victims of Neglect: *In the Matter of Francis Helms*

## II. the Matter of Francis Helms

## A REPORT

**BY THE NEW YORK STATE  
COMMISSION ON  
QUALITY OF CARE  
FOR THE MENTALLY DISABLED  
AND THE MENTAL HYGIENE  
MEDICAL REVIEW BOARD**

June 1989

The Commission and its Mental Hygiene Medical Review Board issued a report on the formal investigation into the death of a middle-aged, mentally retarded man. The report, entitled *In the Matter of Francis Helms* (a pseudonym), describes the death of this man, attributed to neglect and deprivation, because the local protective services network, the local office of the State Office of Mental Retardation and Developmental Disabilities (OMRDD), and conservators appointed by the court to monitor the man's well-being, all failed in their duties.

Mar. 26, 1980 Monday

# A Tragic Case of Neglect

... charged with retarded man's care failed him, state says

**Those**  
By Rick Bragg  
Doubt Haven  
1996

**Those Games**  
By Rick Bragg  
Friedrich Harveit, a 60-year-old retired man, was the beneficiary of a \$100,000 bequest from his late, wealthy wife after spending his last years tucked in a room at "Lombardians Lodge," an exclusive "convalescent" nursing home in the last days of Harveit's life. The nursing home was described as "a place where the old can live in comfort and be taken care of," and it was "one of the best in the country," according to the will. The nursing home was described as "a place where the old can live in comfort and be taken care of," and it was "one of the best in the country," according to the will. The nursing home was described as "a place where the old can live in comfort and be taken care of," and it was "one of the best in the country," according to the will.

The morning papers of Cape Breton, the *Chronicler*, carried the news that the Minister of Finance had announced that the Government was prepared to make a loan of \$1,000,000 to the Government of Cape Breton for the purpose of building a new hospital at Sydney. The loan was to be repaid by the Government of Cape Breton over a period of 10 years.

Hornor's two sisters who were co-trustees of the trust fund were "passive recipients of negative reports." A private physician who consulted on Hornor every two or three months "diagnosed his profound depression" by not keeping appointments or communicating at all.

Although many workers who visited Harvey every day to six months made several efforts to get him placed in alternate facilities for the often tense years to embrace him, and then failed to implement a comprehensive federal program to prevent surviving Harvey from being prosecuted, the report states the state's Long Beach, Calif., medical center was only provided with sampling two blood samples.

As a result of the disclosure, state officials say, seven state Office of Mental Health employees connected with the case have faced disciplinary actions ranging from counseling letters to reprimands.

And Horner's former charges of the commission, in Shagb Fennell, a patient neglect before the state professional board, although state health officials would not confirm the case because of the Horner case. Fennell could not be reached for an interview and state officials

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## Findings

- ❑ Mr. Helms was the beneficiary of a trust fund, under a conservatorship created by his father, amounting to approximately \$200,000. Yet, for the last eight years of his life, he was kept locked in a small, filthy, barren room in a frail, elderly woman's home.
- ❑ His days were spent sitting on a commode, with little or no stimulation, while his few social skills dropped away from disuse.
- ❑ In June 1987, suffering from pneumonia, malnutrition, dehydration and gangrenous bedsores which exposed muscle and bone, Francis Helms was admitted to a hospital, but died of the pneumonia five days later.
- ❑ For several years, the agencies and individuals responsible for Helms' protection and care, including a community physician, social services caseworkers, and staff from the Office of Mental Retardation and Developmental Disabilities, were well aware of his deprivation and virtual incarceration in his room.
- ❑ The Commission attributed the inaction to the limited availability of community residential placements for adults with developmental disabilities, which often causes even substandard homes to be viewed as an asset worth preserving.

## To prevent similar tragedies elsewhere in the state, the Commission recommended...

- ❑ The Department of Social Services and the Office of Mental Retardation and Developmental Disabilities develop a Memorandum of Understanding on their protective services roles, including local interagency cooperative agreements on referrals, assessments, joint service planning, periodic case reviews and staff training;
- ❑ OMRDD establish criteria and time frames for visiting and assessing persons with developmentally disabilities known to be at risk;
- ❑ DSS modify its database on protective services cases to include information on disabilities affecting clients who require protective services; and
- ❑ New York State's judicial system review the Helms' case and the measures to avoid the problem which stemmed from the Connecticut Probate Court's failure to request reports by conservators appointed to protect the interests of vulnerable persons. Included would be required visits and assessments by conservators, and physical examinations by physicians.

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## Improving Guardianship

Persons reaching age 18 in our society legally are considered adults. They have certain rights and responsibilities including the right to vote, marry, work, procreate, the right to freedom of choice and movement, the right to control matters relating to health needs, and the right to manage property and income. Due to the nature of certain impairments and disabilities, some persons require assistance in order to exercise their rights in a meaningful way. It is for this reason that measures of protection and surrogate decisionmaking were instituted, as early as Greek and Roman law. The family was the first legally recognized caretaker and surrogate decisionmaker of such persons well over 2000 years ago and this fundamental principle of law still survives in the legal concept of "guardianship."

In New York State, a statute was enacted in 1969 pertaining to guardianships for persons who are mentally retarded (Article 17-A of the Surrogate's Court Procedure Act). The statute was enacted to enable parents to continue protecting the rights and interests of their children after they had reached adulthood. Now, after 20 years, the first major revision to the statute has been made in response to proposals suggested, in large part, by the Commission. The results were passed into law and signed by the governor as Chapter 675 of the Laws of 1989.

In summary, there are three major changes in the new legislation:

1. The protections and rights of Article 17-A (the previous statute) applied to persons with mental retardation are now extended to include per-

sons with developmental disabilities and those who have suffered a traumatic head injury subsequent to the age of eighteen.

This issue was raised during Commission public hearings. Many parents of persons with developmental disabilities, such as autism, testified that they were unable to avail themselves of the benefits afforded by guardianship as a result of the statute's limitation to persons with mental retardation. Questions were raised as to whether or not an application for guardianship on behalf of certain persons, such as a person with autism, cerebral palsy, or a neurological impairment, could even be considered by the court without a finding of mental retardation. By expanding the availability of guardianship to these classes of individuals who may lack the capacity to manage their own affairs, the State will no longer force parents to choose between having their child intentionally misdiagnosed or precluded from guardianship because of this definitional barrier.

2. There are improved and enhanced safeguards for individuals for whom an application of guardianship has been requested.

Under the new legislation, first of all, those individuals considered by the court as "preferred guardians" are now expanded to include the proposed guardian's spouse, adult sibling or adult child. This amendment reflects the growing recognition that family members, rather than parents alone, play a pivotal role in the life of a person with developmental disabilities and as such this provides the court with discretion to choose from all involved parties the most appropriate member of the family to serve as a guardian, in the guardian's best interest.

Secondly, this new legislation mandates the development of uniform forms by the Office of Court Administration in order to encourage greater uniformity in the procedures used by courts in considering an application for guardianship. Such a change greatly improves the capacity of advocates such as the New York State Association for Retarded Children and the Commission to provide training to parents on the necessary contents of a petition.

Thirdly, there is a requirement that the petition include for the court the name and qualifications of the individual under consideration for appointment as guardian. This change should improve the decisionmaking process of the court so as to consider, not only the need for guardianship, but also the appropriateness of the person being recommended for appointment as guardian.

In addition, as another safeguard, the legislation calls for the participation of the guardian at a hearing if at all possible. Previously this could be waived if the individual, as attested to in the application, was unable to understand the nature of the proceedings. The Commission believes that every effort should be made to ensure the participation of the individual in the proceedings in order to both assist the court in determining the need for guardianship and in protecting the rights of the proposed guardian. Through the Commission's experience in administering the Surrogate Decision-Making Program, the Commission has found the presence of the person whose condition is in question to be significant in the decisions reached by the four-person panels.

### **Improvements in Guardianship Law**

- ☐ Protection and rights applied to persons with mental retardation now extended to persons with developmental disabilities and with a traumatic head injury
- ☐ Improved safeguards for individuals for whom guardianship requested, e.g., expanded "preferred guardians," more uniform procedures
- ☐ General provisions of guardianship now consolidated within a single article of law

Finally, among the procedural changes, the new legislation eliminates the provision which automatically terminated guardianship upon the marriage of a ward. Although this provision originally applied only to a mentally retarded woman, amendments enacted in 1976 eliminated this improper sex distinction. As more and more individuals with disability marry, there can no longer be the assumption that the need for guardianship ends. Such termination or modification occurs only upon review by the court.

3. The new legislation consolidates within a single article of law the general provisions for guardianship.

As difficult as it may be for parents and others to consider applying to court for guardianship, it did not seem appropriate to require individuals to weave between different laws to understand this process. The Commission, through its Protection and Advocacy Program for Persons with Developmental Disabilities, has provided extensive training sessions for parents interested in guardianship. The Commission anticipates that, by establishing a comprehensive statute for guardianship, family members and other applicants will be better able to understand the requirements and procedures for becoming a guardian. Appropriately conducted, guardianship enhances a person's autonomy and allows access to necessary services, such as health care, or participation in meaningful activities, as well as the proper management of financial resources. Conversely, improperly or illegally conducted guardianship can amount to grave harm to the ward's life and health (as the above *Helms* investigation demonstrated).

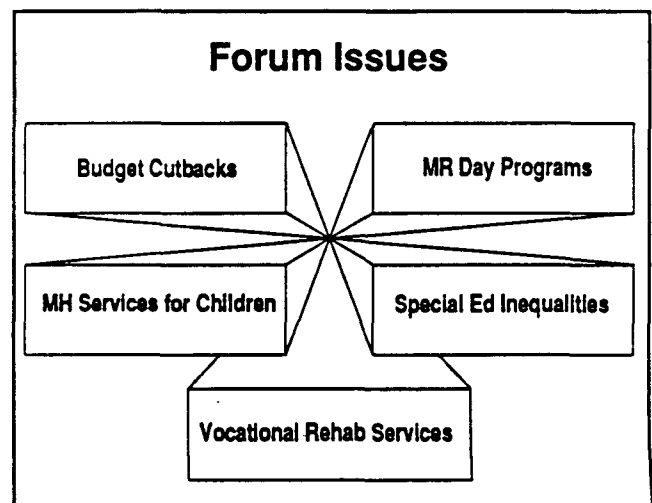
## Promoting Community Dialogue

In April and May 1989, the Commission held four regional forums in Albany, Rochester, New York City, and Long Island to provide individuals the opportunity to speak directly to Commission members on concerns and issues affecting persons with disabilities and on future directions for the State mental hygiene system. Some 100 people presented testimony or filed written statements at the hearings. Participants included consumers,

family members, provider representatives, government representatives, advocates, and educators. Among the issues raised by those presenting at the forums:

- cutbacks in the budget of the Office of Mental Retardation and the impact on persons with developmental disabilities living at home or in the community;
- the perceived restrictive nature of placement of mentally retarded and developmentally disabled individuals in day programs which are seen as inappropriate and not addressing the needs of the individuals placed;
- a lack of guarantees for children who need mental health services because of a "disjointed" service system for children with mental illness and their families;
- the concern by parents and professionals that there are inequalities in the special education system in New York State, particularly related to the segregation of children with handicapping conditions, the selection of impartial hearing officers, and failures to educate in the least restrictive environment; and
- the continued lack of vocational rehabilitation services available to individuals with disabilities, based on disincentives that exist to both consumers and provider agencies in the vocational rehabilitation system, resulting in the unemployment and underemployment of individuals who are disabled.

To assist with specific complaints, Commission staff and advocates from the Protection and Advocacy and Client Assistance Programs were available at the forums.





Plenary Session:  
Wexler

# **Putting Mental Health Into Mental Health Law: Therapeutic Jurisprudence**

David B. Wexler  
Law College Association Professor of Law and Professor of Psychology  
University of Arizona

## Outline of Presentation

Friday, 9:00 - 10:05 am, November 9, 1990

- I. **Traditional Mental Health Law is Not Interdisciplinary**
- II. **Traditional Mental Health Law is Doctrinal/Constitutional**
- III. **The Doctrinal/Constitutional Approach is Running Out of Steam**
- IV. **Therapeutic Jurisprudence Can Invigorate Mental Health Law**
- V. **Definition and Examples of Therapeutic Jurisprudence**
- VI. **Conclusions**

# **THERAPEUTIC JURISPRUDENCE**

## **The Law as a Therapeutic Agent**

**David B. Wexler**  
Law College Association Professor of Law  
and  
Professor of Psychology  
University of Arizona

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# An Introduction to Therapeutic Jurisprudence

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Modern mental health law was conceived when courts and commentators recognized that psychiatrists and other mental health professionals often promised society—and the legal system—far more than they were able to deliver (Szasz, 1963; Kittrie, 1971; cf. *In re Gault*, 1966). That era was typified by the legal profession *deferring* to psychiatry with respect to the content of the law and its administration (e.g., civil commitment effectuated by a “two physician certificate” rather than by a hearing.) Today, by contrast, mental health law emphasizes matters such as procedural protections (due process hearings, assigned lawyers) for persons facing civil commitment. When liberty is at stake, the law is now generally wary of dispensing with procedural safeguards simply because the ultimate disposition may be regarded as therapeutic rather than punitive (compare *Allen v. Illinois*, 1986). In essence, modern mental health law eschews the “medical model” and the “psychiatrization” of the law that was so prominent in the 1950’s.

The law’s civil libertarian concern is to be applauded (Wexler, 1972). Because of its recent history and its antagonism toward psychiatry and related disciplines, however, modern mental health law has not profited from truly interdisciplinary cooperation and interchange—from having the knowledge, theories, and insights of the mental health disciplines help *shape* the law, the legal system, and the behavior of legal actors, just as economic principles have been used to inform legal development in certain other areas of the law, such as antitrust.

But the law’s ignorance of the mental health disciplines should no longer be excused. First of all, courts already *do* occasionally consider (or purport to consider) the anticipated therapeutic outcomes of their rulings, so it is best to focus scholarly attention on such matters to assist courts in reaching correct results. For example, in deciding that juveniles could constitutionally be involuntarily hospitalized without the necessity of a civil commitment hearing, the Supreme Court noted that “it is appropriate to inquire into how such a hearing would contribute to the successful long-range treatment of the patient” (*Parham v. J.R.*, 1979, p.2508; compare Perlin, 1981). Moreover, we are now developing an impressive body of scholarship—known as “social science in law” (Monahan & Walker, 1985)—to aid the law in *evaluating* (not *deferring to*) the contributions of the behavioral sciences (see, e.g., Monahan & Walker, 1986; Walker & Monahan, 1987; Davis, 1987; Perry &

Melton, 1983-84). If mental health information, a subset of the behavioral sciences, is looked to by the law with a healthy skepticism, we ought to be able to profit from some of that information without having the law succumb to passing psychological fads.

Thus, mental health law is now in a reasonably good position both to evaluate mental health information and, because of the law's historical origin and consequent "rights" orientation, to appreciate the crucial importance of certain principles of justice (e.g., the need for counsel; the need for a fair fact-finding mechanism). Within the parameters set by such justice principles, mental health law ought to chart a course that exploits meaningful insights from the mental health disciplines and allows the law to better serve as a therapeutic agent (cf. Melton, 1986). Jurisprudentially, this proposed course of development for mental health law is somewhat akin to a criminal sentencing system that sets sentence *ceilings* according to principles of *justice* ("just deserts") but authorizes the imposition of sentences short of the ceilings according to criminologically-derived *utilitarian* factors, such as the need for general deterrence or for the incapacitation of the offender (cf. Morris, 1981; Morris, 1974; compare Robinson, 1987).

Fortunately, the study of law as a therapeutic agent need not begin completely from scratch. After all, mental health law commentators and investigators have not been wholly oblivious to therapeutic insights. There has been some relevant work. The purpose of this paper is to use that work to suggest an approach for future thought and inquiry and to begin the development of a "therapeutic jurisprudence"—the study of the use of the law to achieve therapeutic objectives.

As I see it, therapeutic jurisprudence can itself be divided into four overlapping areas of inquiry. These involve (1) the role of the law in producing psychological dysfunction, (2) therapeutic aspects of the law, (3) therapeutic aspects of the legal system, and (4) therapeutic aspects of judicial and legal roles. Each will be examined in turn. My purpose throughout will be to raise questions regarding possible relationships between legal arrangements and therapeutic outcomes. Often, I will be aided by the research efforts or outright speculation of others. Regardless of the methodological rigor of the cited literature, however, the references are invaluable in garnering clinical impressions, in raising researchable questions, and in calling attention to possible measures of therapeutic outcome—in short, in helping to devise research strategies and in constructing a research agenda for this important area.

In reading the Introduction and the ensuing chapters, the reader may find it useful to keep in mind the following 9-cell diagram, and to ask whether any particular rule, procedure, or role under discussion is therapeutic, anti-therapeutic, both, or neither:<sup>1</sup>

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1. Thanks to Robert F. Schopp for suggesting the diagram.

	Substantive Law	Legal Procedure	Legal Roles
Therapeutic			
Neutral			
Antitherapeutic			

## Law-Related Psychological Dysfunction

What is at issue here is the extent to which the law itself causes or contributes to psychological dysfunction. The concept of law-related psychological dysfunction ("juridical psychopathology"?) is somewhat similar to the concept of iatrogenic disease in medicine. Because the law may contribute to psychological dysfunction through legal rules, through the workings of the legal system, or through the behavior of legal and judicial actors, this category clearly overlaps with the remaining categories described in this paper. However, because law, like medicine, should strive first to "do no harm," this category (and concept) is of crucial importance and warrants separate attention.

What little work has thus far been done in this area has been highly speculative rather than empirical. Ideally, however, the role of inquiry, research, and policy in this area is to identify and, to the extent such a course of action would be compatible with objectives of justice, to minimize law-produced dysfunction.

The law may contribute to psychological dysfunction in at least three ways. It may (a) discourage persons from seeking needed treatment (or encourage them to terminate treatment prematurely), (b) it may encourage persons to receive unnecessary treatment, or to act in a dysfunctional manner, or to claim to be dysfunctional (which may lead to the perception—and to the self-perception—that they are seriously mentally ill), and—relatedly—(c) the law may, through its labels and attributions, lead persons to regard themselves as dysfunctional or as lacking in control. It is time for some concrete examples.

### *Discouraging Needed Treatment*

As just noted, one example of law-related psychological dysfunction involves the law operating to discourage persons in need from seeking therapy.

In such situations, the law, by discouraging mental health intervention, may contribute indirectly to psychological dysfunction. For instance, laws restricting confidentiality (DeKraai & Sales, 1984) may dissuade patients from divulging to their therapists matters important to the pursuit of successful therapy (compare Shuman & Weiner, 1982). Further, laws permitting insurance companies to refuse to provide health (or life) insurance to persons who have seen a mental health professional more than  $x$  times the preceding year, or who have ever been psychiatric inpatients (Sales, Powell & Van Duizend, 1982, pp. 191-192; Greenley et al., 1978), may work psychological damage because worries over future insurability may operate to discourage persons from pursuing mental health treatment altogether. Research is of course needed to test these behavioral assumptions—that is, to definitively determine whether these laws actually have an anti-therapeutic impact.

### ***Encouraging Unnecessary Treatment and Claims of Dysfunction***

The other side of the coin, of course, deals not with the law discouraging needed treatment, but with it encouraging unnecessary psychiatric treatment. Thus, in a report regarding Veterans Administration psychiatric hospitals and compensation schemes for mental disability, Burt (1973) was particularly troubled by “rules governing compensation and pension eligibility which reward inpatient hospitalization and inadequately assist hospital discharge” (p. 1).<sup>2</sup>

Like disability compensation systems, the incompetence to stand trial (IST) doctrine has the potential of inducing prolonged marginal mental functioning:

If there is a prohibition against bringing to criminal trial a person who is IST and if a person who is IST can be treated on an outpatient basis in his home community, psychologists, psychiatrists, and sociologists might be concerned with certain potential antitherapeutic implications of that psycholegal incentive system. Concern could be expressed over what psychologists might call a “contingency structure” which could induce continued IST status, and psychiatrists might refer to the “secondary gain” advantages that could flow from a patient continuing to

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2. Indeed, there seem to be many examples of compensation-related dysfunction (Estroff, 1981). Some, like the above example, involve encouraging unnecessary treatment. Others involve encouraging claims of dysfunctional behavior, as in the example of clinicians coaching clients how to emphasize dysfunction in order to survive a social security disability hearing (Rosenberg, 1987). Still others involve discouraging needed treatment, as in the example of patients shunning participation in an institutional therapeutic work program for fear that acquisition of work skills might lead to termination of disability benefits (Poitthress, 1987).

play what sociologists refer to as the "psychiatric sick role." In other words, by *remaining* clinically IST while at large in the community, a patient may indefinitely postpone "pending" criminal proceedings without sacrificing liberty (Wexler, 1981, pp. 121-122).

In terms of a possible legal remedy to successfully "treat" that variety of law-related dysfunction, I have noted that "although it is not specifically aimed at overcoming the secondary gain advantages of outpatient IST status, the interesting Burt and Morris (1972) proposal to abolish the incompetence plea—and to criminally try defendants despite their incompetence—would surely deal a crippling blow to any anti-therapeutic aspects of the above-described incentive structure." (Wexler, 1981, p. 122; see also Winick, 1985).

### ***Labels and Attributions***

The IST doctrine may prolong mental illness, but at least it does not encourage violent behavior. The law's treatment of intoxication, however, may produce psychological dysfunction by encouraging intoxicated offenders not only to assume that they lack volitional control, but to act aggressively as well. That is because the law often allows intoxication to mitigate a criminal sentence, to reduce a criminal charge, or even to exculpate an intoxicated offender. In so doing, the law makes certain assumptions about the impact of intoxication on behavior, and it sends a signal that it does not *expect* an intoxicated person to exercise volitional control nor even to be able to cabin aggressive impulses. Some literature, however, calls into question the law's assumptions and wisdom.

It is clear that there is a strong relationship between alcohol and aggression, but precisely "*how* alcohol affects aggression is the significant but presently unresolved question." (Pihl et al., 1981, p. 468, emphasis added). The law surely assumes that alcohol operates pharmacologically to reduce inhibitory controls. But researchers have found strong "expectancy" and "attribution" effects in aggression among intoxicated or supposedly intoxicated subjects. In one study (Lang, et al., 1975, p. 516), for example,

differences in the level of aggression observed were determined largely by subjects' expectation or belief about the content of the beverage they had consumed. Those who thought their drinks contained alcohol, regardless of the actual alcoholic content, gave more intense and larger shocks to their partners than those who believed they had consumed only nonalcoholic drinks.

Given the contribution of the psychological factors, in addition to the pharmacological factors, one commentator has recently written that "current criminal law doctrine may therefore amplify drug-related aggressiveness by publicizing a false picture of the intoxicated offender as wild, dangerous, unconscious or out of control" (Mitchell, 1988, p. 87). He notes further



(p. 87) that "culturally conditioned expectations and patterns of alcohol-related behavior may explain why violence under the influence is less common in some cultures than others."

It would be interesting to learn whether, in cultures with lower levels of alcohol-related violence, the law is different from and less exculpatory than is the law in cultures with higher levels of alcohol-related violence. Of course, even if such a relationship were found, we would not know with certainty whether the law had a role in *causing* the cultural expectations (and the reduced alcohol-related violence), or whether the law simply *reflected* that cultural expectation (or both).

The existence—and scope—of the insanity defense poses somewhat similar concerns. Does labeling an offender insane and nonresponsible lead to providing him with needed treatment he would not receive in prison, or does it create a self-fulfilling prophecy likely to *render* him nonresponsible in the future (Monahan, 1973, pp. 721-723; Wexler 1972, pp. 308-311; cf. Fein, 1984)? And regardless of the impact the label has on such persons, what impact does the existence of the insanity defense have on the *rest* of us?:

The defenders of the insanity defense assume that its invocation affects the attitudes of the populace through the psychological process of contrast. Citizens are exposed to the bizarre behavior of those labeled irresponsible through the ascription of insanity, and contrast their own "normal" behavior with that of the defendant. They reason: "He is irresponsible. I am not like him. Therefore, I must be responsible."

It can also be argued, however, that the psychological process evoked by the insanity defense is more likely to be assimilation. If individuals frequently hear that some people are not being held responsible for their behavior, they may begin to wonder, "Maybe sometimes I, too, am not responsible for my behavior" (Monahan, 1973, p. 724; see also Hans & Slater, 1984).

The law-related psychological dysfunction strand of therapeutic jurisprudence, then, asks us to inquire into ways in which the law itself—or its labels (Sales & Kahle, 1980; Link, Cullen, Frank & Wozniak, 1987)—may be promoting dysfunction. Hence, the ultimate task of scholars and policy-makers will be to recommend changes in the law (or even in its labels) so as to reduce law-caused dysfunction. This contrasts with the objective of the next section, which calls for examining ways in which the law may best affirmatively promote therapeutic objectives.

## Therapeutic Aspects of the Law

When the law seeks expressly to promote therapeutic objectives (Winick, 1988)—as it does paradigmatically in the conventionally-defined area of men-

tal health law—the impact of the law should be examined carefully to see whether that goal is in fact being realized. The “right to treatment,” for example, is obviously intended to achieve therapeutic gains (Perlin, 1976). And the civil commitment system purports to mix police power objectives (i.e., public protection) with paternalistic (i.e., protecting those unable to help themselves) and therapeutic ones. To date, however, surprisingly little empirical work has been performed to evaluate the law’s performance with respect to its promotion of therapeutic objectives in these areas or in the related area of guardianship (Massad & Sales, 1981).

With regard to the right to treatment, O’Reilly and Sales (1986, 1987) have probed some of the assumptions underlying the landmark right to treatment decision of *Wyatt v. Stickney* (1972). As part and parcel of the right to treatment, the *Wyatt* court mandated not only the preparation of individual treatment plans and a certain staff/patient ratio, but also a humane physical environment for ensuring patient privacy. O’Reilly and Sales noted that “if providing privacy is important for the therapeutic milieu, then one would expect better patient recovery, all things being equal, in facilities that provide more privacy” (1987, p. 47). Although privacy seems intuitively to have therapeutic value, therapeutic outcome studies in institutions or wards with varying degrees of privacy have not yet been performed. O’Reilly and Sales did learn, however, that the *Wyatt* court’s notion of equating privacy with physical partitions or screens is far too underinclusive when judged by patient perceptions of adequate privacy. Patients, for example, were concerned also with crowding, noises, odors, and conversational privacy (p. 48).

In terms of the therapeutic outcome of the commitment process itself, the most interesting work has been performed by Durham and LaFond (1985). Examining the impact of the expansion of the “grave disability” commitment criterion of the Washington commitment code, Durham and LaFond found a drastic increase in the number of persons committed, and found much of the increase attributable to a “new” client population: persons who were not committable under the old law but who are now committed as gravely disabled. Moreover, those persons committed as gravely disabled often became recurrent users of the system and seemingly became dependent upon the institution. Perhaps the new law is appropriate and is merely subjecting to commitment a class of people who, under the old law, were particularly distressed and in need of attention. The authors, however, have a different interpretation. They believe the law may be itself creating a class of chronically mentally ill—or at least chronically dependent—persons. If so, this is a dramatic example of law-related dysfunction produced by a law designed to provide treatment for the mentally ill!

Much more work is of course needed in the area of the intended and unintended consequences of forced hospitalization and other coercive treatments on mental patients (Kiesler & Sibulkin, 1987), drug abusers (Salmon

& Salmon, 1983), and alcoholics (Fagan & Fagan, 1982). Studies are needed regarding patient satisfaction following commitment (Kalman, 1983) and following the involuntary administration of antipsychotic medication (Schwartz et al., 1988; see also Appelbaum & Hoge, 1986). With respect to forced medication, Roth (1988) has suggested an interesting research agenda:

Certain comparative studies might also profitably be done between jurisdictions where treatment refusals (inhospital) are now resolved by differing decisionmakers, e.g., by psychiatrists (second opinions), other mental health professionals, committees, or judges in judicial hearings, etc. Such approaches give patients varying degrees of due process, varying opportunities "to have their case heard." They might therefore result in differing patient attitudes and even conceivably different outcomes related to treatment refusal.

Surveying the literature, Durham and LaFond (1988) noted the absence of research on the efficacy of involuntary versus voluntary confinement; they further concluded that there is insufficient evidence to establish the efficacy of psychotherapy or even of drugs in treating non-dangerous, involuntarily confined patients. In fact, they conclude that, if anything, the evidence suggests that involuntary patients are harmed by the experience (see also Dresser, 1984). If effectiveness cannot be established, an interesting legal argument might be mounted to limit mental health testimony at commitment hearings or even to undermine entirely the legal basis for paternalistically-based commitments (cf. *Matter of Wilson*, 1983; *Barefoot v. Estelle*, 1983).

Other commentators have brought less empirically-based insights from the mental health disciplines to bear on the analysis of the proper role of the law in the treatment process. Burt (1979), for example, examines civil commitment and related matters from a largely psychoanalytical perspective. In his view, distressed patients produce stress and discomfort in the rest of us (including treatment personnel), leading us to treat such persons in a destructive manner. Ideally, the destructive consequences of that stress and discomfort can be reduced by ongoing communication and negotiation between doctor and patient. Pre-treatment legal intervention mechanisms such as civil commitment proceedings, however, render unnecessary and thus thwart the possibility of such communication and negotiation. Burt would therefore reform commitment laws to allow only for very short-term commitments, during which time a doctor-patient dialogue would be fostered. Burt's proposal is subject to criticism (Wexler, 1980a), but it provides interesting food for thought.

Relatedly, drawing on the family therapy approach of Jay Haley (1980), I (Wexler, 1986) too have argued that civil libertarian commitment codes (i.e., those that preclude commitment absent a showing of a person's actual

inability to cope in the community) may have greater therapeutic potential than do the so-called paternalistic laws (i.e., those that authorize commitment because of a person's mental deterioration or need for treatment) that threaten to supplant them. Haley believes that mental illness in young adults is attributable to the young person's exploitation of weak and divided parental leadership or to an effort by the young person to stem serious parental conflict. The suggested therapy seeks to achieve normality in the young person through inducing the parents to assert unified authority. They are encouraged by the therapist to agree upon goals, expectations, limits, rules, consequences, and timetables for the young person; the rules and consequences should be specific and should be strictly enforced.

If Haley's view is correct, therapeutic gains might best be achieved not under a paternalistic commitment law where commitment is easily achieved by psychiatric say-so, but rather under a civil libertarian one where factual evidence is required of a respondent's inability to provide food, clothing, shelter, etc. (*Matter of Carl C.*, 1987; *State v. Nance*, 1987). Under such a civil libertarian law, it might at first appear that parents would be faced with only two options, both of which are highly unsatisfactory: either accept the status quo or evict the young person so as to gather evidence of his or her inability to cope in the community. Importantly, however, a civil libertarian commitment law can be implemented in a third way by legally-astute and therapeutically-sensitive commitment officials. That third alternative is to induce the parents seeking legal commitment to do what Haley thinks they should do *therapeutically*: push the young adult to begin to behave independently and responsibly—take a bus, look for a job, etc. If the young person is unsuccessful in doing so, the actual evidence of committability will then be present. But if the process is successful, commitment will not be needed. Thus, if Haley's therapeutic notions are correct, "the very process of gathering evidence of a person's committability under a libertarian law may operate therapeutically to render commitment unnecessary" (Wexler, 1986, p. 54).

The possible dovetailing of Haley's therapy with civil libertarian commitment laws raises some interesting matters. First, it points out the importance—for therapeutic and public policy purposes—of performing needed empirical research on the effectiveness of psychotherapy and treatment generally (Smith, Glass, & Miller, 1980). Second, it raises, in a context very different from the traditional one, the issue of "distributive justice" (Rawls, 1971; Delgado, 1984). If Haley is correct (compare Durham & La Fond, 1988), a civil libertarian commitment law will be the most therapeutic type of law for *young adults*. But what if such a law were *not* the best for *other* age groups? If only a single commitment law for a jurisdiction is feasible (a matter which is itself debatable), whose therapeutic interests should be served by such a unitary law? Clearly, therapeutic jurisprudence will have a strong "jurisprudential" component as well as a "therapeutic" one.

Although Haley's type of therapy seems to fit best with a particular type of mental health code, exercises in therapeutic jurisprudence will often suggest no clear fit between a particular therapy and a particular commitment code. For example, a current family-oriented therapy of considerable interest is "psychoeducation" (Anderson, Reiss, & Hogarty, 1986) to reduce "expressed emotion" (Leff & Vaughn, 1985). Expressed emotion theory differs in many ways from Haley's. Further, unlike Haley's theory, expressed emotion theory has considerable empirical support, though it has come under recent thoughtful attack (Kanter, Lamb, & Loeper, 1987a, 1987b; Hatfield, 1987; Leff & Vaughn, 1987).

Briefly, expressed emotion theory, while not disputing the biological roots of schizophrenia, holds that a patient's schizophrenic symptoms and relapse (and perhaps bipolar disorder as well—Miklowitz et al., 1988) can be seriously exacerbated by high expressed emotion—principally critical comments and emotional overinvolvement—on the part of his or her family. A principal purpose of psychoeducation is to encourage a family to reduce its critical comments to, and its emotional overinvolvement with, the patient.

At first blush, it might seem that a civil libertarian commitment law might itself work eventually to reduce a family's expressed emotion: When commitment is difficult to effectuate, a family having to cope with a problem patient without having the option of commitment readily available might find that its only sensible course of action is to emotionally disengage somewhat from the patient and his or her day-to-day activities—i.e., to increase tolerance and to reduce emotional overinvolvement (Greenley, 1979). According to expressed emotion theory, that course of action should in itself prove therapeutic for the patient and thus perhaps render hospitalization unnecessary.<sup>3</sup>

The problem with that analysis, however, is that a civil libertarian commitment code merely lessens the viability of the option of *involuntary* commitment; it of course does not cut off the patient's opportunity to seek *voluntary* admission. And if involuntary commitment is basically unavailable to a family, the family may turn its time and attention to trying, day-by-day, to convince the patient to seek voluntary admission (Burt, 1979). Instead of reducing expressed emotion, therefore, a civil libertarian commitment code may merely *shift* a family's emotional overinvolvement from the involuntary

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3. It could be argued that expressed emotion would be best reduced by laws where commitment is *readily available*. Under such laws, the patient would be removed from the emotionally-charged environment, and the family might, during that period, receive therapeutic guidance on how best to reduce its expressed emotion. The problem with that analysis, however, is that the *law* would play no role in inducing the family to disengage emotionally. In all likelihood, therefore, the family would go about its business in the patient's absence and resume its emotional involvement upon the patient's return home. Moreover, the readily available commitment option would remain a tool in the family's arsenal of expressed emotion.

commitment route to the voluntary admission route. In other words, under a broad, paternalistic commitment code, familial criticism and emotional overinvolvement might well find expression through the use, contemplated use, or threatened use of the commitment process; under a civil libertarian law, high expressed emotion may well be manifested instead by exerting pressure on the patient to volunteer for admission. In the final analysis, therefore, a civil libertarian commitment code, which fits nicely with Haley's theory, would not clearly lead to reduced emotional overinvolvement under expressed emotion theory. Even if expressed emotion theory is accepted, therefore, a choice between a civil libertarian and a paternalistic commitment code ought to be made on a basis other than supposed therapeutic benefit tied to reducing expressed emotion.

Even within a system designed generally to promote therapy, the law sometimes acts to realize additional, non-therapeutic objectives—such as protecting the interests of potential victims of patient violence, as in the *Tarasoff* case (1976), or in respecting patient autonomy, as in the right-to-refuse treatment context. Here, too, however, more research and critical inquiry is needed regarding the therapeutic consequences of such rules: therapeutic impact is obviously an important factor, even if not a dispositive one, in the interest-balancing process of deciding whether, and to what extent, such rules should be recognized.

For example, Stone (1976) argued forcefully against the recognition of a rule imposing upon a therapist a duty to protect a third person who may be endangered by the violent act of the therapist's patient. Stone asserted that such a duty would operate to destroy therapist-patient trust and would therefore deal a crippling blow to therapy. I have argued (Wexler, 1979), however, that since the great bulk of patient violence (and violent threats) is directed at family members who often contribute to the violence, and since therapeutic efforts in that context should accordingly take a "couple" therapy or a "conjoint" therapy approach, *Tarasoff* might well have an aggregate beneficial effect on therapy by inducing therapists to opt for a conjoint rather than a traditional dyadic approach to therapy (see also Wulsin, Bursztajn, & Gutheil, 1983). In a later piece (Wexler, 1980b), I tried to devise a legal scheme to finesse the "distributive justice" problem of the adverse impact of *Tarasoff* in situations where the potential victim is not a family member or one likely to be a suitable candidate for conjoint therapy.

Obviously, the resolution of the therapeutic controversy surrounding *Tarasoff* should be important to courts considering whether to adopt or retain a *Tarasoff*-type rule. If Stone is correct, courts will be (and should be) more reluctant to adopt such a rule than if I am correct.

In terms of future research, a particular effort should be made to focus on the therapeutic implications of civil libertarian approaches to mental health law. Such approaches (e.g., right to refuse treatment) are typically

designed to promote non-therapeutic values (e.g., autonomy), and it would therefore not be surprising to learn that they in fact inhibit the therapeutic mission much as the exclusionary rule, which is designed to promote police respect for the law, might inhibit the truth-seeking mission of the criminal trial process. But the empirical evidence ought to be relevant to a determination of the extent to which a given right will be recognized (cf. *United States v. Leon*, 1984). If a given right (or proposed right) impacts only slightly or moderately on the therapeutic mission, that right is likely to gain (or retain) recognition far more easily than if its recognition would deal the therapeutic mission a crippling blow. Similarly, it is always possible—as the discussion of the possible therapeutic potential of civil libertarian commitment codes suggests (see also Wexler, 1986, p. 40, n. 10)—that civil libertarian approaches may be found to be compatible with, and even advantageous to, the therapeutic mission. If so, the result should be clear, for the interest-balancing process should then tip dramatically in a single direction.

### Therapeutic Aspects of the Legal System

Apart from specific substantive rules of law, the legal system itself—especially the legal apparatus used to litigate questions of committability and the like—should be examined, and perhaps restructured, to maximize its therapeutic aspects and to minimize its anti-therapeutic aspects. In particular, the commitment hearing should be grist for the interdisciplinary research mill, though grievance procedures and other conflict resolution mechanisms are also ripe for examination (Drake & Osher, 1987).

Commentators have at least begun to scratch the surface of the impact on respondents of civil commitment hearings. They have catalogued some of the purported pros and cons of such hearings, have provided some anecdotal evidence, and have on occasion raised some seemingly researchable questions (Wexler, 1971, pp. 69-76; Ensminger & Liguori, 1978; Amaya & Burlingame, 1981).

One of the most pressing issues, of course, is the question of trauma, particularly in terms of the revelation of embarrassing material, the revelation by a mental health professional of a serious diagnosis or a poor prognosis, the reinforcement of persecutory delusions, the disclosure to the patient of the opinions of family members, and so on (Ensminger & Liguori, p. 6). Amaya and Burlingame, in an attempt to urge states to take advantage of the *Parham* (1979) rule, which does not mandate commitment hearings for the commitment of juveniles, catalogue what the authors believe are the particularly stressful and counterproductive aspects of commitment hearings involving juveniles (p. 766; compare Perlin, 1981).

Even if the commitment hearing appears traumatic, some writers have asked whether the trauma is actually attributable to the hearing or whether it flows from the very existence of a system of involuntary hospitalization (Wexler & Scoville, 1971, p. 710). A meaningful question is whether even greater Kafka-esque trauma (and a sense of injustice) would be produced by dispensing with the hearing altogether. With respect to juveniles, this matter may indeed be profitably researched, as may the claim made by Amaya and Burlingame that, because of its adversarial nature, "the hearing seems to reduce, at least temporarily, the staff's authority and credibility in the eyes of the children" (p. 772). Research is possible because our federal system has provided us with a natural laboratory: some states have followed *Parham's* cue and have dispensed with juvenile commitment hearings, while others have decided to exceed the constitutional minima of *Parham* and have provided for hearings in juvenile commitment cases. Even with respect to adults, there is sufficient variation across the country to provide a natural laboratory. For example, some jurisdictions require pre-commitment hearings while others continue to opt for medical certification procedures with hearings available after-the-fact.

The argument has also been made that commitment hearings themselves are actually therapeutically advantageous. They may, for example, serve as a type of "reality therapy," informing the patient of behaviors thought to be objectionable. Even Amaya and Burlingame, themselves strong opponents of hearings at least in the juvenile context, believe that hearings can be useful in cases of manipulative, acting-out adolescents. In such cases, "the addition of one more authoritative voice [i.e., the judge] to the ensemble that is insisting that the personality-disordered youth must change herself, not her environment, can be useful" (p. 773).

In their strong defense of the therapeutic potential of commitment hearings, Ensminger and Liguori (1978) make several interesting assertions that seem susceptible to empirical investigation (see also Ellis, 1976; Eisenberg et al., 1980). They claim, for example, that the use of outside experts by respondents' attorneys is likely to be therapeutically useful to the patient because "inevitably, such contact with psychiatrists and psychologists from the community places additional pressure on the hospital to get to know the patient, as this may be necessary to refute charges of misdiagnosis or inappropriate treatment" (p. 17). Future research might seek to uncover whether there is in fact greater therapist knowledge regarding patients in jurisdictions that authorize (and actually use) independent evaluators compared with jurisdictions that do not. Similarly, Ensminger and Liguori assert that the prospect of cross-examination tends to encourage testifying mental health professionals to prepare for court, and "the introduction of commitment hearings leads to better documentation and earlier staffing for involuntarily committed patients" (p. 20).



Ensminger and Liguori also claim that commitment hearings are therapeutic—or, with some hospital staff effort, could be made to be therapeutic—because of some similarities between commitment proceedings and “therapeutic community” principles (p. 21):

For instance, the “therapeutic community” concept suggests that a crisis resolution should involve (a) a face-to-face confrontation involving all major participants in the crisis situation; (2) occurring as soon as possible after the crisis arises; (3) under skilled neutral leadership; (4) allowing for open communication without fear of reprisal; and (5) with an appropriate level of feeling, neither too little nor too much. The analogies to the commitment process are evident.

Of course, those who subscribe not to “therapeutic community” principles, but instead to notions of “expressed emotion” causing schizophrenic relapse, might find this procedural mechanism objectionable and anti-therapeutic (Drake & Osher, 1987). Interestingly, however, if these two schools of thought do in fact conflict over the therapeutic or anti-therapeutic impact of commitment hearings, research in the commitment context may be able indirectly to shed some light on the relative merits of the respective theories and therapeutic approaches. The diversity of hearing requirements in different states, such as whether hearings are conducted by a judge or by a panel of doctors and lawyers, also invites research on the therapeutic value of various procedural models (Amaya & Burlingame, pp. 773-774; Wexler & Scoville, 1971, p. 72).

### **Therapeutic Aspects of Judicial and Legal Roles**

A final aspect of therapeutic jurisprudence to be discussed here is the examination of and eventual tinkering with the roles and behavior of judges and attorneys so that those persons may perform in a fashion that meshes with professional ethics and yet is therapeutically beneficial.

Amaya and Burlingame (p. 769, 772-773) have given examples of how judges have rendered both a therapeutic service and a therapeutic disservice to respondents appearing before them at commitment hearings (Amaya & Burlingame, p. 769, 772-773). As noted in the preceding section, judges can be therapeutically helpful in dealing with acting-out adolescents who are attempting to evade responsibility for their actions. But if they are not sufficiently sensitive in their communications from the bench—as when finding a respondent to have diminished intellectual capacity—they may unnecessarily produce agitation and major problems of self-esteem (p. 769).

More so than judges, lawyers have come under fire from mental health professionals for unwittingly encouraging acting-out behavior and for fos-

tering patients' resistance to therapy (Amaya & Burlingame, p. 768; Miller et al, p. 116; Gutheil, 1985). In an interesting piece, Miller, Maier, Blancke, and Doren (1986) described how patient grievances are sometimes asserted "to protect patients from having to deal with painful intrapsychic conflicts unrelated to the subjects of the actual grievances" (p. 112). When attorneys uncritically accept and press these grievances, the actions of the attorneys may reinforce patient resistance to therapy. The authors assert from their experience, however, that attorneys can be taught to play a therapeutic role in the process. In one case, for example (p. 117),

at first, the supervising attorneys in the state patient's rights office, who had no clinical experience and a significant libertarian orientation, did not recognize the hidden agendas behind many of Mr. A's charges, and unwittingly contributed to his therapeutic resistance by supporting his overt grievances. After considerable effort at education by clinical staff about borderline psychodynamics, however, the attorneys realized how they had been furthering their clients' resistance (and thus hindering his treatment) by accepting his grievances at face value. Once they understood the nature of his resistance, they often reinforced the therapy through clinically insightful responses to his grievances, while still maintaining their concern for his rights.

To me, the Miller, Maier, Blancke, and Doren piece raises several important questions:

1. Is "resistance" through invoking the legal process a real phenomenon, or is it merely a self-serving maneuver by mental health professionals to coopt advocates and thereby to reduce the legal pursuit of patient grievances?

Whether such resistance really exists may be difficult to determine. But it at least seems clear that mental health professionals believe in good faith that it exists in at least some contexts. For example, mental health professionals claim to have observed the phenomenon not only in psychiatric patients resisting therapy, but also in *psychiatric residents* handling training anxiety (fear of dealing with frightening patients, distaste for time-consuming paper work) by inappropriately stretching legal concepts (patient's right to refuse treatment, patient's right to confidentiality) to avoid engaging in unpleasant professional work (Gutheil, 1979).

2. In precisely what ways do attorneys interfere with therapy, and what sort of training is necessary to render them "clinically-sensitive"? Will attorneys and judges resist taking on a quasi-clinical role (just as many attorneys and judges resented the "social worker" role thrust upon them by juvenile courts of an earlier era)?

Here, there is a need for research, particularly of a descriptive nature. As noted above, some anecdotal information is provided in the piece by Miller, et al. Ensminger and Liguori (1978), who write from the vantage

point of an advocacy organization but who believe lawyers and judges can perform their roles to therapeutic advantage, also provide some examples. And Brakel (1981), who has studied legal services in mental hospitals, has provided detailed descriptions of the functioning of mental hospital legal aid offices with varying philosophies and priorities.

Eventually, if other variables could be controlled, it might be interesting and helpful to compare therapeutic outcomes of hospital patients serviced by purely adversarial attorneys and of patients serviced by "clinically-insightful" attorneys. Long before then, however, we will need considerably more descriptive research regarding the actual behavior of attorneys in varying settings, together with analyses of mental health professionals on the therapeutic helpfulness or harmfulness of such behavior. We will need information, too, on the feasibility and effectiveness of training programs designed to provide attorneys with clinical insight.

3. What is the ethical propriety of judges and lawyers behaving in a therapeutic fashion, particularly if lawyer behavior departs from the traditional advocacy model?

With little difficulty, and without a major change in role, judges can be sensitized to perform in a more therapeutic fashion. Some examples have been given previously. In addition, Ensminger and Liguori (pp. 12-14) believe that hearings will be more therapeutic if matters are honestly expressed and if mixed messages are avoided. They call upon judges to play a more active role in regulating such hearings and in limiting the confusion.

With respect to the role of attorneys, it is best to distinguish ethically between behavior at a commitment hearing itself and behavior in asserting post-commitment institutional grievances. At a commitment hearing, where, like in a criminal proceeding, the state is the moving force and the respondent's liberty is at stake, the adversary nature of an attorney's role is—or at least should be (Poitress, 1978)—at its highpoint (National Center for State Courts, 1987; Note, 1975). Even so, the attorney may be able in some ways to consider therapeutically-sound strategies, such as moving to exclude the public when embarrassing material is about to be presented (Ensminger & Liguori, p. 15).

It is in the post-hearing institutional setting, however, where a departure from the adversarial role is most palatable, and where therapeutic insights may perhaps most profitably be brought to bear on the role of the attorney. Grievances are now brought by the *patient* as initiator, not the state (Ross v. Moffitt, 1974). Further, as Brakel (1981) has shown (see also Brakel, 1977), demand for legal services in this context will far outstrip supply, and hence the nature and type of cases brought must inevitably involve the setting of priorities by program attorneys. Brakel's work is an excellent example of how descriptive ethics can inform normative ethics (Schneyer, 1986).

Often, the case priorities will be set implicitly by subjective preferences of the attorneys. But there is surely room here for explicit consideration of

priorities, as well as for the lawyers to view themselves largely in the role of counselor, as they often do in domestic relations and child custody disputes. Especially given the limitations on supply, there is no need for lawyers to accept uncritically and to press every institutional claim brought to them. Indeed, Rule 1.14 of the American Bar Association Model Rules of Professional Conduct (1983) recognizes that a lawyer representing a mentally disabled client may sometimes have to function as a *de facto* guardian. Moreover, just as lawyers may (should?) advise family members that the pursuit of a wrongful death claim may interfere with the grieving process (Rosenblatt, 1983), lawyers may, for example, ask a client to consider whether the pursuit of a certain grievance is in actuality an attempt to resist therapy. For lawyers properly to play such a role, however, further work needs to be performed in marshalling mental health insights, in documenting the extent to which lawyers can be trained to function as therapeutic agents, and in examining the ethical implications of that revised role. Such work is particularly needed now that Protection and Advocacy Systems have been established to serve the legal needs of the institutionalized mentally ill.<sup>4</sup>

## Conclusion

I hope the preceding discussion points scholars in the field of mental health law in a direction that may profitably unite those with mental health and those with legal backgrounds for the purposes of critical thinking, inquiry, research, and action.

A research agenda in therapeutic jurisprudence carries with it certain priorities in terms of mental health research generally. First of all, despite recent meaningful advances in biochemical approaches to mental illness and its treatment, the therapeutic jurisprudence perspective calls upon us not to overlook the social-psychological domain (compare Miles, 1987). Surely, if the *law* is to have any role in reversing mental illness and in promoting therapy, we must be alert to *manipulable social forces* that cause, contribute to, exacerbate, alleviate, etc., mental illness. After all, if the *law* works to influence behavior at all, it does so as a *psychosocial process*.

Further, the law in this area cannot prosper in the absence of meaningful research on therapy. By focusing on the type of therapeutic research that can inform the law, therapeutic jurisprudence can also help us set priorities on *which* therapeutic schemes deserve particular research support. (Consider, for example, the relevance of research on therapy to the resolution of a number of questions raised in our earlier discussion: How viable is Haley's theory

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4. Work is also needed regarding the role of the attorney for the *state* (Miller & Maier, 1987; Hoge & Gutheil, 1987; Wexler, 1983).

and therapy relating to disturbed young adults? Are persons who threaten violence to others best treated through a conjoint or through a dyadic therapeutic approach? Do principles of the "therapeutic community" conflict with principles of "expressed emotion?" In the treatment of schizophrenics, how important is straight talk and the avoidance of mixed messages?).

Besides providing a research agenda, therapeutic jurisprudence should help us focus our thought and action. Despite research efforts, for example, some areas will continue to spawn serious debate among different therapeutic schools of thought (Fischl, 1987, p. 522). At the least, however, those combatants ought to have an appreciation of the law and an understanding of which legal schemes best foster—or can be implemented to foster—the particular therapeutic approach to which they subscribe. For example, even without further research on the effectiveness of Haley's therapy, mental health professionals who favor his approach may, from the therapeutic jurisprudence literature, learn how civil libertarian commitment codes can be implemented to dovetail nicely with his therapeutic approach.

Finally, in the aftermath of the research and thinking, the accumulated body of knowledge may be useful to practicing legal and mental health professionals. Indeed, with such knowledge, the professionals might strive together to reform the law and the legal system to help counteract mental illness and to help promote mental health.

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Health Care Compliance Principles and the Insanity Acquittee  
Conditional Release Process

David B. Wexler<sup>\*</sup>

The medical profession has long known that patients often fail to comply with medically-prescribed treatment regimens. Increasingly, the health care compliance problem has attracted the attention of psychologists interested in understanding, explaining, and improving patient compliance. Now, Donald Meichenbaum and Dennis Turk have marshalled the literature and have published a book entitled Facilitating Treatment Adherence: A Practitioner's Guidebook.<sup>1</sup> The book presents a set of principles designed to help the medical profession increase patient treatment adherence.

The book does not deal with the legal system at all. And although it discusses the research on compliance and non-compliance by mental health outpatients (particularly those diagnosed as having schizophrenia,<sup>2</sup> bipolar disorder,<sup>3</sup> and alcoholism),<sup>4</sup> it cannot be classified as a book specializing in mental patient compliance. Nonetheless, the Meichenbaum and Turk principles have the potential of making a substantial contribution to the field of mental health law. In fact, the purpose of the present article is to demonstrate how health care compliance principles might be used by the judiciary and the legal system to increase the medication and



treatment compliance of a very worrisome group -- conditionally released insanity acquittees.

More specifically, the article will suggest how, consistent with psychological principles of health care compliance, insanity acquittee conditional release hearings might be restructured, and how the judicial role in such hearings might be altered, so as to enhance the probability of adherence by the patients eventually granted conditional release. As such, the topic falls squarely within the research agenda of "therapeutic jurisprudence."<sup>5</sup>

Before turning to the health care compliance principles, we had best review briefly the law and practice regarding insanity acquittee conditional release. It is that body of law that will ultimately be scrutinized for its ability to accommodate and exploit the Meichenbaum and Turk principles.

## I

### The Legal Landscape

In a distinct minority of jurisdictions, insanity acquittees are committable only through the generic civil commitment procedure.<sup>6</sup> As such, the duration of their confinement, and the mechanisms for their securing institutional passes and conditional and unconditional releases, are no different from those governing civilly committed mental patients who have not had contact with the criminal justice system. For that group, trial visits, conditional release, and even ultimate release are usually within the unilateral

discretion of the hospital authorities, unscrutinized by the courts.<sup>7</sup>

Far more common, however, especially since the Hinckley verdict, are "special" commitment systems governing the commitment, duration of confinement, and release (conditional or otherwise) of insanity acquittees.<sup>8</sup> Some jurisdictions regard an insanity acquittal as sufficient grounds for automatic commitment;<sup>9</sup> others require a fresh judicial inquiry into the acquittee's present mental condition and likely future dangerousness.<sup>10</sup> Once committed, the acquittee might constitutionally face a potentially indefinite confinement period.<sup>11</sup> A number of jurisdictions, however, limit the confinement of the acquittee to the maximum sentence that could have been imposed had a conviction, rather than an insanity acquittal, followed the criminal trial.<sup>12</sup> In those jurisdictions, at the expiration of the "hypothetical maximum criminal sentence," the insanity acquittee would have to be released or, if warranted by the acquittee's current mental condition and predicted dangerousness, civilly committed under the applicable generic civil commitment code.<sup>13</sup>

Even more pertinent for purposes of the present article are the provisions governing release, particularly conditional release and shorter-term institutional leaves, variously referred to as passes, trial visits, and furloughs. The states invariably allow the acquittee and his or her attorney to file, at specified intervals, a petition for release and a

request for a judicial hearing.<sup>14</sup> Typically, the acquittee will bear the burden of persuasion at the release hearing.<sup>15</sup>

Further, whenever the superintendent believes the acquittee is ready for conditional or unconditional release, a hospital-initiated petition for release may be filed.<sup>16</sup> In progressive jurisdictions, a period of conditional release will usually precede an application for outright release.<sup>17</sup> Indeed, under a "graduated release" model,<sup>18</sup> even conditional release is typically preceded by passes or trial visits.<sup>19</sup> Under modern statutes, particularly those passed post-Hinckley, even short-term hospital absences ordinarily require court approval,<sup>20</sup> particularly if the acquittee is to enter the community unaccompanied by public officials.<sup>21</sup>

When a superintendent files a petition for an acquittee's conditional release, some jurisdictions require a court hearing on the matter,<sup>22</sup> while others permit such a hearing on the court's own motion<sup>23</sup> and require a hearing only if the prosecuting attorney objects to the proposed conditional release.<sup>24</sup> In any event, a study of the District of Columbia practice concludes that "although holding a court hearing is optional, some form of hearing occurs in virtually all cases, to make a record, test the opinion of the Hospital and wisdom of its recommendation, and to assure protection for the public."<sup>25</sup> That same study concludes that in the "vast majority of cases,"<sup>26</sup> the court will concur with the hospital's recommendation.<sup>27</sup>

When a conditional release is granted, the court will order the acquittee to comply with certain conditions. Under the federal statute, for example, the court shall

(A) order that he be conditionally discharged under a prescribed regimen of medical, psychiatric, or psychological care or treatment that has been prepared for him, that has been certified to the court as appropriate by the director of the facility in which he is committed, and that has been found by the court to be appropriate, and

(B) order, as an explicit condition of release, that he comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment.<sup>28</sup>

Typical conditions that have been imposed by courts relate to taking medication (perhaps in the presence of another),<sup>29</sup> to living in a particular household,<sup>30</sup> to keeping weekly outpatient therapy appointments,<sup>31</sup> and to attending Alcoholics Anonymous meetings.<sup>32</sup> Failure to comply with the conditions can, of course, lead to revocation and rehospitalization,<sup>33</sup> typically triggered by a due process hearing.<sup>34</sup>

When courts are charged with making conditional release decisions, a jurisdictional issue also arises. Typically, the criminal court -- which becomes the committing court when a defendant is acquitted by insanity -- has jurisdiction over conditional release matters.<sup>35</sup> Under some schemes, however, jurisdiction is vested in the probate court of the county in which the hospital is located.<sup>36</sup> These jurisdictional niceties are skirted in a state like Oregon, where release and conditional release decisions of committed insanity acquit-

tees reside in an administrative body known as the Psychiatric Security Review Board.<sup>37</sup>

Oregon's highly regarded<sup>38</sup> Psychiatric Security Review Board is composed of five members (a psychiatrist, psychologist, lawyer, parole expert, and a member of the public).<sup>39</sup> By majority vote,<sup>40</sup> the Board elects a chair<sup>41</sup> and conducts other business. Much of its business consists of making insanity acquittee conditional release decisions.<sup>42</sup> The Board holds hearings, retires to deliberate, makes findings, and, within 45 days of the conclusion of a hearing, issues written notice of its decision.<sup>43</sup>

The administrative model of the Psychiatric Security Review Board is the chief competitor to the traditional model, which vests insanity acquittee release decisions in the hands of the judiciary. Later, we will return to this issue and, indeed, to virtually all the legal material presented in this section. Now, however, it is time to turn our attention to the psychological principles of health care compliance.

## II

### Health Care Compliance Principles

This section will set forth those health care compliance principles discussed by Meichenbaum and Turk that have potential relevance to the insanity acquittee conditional release process. In the current section, the principles will be discussed without reference to the legal system. Inte-

grating the psychology and the law is the task of the ensuing sections.

As noted earlier,<sup>44</sup> Meichenbaum and Turk deal in part with mental patients, but their volume covers the full gamut of health care patients and professionals. The principles they propound have apparent general applicability to both physical and mental health compliance. This section will assume the accuracy and efficacy of the principles, which were derived from an extensive review of the research and clinical literature. Further research is obviously needed, but that is typically the case. From a therapeutic jurisprudence perspective, it should be highly instructive to regard those principles as tentatively true, and to examine how the legal system might be reshaped to accommodate them.<sup>45</sup>

One of the most important reasons for nonadherence is that the patient has not been adequately instructed by the health care professional (HCP) about the treatment regimen.<sup>46</sup> Indeed, although physicians seem not to commonly acknowledge it, "the behavior of the HCP plays a critical role in the adherence process".<sup>47</sup> Nonadherence is promoted when the HCP is distant, looks and acts busy, reads case notes during the interview, uses jargon, asks patients questions calling for "yes or no" answers, cuts off the patient, does not permit patients to tell their stories in their own words, fails to state the exact treatment regimen or states it in unclear or technical terms, adopts a moralizing, high power stance, fails to sit at the same level as the patient, keeps a desk

between the HCP and the patient, and terminates the interview abruptly.<sup>48</sup> By contrast, Meichenbaum and Turk advise HCPs to introduce themselves, to avoid unexplained jargon, and to elicit patient suggestions and preferences.<sup>49</sup>

The patient's active involvement in negotiating and designing the treatment program is of tremendous importance to adherence and favorable outcome.<sup>50</sup> Even giving a patient a choice over some of the more minor details -- such as the form of medication and the scheduling of injections -- can have salutary effects.<sup>51</sup>

To promote patient adherence, the HCP should linguistically cast the treatment program in a manner that capitalizes on the patient's involvement and agreement. For example, directive terminology such as "What you are to do is. . ." should be replaced by a softer, more bi-lateral statement, such as "So what you have agreed to try is. . ."<sup>52</sup> Adherence will be further nurtured if the HCP has high prestige and is perceived to be competent, attentive, practical, and to be motivated by the best interests of the client.<sup>53</sup>

In questioning a patient, the compliance literature also suggests that the HCP needs to achieve a delicate balance with respect to the nature of self-disclosure requested of patients.<sup>54</sup> Thus, "seeking high self-disclosure or asking patients about material that they would not usually share with other family members or friends"<sup>55</sup> seems detrimental to adherence. In contrast, a moderate (rather than low) level of self-disclosure, focusing both on personal strengths and

weaknesses, seems to increase perceived self-efficacy and the patient's adherence.<sup>56</sup> A particularly profitable avenue of HCP questioning relates to the patient's past compliance efforts: "What kinds of things in the past have you tried that were unsuccessful? How is what you have agreed to do now different?"<sup>57</sup>

Relatedly, it is profitable for the HCP to raise mild counterarguments about the patient's prospective compliance.<sup>58</sup> When the HCP indicates to the patient certain obstacles and drawbacks to compliance, the patient will have an opportunity to minimize and counter the HCP's arguments, thus "fostering the patient's sense of control, commitment, and degree of hope."<sup>59</sup> A patient presented with mild counterarguments to compliance who nonetheless announces to a prestigious HCP his or her intention to comply will be "anchored" to the compliance decision by anticipated disapproval from the HCP and by anticipated self-disapproval.<sup>60</sup>

Involving significant others -- such as family members -- in the treatment process is also likely to enhance patient adherence.<sup>61</sup> Family members aware of the treatment regimen can encourage, remind, and prod the patient, and can help the HCP assess patient compliance.<sup>62</sup> One suggested technique for involving significant others is for the HCP to bring in family members and to have the patient personally explain to them the nature of the illness and the proposed treatment.<sup>63</sup>

So long as the patient is agreeable to the involvement of certain family members,<sup>64</sup> their presence and participation



is likely to be beneficial. Greater patient adherence has been found, for example, by patients accompanied to evaluations by family members than by those patients who attended those evaluations alone.<sup>65</sup>

When an HCP has a patient explain her medical problem and agreed-upon course of treatment to family members, the active patient participation provides an opportunity to "assess her comprehension, to elicit a public commitment, and to strengthen her adherence-related attitudes."<sup>66</sup>

One reason why the presence of significant others enhances patient compliance is that "public commitment leads to greater adherence than does private commitment."<sup>67</sup> In addition to the motivational power of anticipated self-disapproval and the anticipated social disapproval of the HCP, discussed above,<sup>68</sup> a patient who has previously made a commitment to significant others will be anchored to compliance by their anticipated disapproval as well.<sup>69</sup> Thus, Meichenbaum and Turk note that "insofar as patients can be encouraged to inform one or more people (in addition to the HCP) of their intentions to follow the treatment regimen, there is an increased likelihood of adherence."<sup>70</sup>

When negotiating a course of treatment with a patient, HCPs can profit from the behavior modification literature regarding "behavioral contracting."<sup>71</sup> Such "behavioral" or "contingency" contracting "capitalizes on the patient-HCP relationship by actively involving the patient in the therapeutic decision-making process and by providing additional

incentives (rewards) for achievement of treatment objectives."<sup>72</sup>

Meichenbaum and Turk summarize the relevant literature. Apparently, behavioral contracting works best when the contract is individually tailored to the particular needs and desires of a specific patient,<sup>73</sup> when it defines the target behavior expected of the patient with specificity,<sup>74</sup> when it spells out the positive and aversive consequences that will attach, respectively, to compliance and to noncompliance,<sup>75</sup> when significant others (rather than the HCP alone) deliver the consequences,<sup>76</sup> when the contracts include the "specific dates for contract initiation, termination, and renewal,"<sup>77</sup> when the patient's commitment is solicited in both oral and written form,<sup>78</sup> and when the contract is "signed by at least two parties as well as other interested and relevant"<sup>79</sup> ones.

Unfortunately, despite evidence of short-term benefits flowing from behavioral contracting in the health area,<sup>80</sup> the long-term benefits have yet to be established.<sup>81</sup> There is evidence that health-related behavioral changes "are maintained only for the duration of the contract, and after its termination or when the treatment contract is withdrawn the patient may stop performing health-related behaviors (e.g., pill taking, diet, exercise)."<sup>82</sup>

Some principles may be invoked to lessen the chances of disappointing post-termination results. For example, during the contract period itself, "the greater the continuity of care whereby patients can see the same HCP upon repeated

visits, the greater the likelihood of adherence."<sup>83</sup> The HCP should not abruptly terminate treatment but should instead gradually wean the patient from the process.<sup>84</sup> While doing so, the HCP should help the patient make "self attributions"<sup>85</sup> about successful behavioral changes. It is best that patients attribute beneficial changes to themselves rather than to external events or persons.<sup>86</sup>

Interestingly, although Meichenbaum and Turk devote much of their volume to patient nonadherence to HCP recommendations, they close their volume with a discussion of why HCPs might not adhere to the recommendations set forth in the book:<sup>87</sup> Patients should take their advice or simply suffer the consequences of noncompliance; the principles simply will not work with their particular patient populations; the recommended procedures are too complicated and numerous; there is simply no time in day-to-day practice to implement the procedures; the system does not support frills like adherence counseling; and, finally, they cannot make use of the principles because most HCPs are not mental health professionals and accordingly have not been trained in psychological techniques of adherence.<sup>88</sup>

Meichenbaum and Turk provide powerful counterarguments to the anticipated HCP reluctance to implement the recommended health care compliance principles. Thus, although the procedures may seem a bit complicated initially, they will soon require less attention<sup>89</sup> and will in the long-run improve the quality of service.<sup>90</sup> At the early stages, the HCP

can use checklists as memory prompts.<sup>91</sup> Finally, with regard to clinical skill, the authors note that "no great amount of specialized training" is ordinarily required to use the recommended enhancement techniques.<sup>92</sup>

### III

#### Applying the Health Care Compliance Principles in the Insanity Acquittee Conditional Release Process

To some extent or another, the health care compliance principles can be invoked in a variety of legal contexts -- such as insanity acquittee conditional release, parole, and outpatient civil commitment.<sup>93</sup> The present article deals only with the insanity acquittee conditional release process. In fact, to maximize the potential application of the health care compliance principles, the insanity acquittee conditional release process will itself be discussed in a somewhat limited legal and geographical context.

From a legal perspective, we will examine only hospital-initiated conditional release petitions, not conditional release claims triggered by patients over the objection of the hospital. As a practical matter, hospital-initiated petitions are the most viable ones -- the ones that typically lead to conditional release<sup>94</sup> rather than to continued hospitalization.

Geographically, we should bear in mind that, for reasons of efficiency, security, and transportation, the recommended principles will be easiest to implement if the hospital, the criminal court where the insanity acquittal occurred, and the

acquittee's home community all fall within the same general area.<sup>95</sup> — That way, the inconvenience to the hospital, the community facility, and to the patient and patient's family will not be great even if a series of conditional release hearings are held.

With the above limitations and caveats in mind, let us turn our attention to the means by which a court versed in the health care compliance principles might exploit those principles to increase the adherence behavior of a patient proposed by the hospital for conditional release status. Such hospital-initiated cases are likely to lead to conditional release (whether the prosecutor supports or opposes the hospital's recommendation),<sup>96</sup> and in this relatively low stress context the court might rather comfortably see its role as facilitating as well as predicting compliance.

It is important to recognize, however, that courts might sometimes increase eventual patient adherence not by simply deferring to the hospital's conditional release recommendation but by truly scrutinizing hospital-initiated conditional release petitions for their conformity to the health care compliance principles. To the extent that HCPs may themselves fail to comply with the recommended procedures for facilitating treatment adherence, as Meichenbaum and Turk worry they often will,<sup>97</sup> courts can encourage HCP compliance by denying (or deferring action on) hospital petitions that demonstrate insufficient use of the fundamentals of treatment adherence.

The use of some of the fundamentals will be easier for courts to monitor and oversee than will others. Courts may not have much control over the give-and-take of doctor-patient office dialogue, for example, but they can -- through the actions of denial and deferral -- encourage the hospital, patient, and community facility to negotiate, prepare, sign, and submit with the judicial petition a rather specific behavioral contract setting forth the terms and conditions of the proposed conditional release.<sup>98</sup>

Once the behavioral contract is "signed by at least two parties [the patient and the hospital] as well as the other interested and relevant parties [the community facility and perhaps family members],"<sup>99</sup> the court can use the contract as the basis of a judicial conditional release hearing, and can view the hearing as somewhat akin to (but far less routinized than) a Rule 11 hearing held to approve a previously-negotiated plea agreement.<sup>100</sup> Rule 11 hearings require a dialogue with the defendant in open court to assure that the defendant understands and agrees to the plea.<sup>101</sup> Similarly, the conditional release hearing can actively involve the acquittee -- to test the patient's understanding of the treatment regimen and to insure that the patient agrees with it and had input into its design.

The court can structure and shape the conditional release hearing so as to invoke a number of other important health care compliance principles -- principles that may or may not have been used by the HCP when negotiating the plan

with the patient. For example, the hearing will serve as a forum for the patient to make a "public commitment" to comply with the treatment regimen. That way, the commitment will be made not only to the HCP, but also to a high-status judicial official<sup>102</sup> and to any significant others<sup>103</sup> -- such as family members -- whose presence at the hearing has been approved by the patient.<sup>104</sup>

A conditional release hearing can also provide an excellent opportunity for the court to seek from the patient the appropriate level of self-disclosure,<sup>105</sup> particularly regarding past unsuccessful compliance efforts and the extent to which the current treatment plan differs from any earlier, unsuccessful ones.<sup>106</sup> The hearing is also an ideal forum for presenting the patient with "mild counterarguments"<sup>107</sup> to compliance, enabling the patient to counter those arguments and to accordingly become "anchored" to the compliance decision.<sup>108</sup>

Where the hospital-initiated conditional release petition is unopposed by the prosecution, the judge might personally elicit the patient self-disclosure and might personally express concern in the form of "mild counterarguments." Where the hospital's petition is opposed by the prosecution, those matters will naturally fall to the prosecuting attorney.<sup>109</sup>

As a result of matters ventilated at the hearing, the behavioral contract may be somewhat revised before it is finally approved by the court. When the agreement is finally

approved, however, the patient's commitment will have been solicited both orally and in writing,<sup>100</sup> and the other important behavioral contracting principles (e.g., individually tailored, specific regarding expected patient behavior and positive and aversive consequences, involvement of significant others, specification of termination or renewal dates) will have been attended to as well.<sup>111</sup>

In terms of court approval of the conditional release, the statutes -- especially the federal one<sup>112</sup> -- convey the flavor of a court ordering a passive acquittee to be "conditionally discharged under a prescribed regimen of . . . treatment that has been prepared for him,"<sup>113</sup> and ordering "as an explicit condition of release, that he comply with the prescribed regimen."<sup>114</sup> Despite the unfortunate linguistic flavor of the statutes, a court is free to follow the more therapeutic course and to conceptualize and frame the conditional release as an agreement ("So what you have agreed to try is . . .")<sup>115</sup> rather than as an order ("What you are to do is . . .").<sup>116</sup>

Indeed, to the extent that the court is in some sense shaping or approving the release conditions, the court is itself an HCP, and the judge should therefore attend to the HCP behavioral factors thought to enhance patient adherence. For instance, the judge can make sure to introduce himself or herself to the patient, can be attentive, can avoid using legal or medical jargon, can allow the patient to tell his or her story without undue interruption, can make sure the



patient understands the precise treatment regimen, and can even sit at the same level and at the same conference table as the patient -- perhaps in a mental health facility conference room rather than in a courtroom.<sup>117</sup>

The suggested model of judicial behavior is remarkably similar to the model employed in some jurisdictions by judges presiding at civil commitment hearings.<sup>118</sup> In the civil commitment context, that model has been criticized as appearing "confusingly like a treatment conference. . . ."<sup>119</sup> The criticism is well taken in a context, like civil commitment, where the state is seeking to deprive an individual of liberty and where the model might lead us to relax our due process guard. In the insanity acquittee context, however, the acquittee has already lost his or her liberty, and following the hearing on the hospital-initiated conditional release petition, the acquittee is likely to regain a taste of liberty. In that context, it seems somewhat less crucial to maintain traditional judicial formalities. In any event, there is of course no inherent conflict between maintaining judicial decorum and treating an insanity acquittee respectfully; nor is there an inherent conflict between being competent, expert, and of high prestige and nonetheless being motivated by the acquittee's best interest.<sup>120</sup>

In order to enable the insanity acquittee to reenter the community gradually, and to allow the relevant authorities to keep close tabs on the patient's adjustment, it is probably best that the acquittee first return to the community not

under conditional release, but under the authority of very brief passes or furloughs. In fact, such leaves, which by statute increasingly require court approval,<sup>121</sup> should perhaps be used, much more than they currently are, as a partial substitute for conditional release.

For example, after laying the conditional release groundwork by according an acquittee a series of brief furloughs, a court might be inclined to grant the acquittee conditional release status. Instead of granting a full-blown conditional release, however, the court might instead grant the acquittee a longer, time-limited furlough. The furlough could be issued according to a behavioral contract obliging the acquittee to follow an agreed-upon therapeutic program, and compliance could be rewarded by renewal of the furlough. In all other respects, the agreements and hearings could follow the suggestions given above for the conditional release process.

By using a series of furloughs as a precursor to conditional release, the court may be able to tap some additional health care compliance principles. Furlough termination and renewal dates can be noted with great precision,<sup>122</sup> and the acquittee can have some input into the appropriate duration -- and renewal date hearing -- of each furlough.<sup>123</sup> Significant others can be nominated by the patient to monitor compliance and to appear and testify at follow-up (renewal) hearings.<sup>124</sup> The follow-up hearings will provide a type of "continuity of care," especially if the same judge is able to

oversee the acquittee's community adjustment.<sup>125</sup> The fade-out from furlough to full-fledged conditional release can be gradual, giving the court an opportunity to help the patient make "self-attributions" about the patient's continual progress.<sup>126</sup> Further monitoring, follow-up, and fading-out can and should of course occur during the period of conditional release proper.

If the health care compliance techniques are brought by the judiciary into the insanity acquittee furlough and conditional release process in the manner described above, the therapeutic value of that process may be enhanced without treading upon values of justice. Of course, the law in some jurisdictions will make it easier than in others for the judiciary to import the health care compliance principles. Accordingly, the next section briefly assesses the ability of various legal schemes to accommodate the compliance principles.

#### IV

##### The Law and the Health Care Compliance Principles

Certain legal schemes stand out as frustrating the application of the health care compliance principles to the insanity acquittee conditional release process. For instance, those states that process insanity acquittees through the civil commitment system typically leave release, conditional release, and furlough matters to the hospital itself;<sup>127</sup> the courts accordingly play no role in such matters and therefore lack leverage to urge the adoption of appropri-

ate adherence techniques. Almost as bad -- in terms of lack of leverage -- are special insanity acquittee commitment laws that nonetheless mandate the court to order release in the absence of objection from the prosecution.<sup>128</sup> And even worse are legal systems where insanity acquittees fall under special commitment laws but where those laws are read as not even authorizing conditional release.<sup>129</sup>

Laws favorable to the use of principles expressed here are those requiring court approval even of furloughs,<sup>130</sup> and those authorizing or even requiring conditional release hearings.<sup>131</sup> Jurisdictionally, it is probably best if release matters are heard in the original commitment court, rather than in the probate court of the county where the hospital is located.<sup>132</sup> Such a resolution, although not taking advantage of any specialized knowledge that probate courts located in the vicinity of the hospital might develop, spreads the judicial work load more equitably,<sup>133</sup> appears not to lead to harsher treatment of insanity acquittees,<sup>134</sup> and will make more feasible the holding of follow-up hearings at which the most important witnesses should be the patient, the community treatment facility staff, and the patient's family. Of course, as a practical matter, such hearings will be easiest to conduct when, as noted earlier,<sup>135</sup> the committing court, hospital, and the patient's home community are all located in the same area.

Because of the behavioral contracting data suggesting diminished treatment adherence after the expiration of the

contract period,<sup>136</sup> the period a releasee can be held on conditional release ought not to be too short. On the other hand, the indefinite control over an insanity acquittee is probably not necessary,<sup>137</sup> and may be countertherapeutic if its prospect leads defendants not to assert the insanity defense in the first place.<sup>138</sup> State control over an acquittee for the period of the "hypothetical maximum criminal sentence"<sup>139</sup> should be sufficient, especially since persons acquitted by insanity of very serious crimes will be under state control for a long-term, and perhaps for a lifetime.

Curiously, Oregon's administrative model -- the Psychiatric Security Review Board -- does not fare very well when scrutinized from the perspective of the compliance principles.<sup>140</sup> The Board may perform exceptionally well in terms of monitoring and in terms of other important areas beyond the scope of the present article. The model seems to fall short, however, in terms of its potential for inducing compliance through the hearing process itself.

The Board, composed of five members,<sup>141</sup> would probably not be able to depart sufficiently from formality to play the HCP role described earlier. Further, following the hearing, the Board is expected to deliberate in closed session and, by majority vote, to reach a decision and later issue its findings and order.<sup>142</sup> Such a model does not comport well with the model developed earlier in the article: a single judge holding a hearing to review a previously negotiated agree-

ment, questioning the patient about the agreement, putting the final touches on it, extracting from the patient a public commitment to comply, setting a follow-up hearing at which the same judge will preside, and, in the presence of the patient, entering an order approving the patient's temporary release according to the terms and conditions set out in the agreement.

## VI

### Conclusion

This exercise in therapeutic jurisprudence demonstrates what legal structures square best with importing health care compliance principles into the insanity acquittee conditional release process and, even more, demonstrates how courts can restructure the process and the hearings to facilitate treatment adherence. In their text, Meichenbaum and Turk express the fear that, for a variety of reasons, HCPs themselves will not comply with the recommendations.<sup>143</sup> In this article, the issue of HCP noncompliance has been partly finessed, for courts can exert compliance leverage over a hospital seeking to conditionally discharge an insanity acquittee. Only one major issue seems to remain: Will courts comply?

Courts may resist for reasons similar to those given by HCPs:<sup>144</sup> Patients should adhere or else suffer the consequences; the principles will not work on a population of insanity acquittees; the procedures are too complicated and numerous; there is no time in day-to-day courtroom practice to implement the procedures; the system does not support

frills like adherence-enhancing strategies; and, finally, courts cannot make use of the principles because judges are not mental health professionals and accordingly have not been trained in psychological techniques of adherence.

The responses given by Meichenbaum and Turk to the HCPs are similar to those that can be given to the courts:<sup>145</sup> the procedures may seem complicated at first, but, after a hearing or two, should require less attention; in the long-run the modification in procedures should improve patient adherence and thus better serve society; manuals and checklists can be used to introduce courts to the procedures and principles; and, finally, no particularly specialized training is necessary to implement the procedures.

Just as "the behavior of the HCP plays a critical role in the adherence process,"<sup>146</sup> it is probable that, like it or not, the behavior of courts plays a critical role in the adherence behavior of conditionally released insanity acquittees.<sup>147</sup> If that is so, courts should be receptive to learning new techniques for carrying out more effectively their important work.

#### Footnotes

- \* Law College Association Professor of Law and Professor of Psychology, University of Arizona. This article grew out of my role as commentator on a paper presented by Donald Meichenbaum, Ph.D., to a working session of the John D. and Catherine T. MacArthur Foundation Research Group on Mental Health and Law, of which I am a member.
1. D. Meichenbaum & D. Turk, Facilitating Treatment Adherence: A Practitioner's Guidebook (Plenum 1987) (hereinafter cited as Facilitating).
  2. Id. at 11, 27.
  3. Id. at 119.
  4. Id. at 28, 178.
  5. D. Wexler, Therapeutic Jurisprudence: The Law as a Therapeutic Agent (Carolina Academic Press 1990). The therapeutic jurisprudence perspective looks at the role of the law as a therapeutic agent. It recognizes that substantive rules, legal procedures, and the roles of lawyers and judges may have therapeutic or antitherapeutic consequences. Drawing on material from the behavioral sciences -- such as the Meichenbaum and Turk book -- it explores the extent to which rules, procedures, and roles might be reshaped to maximize therapeutic interests without sacrificing interests of justice. The instant project draws on psychological health care compliance principles mainly to suggest the



reshaping of a legal procedure and a judicial role -- the insanity acquittee conditional release hearing and the judge's behavior at that hearing. To a lesser extent, substantive rules are also implicated -- such as the one relating to the suggested maximum period of commitment for insanity acquittees. For other explicit applications of the therapeutic jurisprudence perspective, see Wexler, *Inducing Therapeutic Compliance Through the Criminal Law*, 14 *Law and Psychology Review* 43 (1990); Wexler & Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, 7 *Behavioral Sciences and the Law* 485 (1989); Schopp & Wexler, *Shooting Yourself in the Foot with Due Care: Psychotherapists and Crystallized Standards of Tort Liability*, 17 *Journal of Psychiatry and Law* 163 (1989); Winick, *Competency to Consent to Treatment: The Distinction between Assent and Objection*, 28 *Hous. L. Rev.* \_\_\_\_ (1990); Winick, *Harnessing the Power of the Bet: Wagering with the Government as a Mechanism for Social and Individual Change* (get full cite).

6. Note, *Commitment Following an Insanity Acquittal*, 94 *Harv. L. Rev.* 605 (1981).
7. A.B.A. *Crim. Just. Mental Health Standards* 444 (1989).
8. A.B.A. *Crim. Just. Mental Health Standards* 7-7.3(a) (1989).

9. 18 U.S.C. § 4243(a) (Supp. 1990). The acquittee is entitled to a judicial hearing within forty days, § 4243(c), but the acquittee bears the burden of establishing release readiness. § 4243(d). The District of Columbia follows a similar pattern. D.C. Code Ann. § 24-301 (1989).
10. Ore. Rev. Stat. 161.325 (1989); A.B.A. Crim. Just. Mental Health Standards 7-7.1 (1989).
11. Jones v. United States, 463 U.S. 354 (1983).
12. Ill. Rev. Stat. 38-1005-2-4(b) (Supp. 1990); Ore. Rev. Stat. 161.327 (1989); A.B.A. Crim. Just. Mental Health Standards 7-7.7 (1989). An earlier Illinois provision specified that the period of confinement "shall not exceed the maximum length of time that the defendant would have been required to serve, less credit for good behavior, before becoming eligible for parole...." Ill. Rev. Stat. 38-1005-2-4(b) (1982).
13. A.B.A. Crim. Just. Mental Health Standards 7-7.7(a) (1989).
14. 18 U.S.C. § 4247(h) (Supp. 1990); Ill. Rev. Stat. 38-1005-2-4(e) (Supp. 1990).
15. Ill. Rev. Stat. 38-1005-2-4(g) (Supp. 1990). Compare A.B.A. Crim. Just. Mental Health Standards 7-7.4(b) (1989) (assigning the burden of persuasion to the state).
16. 18 U.S.C. § 4243(f) (Supp. 1990).

17. Final Report of the National Institute of Mental Health (NIMH) Ad Hoc Forensic Advisory Panel, 12 Mental & Physical Disability Law Reporter 77, 87-89 (1988) (hereinafter cited as Final Report) (describing the law and practice of the graduated release process operative at St. Elizabeths Hospital). In sharp contrast, some jurisdictions do not even recognize conditional release as an available option. State v. Jacob, 669 P.2d 865 (Utah 1983).
18. Final Report, supra note 17, at 87.
19. Id. at 87-88.
20. 18 U.S.C. § 4243(h) (Supp. 1990); Ill. Rev. Stat. 38-1005-2-4(b) (Supp. 1990).
21. A.B.A. Crim. Just. Mental Health Standards 7-7.11(a) (1989). See also the discussion id. at 450.
22. Ill. Rev. Stat. 38-1005-2-4(d) (Supp. 1990).
23. 18 U.S.C. § 4243(f) (Supp. 1990); D.C. Code Ann. § 24-301(e) (1989); A.B.A. Crim. Just. Mental Health Standards 450 (1989).
24. See references in note 23 supra. Occasionally, one encounters a scheme whereby, absent objection by the prosecution, the court must order release. State ex rel. Schafer v. Casteel, 732 S.W.2d 903 (Mo. 1987).
25. Final Report, supra note 17, at 95.
26. Id. at 96.
27. Id.
28. 18 U.S.C. § 4243(f)(2)(A) & (B) (Supp. 1990).

29. Hill v. State, 358 So. 2d 190, 209 (Fla. Dist. Ct. App. 1978).
30. Id.
31. Bowman v. Wilson, 672 F.2d 1145, 1148 n.4 (3d Cir. 1982).
32. Id. See Ill. Rev. Stat. 38-1005-2-4(a)(1)(D) (Supp. 1990) (enumerating various possible conditions).
33. 18 U.S.C. § 4243(g) (Supp. 1990).
34. Id.
35. Final Report, supra note 17, at 95. See also Hill v. State, 358 So. 2d 190, 210 (Fla. Dist. Ct. App. 1978) (conditional release authority is "inherent in the court's continuing jurisdiction" over insanity acquittees). The fact that the criminal-commitment court has jurisdiction over release matters does not necessarily mean the trial judge who presided at the criminal trial will make the conditional release decision, as is the case with respect to U.S. District Court cases in the District of Columbia. Final Report, supra note 17, at 95. That is purely an assignment system matter. In D.C. Superior Court cases, for example, the judges are assigned release hearings in rotation. Id.
36. State ex rel. Schafer v. Casteel, 732 S.W.2d 903, 906 (Mo. 1987). See Callahan & Steadman, Insanity Defense Reform in Ohio: Does the Court of Jurisdiction Matter? 19 Capital L. Rev. 1 ( ).

37. Rogers, 1981 Oregon Legislation Relating to the Insanity-Defense and the Psychiatric Security Review Board, 18 Willamette L. Rev. 23 (1982).
38. A.B.A. Crim. Just. Mental Health Standards 449 n.2 (1989).
39. Ore. Rev. Stat. 161.385 (1989).
40. Ore. Rev. Stat. 161.385(6)(b) (1989).
41. Ore. Rev. Stat. 161.385(6)(a) (1989).
42. Ore. Rev. Stat. 161.336 (1989).
43. Ore. Rev. Stat. 161.346 (1989).
44. See text accompanying notes 2-4.
45. See Monahan & Walker, Empirical Questions Without Empirical Answers (get full cite). See also Stone, The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society, 90 Harv. L. Rev. 358, 370 (1976) ("In the absence of a reliable empirical study, a judgment based on clinical experience is obviously preferable to a judgment that contradicts such experience.").
46. Facilitating, supra note 1, at 67. See also id. at 56.
47. Id. at 63 (italics deleted).
48. Id. at 78.
49. Id. at 81.
50. Id. at 81, 171.
51. Id. at 171.
52. Id. at 79.
53. Id. at 172.
54. Id. at 79.

55. Id.
56. Id. at 80.
57. Id. at 175.
58. Id.
59. Id. at 176.
60. Id.
61. Id. at 124.
62. Id. at 162. See also id. at 180. Of course, it is also important to try to get the patient to self-monitor. Id. at 176.
63. Id. at 124. While the family can serve as an important therapeutic tool, family dynamics are often such that the family might threaten therapeutic advances. Thus, the HCP must consider the question of family involvement carefully and delicately, and the HCP should approach the family with the patient's knowledge, involvement, and approval. Id. at 216. See also id. at 180.
64. See note 63 supra.
65. Id. at 214.
66. Id. at 124.
67. Id. at 174.
68. See text accompanying note 60.
69. Massaro, The Revival of Shunning and Shaming in American Criminal Law (unpublished manuscript) (get full cite).
70. Facilitating, supra note 1, at 174.

71. Id. at 164-73.
72. Id. at 164-65.
73. Id. at 167-68.
74. Id. at 174.
75. Id. at 168.
76. Id. at 171.
77. Id. at 170.
78. Id. at 175.
79. Id. at 170.
80. Id. at 166.
81. Id. at 167.
82. Id.
83. Id. at 65 (*italics deleted*).
84. Id. at 168. See also Janis, *The Role of Social Support in Adherence to Stressful Decisions*, 38 *American Psychologist* 143, 150 (1983).
85. Facilitating, supra note 1, at 176.
86. Id.
87. Id. at 257.
88. Id.
89. Id. at 262.
90. Id. at 263.
91. Id. at 262.
92. Id. at 261.
93. Miller, *Outpatient Civil Commitment of the Mentally Ill: An Overview and an Update*, 6 *Behavioral Sciences and the Law* 99 (1988); Brooks, *Outpatient Commitment*

for the Chronically Mentally Ill: Law and Policy, in D. Mechanic (ed.), Improving Mental Health Services: What the Social Sciences Can Tell Us 117 (1987); Stefan, Preventive Commitment; The Concept and its Pitfalls, 11 Mental & Physical Disability Law Reporter 288 (1987).

94. Final Report, supra note 17, at 96 (in vast majority of cases, courts agree with hospital's recommendation).
95. The District of Columbia would be the paradigmatic example. In a number of jurisdictions, however, the major state hospital lies in or near the state's largest city, and most insanity acquittals will presumably come from, and return to, that city.
96. Final Report, supra note 17, at 96.
97. See text accompanying notes 87-88.
98. See Final Report, supra note 17, at 89 (St. Elizabeths Hospital Review Board defers decision on Convalescent Leave if a joint aftercare plan has not been prepared by the inpatient treatment team and the outpatient section staff). Cf. Brooks, Outpatient Commitment for the Chronically Mentally Ill: Law and Policy, in D. Mechanic (ed.), Improving Mental Health Services: What the Social Sciences Can Tell Us 117, 123 (1987) ("[I]n states with more well-developed statutes, outpatient commitment is not ordered unless the community mental health agency has a treatment program available for the patient, is willing to accept him or her, and the pa-



tient is willing to comply with the treatment program"). But see *Schafer v. Casteel*, 732 S.W.2d 903 (Mo. 1987) (court has no leverage, for, absent objection by prosecution, release must be granted).

99. Facilitating, supra note 1, at 170.
100. Fed. R. Crim. Pro. 11 (1986) (Supp. 1990).
101. Fed. R. Crim. Pro. 11(c) & (d) (1990).
102. See text accompanying note 70.
103. See text accompanying notes 61-66.
104. See text accompanying note 64.
105. See text accompanying note 54-57.
106. See text accompanying note 57.
107. See text accompanying notes 58-60.
108. See text accompanying note 60.
109. A familiarity with the compliance literature and with the legal reality should serve to keep the prosecutor's behavior within the bounds of restrained advocacy. True, if the prosecution is very forceful, the hospital's conditional release petition may be denied. Typically, however, the courts will follow the hospital's conditional release recommendation despite the prosecutor's objection. Final Report, supra note 17, at 96. If conditional release is in any event likely, and if high (as opposed to moderate) patient self-disclosure lessens the prospects of adherence, a prosecutor who seeks anything more than moderate patient

self-disclosure runs the risk of contributing to the conditionally released patient's noncompliance.

110. See text accompanying note 78.
111. See text accompanying notes 73-79. The agreement may require the acquittee to live in a particular place, to attend an outpatient clinic on a weekly basis, and to take prescribed medication -- perhaps in the presence of others. See notes 29-32 and accompanying text. At this stage in the acquittee's hospitalization, he or she will presumably have become stabilized on a particular medication and dosage, and the specific medication regime could conceivably become part of the behavioral contract. *State v. Jacob*, 669 P.2d 865, 867 (Utah 1983) ("defendant continued to suffer from paranoid schizophrenia, but with the appropriate dosage (which had now been identified) of neuroleptic drugs every two weeks his behavioral symptoms and hence his dangerousness to himself and others would be very unlikely to recur.") The positive consequences for compliance will be continued conditional release (or renewal of furlough), whereas the aversive consequences could be revocation, nonrenewal, and even conceivably contempt or criminal prosecution for reckless endangerment. See Wexler, *Inducing Therapeutic Compliance Through the Criminal Law*, 14 *Law & Psychology Review* 43 (1990); Note, *Criminal Responsibility and the Noncom-*

pliant Psychiatric Offender: Risking Madness, 40 Case Western L. Rev. 271 (1989-90). Ill. Rev. St. 38-1005-2-4(i) (Supp. 1990) (contempt). Positive reinforcers of a "bonus" variety can be dispensed by family members so as to capitalize on the "immediacy effects" that flow from promptly reinforcing appropriate patient behaviors. Facilitating, supra note 1, at 154. Under the principle of "response cost," the patient might even agree to part with items of his or her own, items that can be earned back from family members by engaging in appropriate behavior. Id. at 178. Patient lawyers can play an important role in negotiating such "side agreements" with family members, and in working with the hospital to present a forceful petition for conditional release. On the right of insanity acquittees to legal assistance, see A.B.A. Crim. Just. Mental Health Standards 7-7.8(c) (1989).

112. 18 U.S.C. § 4243(f)(2)(A) & (B) (Supp. 1990).

113. 18 U.S.C. § 4243(f)(2)(A) (Supp. 1990).

114. 18 U.S.C. § 4243(f)(2)(B) (Supp. 1990).

115. See text accompanying note 52.

116. Id.

117. See text accompanying notes 46-49.

118. National Center for State Courts' Guidelines for Involuntary Civil Commitment, 10 Mental & Physical Disability Law Reporter 409, 481 (1986).

119. Id.
120. Facilitating, supra note 1, at 172.
121. See notes 18-21 and accompanying text.
122. See text accompanying note 77.
123. See text accompanying note 51.
124. See text accompanying note 62. At some point, after there have been a number of renewal hearings all leading to renewal of the furlough, the acquittee may develop a constitutionally-recognized expectation to continued conditional liberty. *Bd. of Regents v. Roth*, 408 U.S. 564 (1972). If and when that happens, the acquittee will, for procedural due process purposes, be considered to be on full-blown conditional release, and nonrenewal of a furlough could be constitutionally accomplished only if the acquittee were to be furnished a conditional release revocation hearing.
125. See text accompanying note 83. Insanity acquittals are sufficiently rare that even requiring a series of hearings for each furloughed or conditionally released patient ought not to be unduly burdensome -- especially given the anticipated gains in adherence. The burden will be particularly easy to share if insanity acquittee release jurisdiction is vested in the criminal court rather than concentrated in the probate court of the county where the hospital is located. See notes 35-36 supra and accompanying text.

126. See text accompanying notes 84-86. The shift from furlough to conditional release may constitute an appropriate time to fade-out any "artificial" or "bonus" reinforcers provided the patient by significant others. See note 111 supra. See Facilitating, supra note 1, at 176 (to help with the self-attribution process, "the least powerful reward or punishment should be used to elicit behavior change").
127. See notes 6-7 supra and accompanying text. There are a host of additional reasons why insanity acquittees should not be processed through the civil commitment system. For example, such processing is bad for insanity acquittees because hospitals may be reluctant to release them on the hospital's unilateral say-so, even when the acquittees appear clinically ready for release. D. Wexler, Mental Health Law: Major Issues 125 (1981). And such processing is also bad for the civil patients, for if the civil system has to accommodate the insanity acquittees, that accommodation (of a very small number) will likely lead to pressure to make the entire civil system for more harsh (to the detriment of the great bulk of rather innocuous patients processed through that system). Wexler, The Structure of Civil Commitment: Patterns, Pressures, and Interactions in Mental Health Legislation, 7 Law and Human Behavior 1, 17 (1983).

128. State ex rel. Schafer v. Casteel, 732 S.W.2d 903, 905 (Mo. 1987).
129. State v. Jacob, 669 P.2d 865, 869-70 (Utah 1983).
130. See notes 19-21 and accompanying text.
131. See notes 22-24 and accompanying text. At the hearing, the court should require live testimony -- of the patient and others -- and not base its decision on the reports of the hospital and its doctors. Bocclair v. State, 524 So. 2d 467, 469 (Fla. Dist. Ct. App. 1988).
132. See note 125 supra and references cited therein.
133. See note 125 supra. Regardless of whether release cases are assigned randomly or are assigned to the judge who presided over the original criminal trial, see note 35 supra, continuity of care principles suggest that once a particular judge is assigned a particular patient's release matter, that judge should also be assigned subsequent release matters relating to that patient.
134. Callahan & Steadman, Insanity Defense Reform in Ohio: Does the Court of Jurisdiction Matter?, 19 Capital L. Rev. 1 ( ).
135. See text accompanying note 95.
136. See notes 80-82 and accompanying text.
137. Jones v. United States, 463 U.S. 354 (1983).
138. D. Wexler, Therapeutic Jurisprudence: The Law as a Therapeutic Agent 21 (1990).

139. See text accompanying notes 12-13. A theoretical midpoint between confinement for the "hypothetical maximum criminal sentence" and the prospect of indefinite confinement under Jones might be to release an acquittee on mandatory supervised release -- rather than outright -- when the hypothetical maximum criminal sentence is reached. On mandatory supervised release in the criminal system, see T. Hafemeister, *Improving Interactions with the Criminal Justice System: A Manual for Community Mental Health/Developmental Disabilities Providers of Illinois* 30 (1989). Releasing an acquittee at that time on condition that he or she follow an appropriate therapeutic course is not dramatically different from releasing the person at that time outright, but with a warning that therapeutic noncompliance that runs the risk of danger to others may result in criminal prosecution for reckless endangerment. Wexler, *Inducing Therapeutic Compliance Through the Criminal Law*, 14 *Law and Psychology Review* 43 (1990); Note, *Criminal Responsibility and the Noncompliant Psychiatric Offender: Risking Madness*, 40 *Case Western L. Rev.* 271 (1989-90). Professor Winick's wagering approach suggests a more positive strategy: governmental wagering with the released patient, rewarding the patient for engaging in therapeutically-appropriate behavior even after the period of coercive state control has expired. Winick, *Harnessing the Power of the Bet: Wagering with*

the Government for Social and Individual Change (get full cite).

140. See text accompanying notes 37-43.
141. See note 39 and accompanying text.
142. See notes 37-43 and accompanying text.
143. Facilitating, supra note 1, at 257.
144. See text accompanying notes 87-88.
145. See text accompanying notes 89-92.
146. Facilitating, supra note 1, at 63 (*italics deleted*).
147. Cf. Wexler & Schopp, Therapeutic Jurisprudence: A New Approach to Mental Health Law, in D. Kagehiro & W. Laufer (eds.), Handbook of Psychology and Law (in press) (making the point that as a matter of fact court decisions often have therapeutic or antitherapeutic consequences, and that recognition of that fact by courts can be helpful to them in decisionmaking).





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For more information, contact David I. Tevelin, Executive Director, or Richard Van Duizend, Deputy Director, 120 S. Fairfax Street, Alexandria, Virginia, 22314, (703) 684-6100. If you would like to receive the annual *Grant Guideline* and other Institute publications, please contact Allison Leopold, Publications Coordinator.

# State Justice Institute

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The National Center for State Courts is a nonprofit organization dedicated to modernizing court operations and improving justice at the state and local levels throughout the country. To accomplish its basic purpose—helping courts better serve both litigants and the general public—the National Center is active in four primary areas: research on courts and court-related topics; education and training programs for court personnel; direct assistance to state and local courts; and information exchange.

## Structure

The leadership of the National Center for State Courts comes from the state court systems. Its board of directors is representative of the state courts of the country and sets policy and priorities for the direction of National Center services and projects.

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Caseload management and delay reduction, application of modern business methods to court organization and structure, study of pressing current problems (e.g., child support enforcement), automation, trial and appellate caseload data collection, alternative dispute resolution, adoption information systems, questions of mental disability and the law, and streamlining jury operations are among the National Center's major areas of activity.

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The Institute for Court Management of the National Center for State Courts spearheads the drive to improve court management through a program of training and education for those in key administrative positions in the courts. The Institute's seminars and workshops are designed to keep court managers and justice system professionals informed about the growing body of knowledge dealing with management concepts and their application to court operations.

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State Charges and Contracts	\$5,214,798	\$5,500,000
Federal Grants	3,969,020	4,440,509
Private Contributions	485,493	490,000
Seminar & Conference Fees	871,959	662,500
Other Income	597,998	235,000
Total	\$11,139,268	\$11,328,009

*Audited financial statements are available upon request.*

# National Center for State Courts

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1993

# NATIONAL CENTER FOR STATE COURTS

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## **Institute on Mental Disability and the Law**

The National Center for State Courts is a non profit organization dedicated to modernizing court operations and improving justice at the state and local levels throughout the country. The NCSC serves the states from its headquarters in Williamsburg, Virginia and in regional offices in Denver, Kansas City, North Andover (MA), San Francisco, and Washington, DC.

### **Mission**

The Institute on Mental Disability and the Law was created as a unit of the National Center in 1981 in recognition of the increasing number and complexity of mental health claims and problems facing the courts in criminal, civil, juvenile, and domestic relations proceedings. The Institute's multi-disciplinary staff provides research, program evaluation, policy analysis, consultation, technical assistance, and training to judges, court managers, mental health practitioners, and others at state and local levels who are involved in justice and mental health interactions. Through its activities, the Institute aims to improve the interactions of the justice and mental health systems by working toward better coordination, continuity, communication, and cooperation among the components of the two systems.

### **Research**

Since its beginnings in 1981, the Institute's work has concentrated in three major areas of mental disability and the law: mental health and civil justice interactions, including such matters as involuntary civil commitment, guardianship, competency to make informed



choices, and other civil justice issues involving mental disability considerations; mental health and criminal justice interactions, including incompetency to stand trial, the insanity defense, mental health factors relevant to sentencing, and the structural arrangements and operations of court clinics; and mental health and juvenile justice system interactions, including concerns about the handling of disabled and handicapped young offenders by the juvenile courts, law enforcement agencies, corrections departments, mental health facilities, and social service systems.

National-scope and regional projects in 1989-90 include:

- An Evaluation of Mental Health Expert Assistance Provided to Indigent Criminal Defendants: Organization, Administration, and Fiscal Management (the Ake Project)
- Decisionmaking in Authorizing and Withholding Life-Sustaining Medical Treatment: Guidelines for State Courts Project
- Virginia Involuntary Civil Commitment Study
- Illinois Mental Health/Criminal Justice Manual Project
- The 1990 National Symposium on Justice-Mental Health Interactions

#### **Education and Training**

Major efforts have been made in conjunction with the Institute for Court Management (ICM), the educational division of the National Center for State Courts. ICM is dedicated to improving the management of the nation's courts through educational and training services. Since 1970, ICM has provided management training to thousands of administrators, clerks, judge, and other personnel from courts in the United States and many foreign jurisdictions. By joining forces with the Institute, ICM expands its education and training to court personnel and mental health officials and practitioners who are involved in criminal, civil, juvenile,

and domestic relations proceedings in which claims or problems of mental disability arise.

The 1990 ICM Course Catalog includes three programs developed and conducted by Institute faculty:

- Mental Health Services and the Juvenile Justice System, May 5-6, 1990, St. Louis, Missouri
- Improving the Interactions of the Justice and Mental Health Systems, October 7-10, Williamsburg, Virginia
- Guidelines for Processing "Right-to-Die" Cases, December 4-7, 1990, San Diego, California

These programs are intensive three or four-day workshops attended by 25-50 court and forensic mental health personnel and others concerned with mental disability law issues. The workshop format integrate lectures, group discussions, and small workgroups. Learning is facilitated through case studies, needs assessments, and the development of individual actions plans.

#### **Consultation Services and Information Transfer**

Although the bulk of the work of the Institute is conducted as part of national-scope or regional projects, the Institute increasingly is providing short-term information and consultation services to individuals and groups independent of those projects. In 1989, Institute staff responded to 223 requests for consultation services and information. Individuals representing both public and private interests in mental disability and the law made requests.

#### **Advisory Board**

The Institute is advised by a 14-member multi-disciplinary board. 1989-1992 members include: Professor David B. Wexler, (Chair), University of Arizona; Dr. Joseph Bevilacqua, Commissioner of Mental Health, South Carolina Department of Mental Health; Mr. Robert Carlberg, Court Administrator, Spokane County Superior Court, Washington; Ms. Dorothy Crawford, President, Research and Development Training Institutes, Inc., Arizona; Dr. Joel Dvoskin, Associate Commissioner, New York

State Office of Mental Health; Dr. Thomas Grisso, Professor of Psychiatry, Director of Forensic Training and Research, Massachusetts; Honorable Gordon R. Hall, Chief Justice, Supreme Court of Utah; Ms. Marilyn Hall, State Court Administrator, Michigan; Mr. Robert L. Lovato, Administrative Director, Supreme Court of New Mexico, Professor Michael Perlin, New York Law School; Honorable Floyd Propst, Judge, Probate Court of Fulton County, Georgia; Dr. Jonas R. Rappeport, Chief Medical Officer, Circuit Court of Baltimore City; and Dr. Loren Roth, Associate Professor of Psychiatry and Director of the Law and Psychiatry Program, Western Psychiatric Institute and Clinic, Pennsylvania.

**Further  
Information**

Institute on Mental Disability and the Law,  
National Center for State Courts, 300 Newport  
Avenue, Williamsburg, Virginia, 23187-8798,  
(804) 253-2000, FAX (804) 220-0449

**National Center for State Courts'  
Institute on Mental Disability and the Law**

**Advisory Board Members**

1989-1992

Professor David B. Wexler (Chair)  
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University of Arizona  
Tucson, AZ 85721

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Western Psychiatric Institute  
and Clinic  
3811 O'Hara Street, Room 1086  
Pittsburgh, PA 15261



## WASHINGTON ATTRACTIONS

### FAMOUS HOUSES AND BUILDINGS

U.S. Capitol -- National Mall (East End): (202) 224-3121 / (202) 225-6827 (tours). Under the magnificent 180-foot white dome, elected Senators and Representatives meet to shape U. S. legislative policy. Start the free half-hour tour at Randolph Rogers' superb ten-ton bronze doors on the Capitol's east side. See the Rotunda (painted by Constantino Brumidi). Statuary Hall (with two statues from each state), the House of Representatives (the largest legislative chamber in the world), the Senate (with its famous reception room) and the Crypt (original Supreme Court chamber). Open daily, 9:00 AM-10:00 PM. Tours, 9:00 AM-3:45 PM.

House of Representatives: Rayburn, Longworth, and Cannon buildings on Independence Avenue between 2nd SE, and 1st SW.

Senate: Russell, Dirksen, and Hart buildings on Constitution Ave. between 2nd NE, and Delaware.

N.B.: Get passes from your Senator's or Representative's office for entry to Visitors' galleries.

The White House -- 1600 Pennsylvania Ave., N.W.: (202) 456-7041. Home of every U. S. President since 1800, this famous house is visited by more than one million people each year. Five of the mansion's 132 rooms are open to the public: the East Room, the Green Room, the Blue Room, the Red Room, and the State Dining Room. Visitors can also catch a glimpse of the beautiful gardens and grounds. Open Tues.-Sat., 10:00 AM-Noon. Public tours are self guided. Congressional tours are guided from 8:15 AM-9:00 AM, Tues.-Sat. Tickets must be arranged ahead through your Senator's or Representative's office.

The Supreme Court -- 1st & Maryland Ave., NE 20543: (202) 479-3000. The highest court in the land, where the nine presidentially-appointed Justices rule on Constitutional matters. The massive classical building was built in 1935 by architect Cass Gilbert. Court is in session two weeks of every month (October-April). Open Mon.-Fri., 9:00 AM-4:30 PM. Tours, 9:00 AM-3:30 PM, arranged through your Senator's or Representative's office.

National Archives -- 7th & Pennsylvania Ave., NW 20408: (202) 523-3000. The National Archives displays many historical documents, such

as the Declaration of Independence, the Constitution, and the Bill of Rights. The Archives Museum Shop offers many books, reference aids, genealogical publications, facsimiles of famous documents, and many other materials related to the billions of records in the Archives' holdings. Open Mon.-Fri., 10:00 AM-3:00 PM.

Old Executive Office Building -- 17th & Pennsylvania Ave., NW 20503: (202) 395-5895. Building of historical and architectural importance which originally housed the Departments of War, State, and Navy. In the 1940s it became an extension of the White House offices. Tours conducted Saturday morning from 9:00 AM-Noon by reservation only.

Library of Congress -- Jefferson Building, 10 First St, SE 20540; and Madison Building, 101 Independence Ave., SE 20540: (202) 287-5000 / (202) 287-5458 (tours / (202) 287-6400 (tape). Jefferson is ornate Beaux Arts building decorated with frescoes and statues. Volumes of a Gutenberg Bible and a 15th-century manuscript Bible on exhibit. Other exhibits change periodically in both buildings. Exhibit halls open Mon.-Fri., 8:30 AM-9:30 PM; Sat., 8:30 AM-6:00 PM. Jefferson Building tours given every hour, 9:00 AM-4:00 PM beginning with a slide show 15 minutes before the hour. Jefferson Building also has a snack bar; Madison Building has a cafeteria open Mon.-Fri., 8:30 AM-3:30 PM.

Martin Luther King Memorial Library -- 901 G St., NW 20001: (202) 727-0321 / (202) 727-1111 (tape). Main Library and Administrative Headquarters of the D.C. Public Library. Subject divisions including Washingtoniana, Black Studies, all subjects. Many educational and cultural programs. Mural on the life of Martin Luther King. Open Mon.-Thurs., 9:00 AM-9:00 PM; Fri.-Sat., 9:00 AM-5:30 PM; Sun., 1:00 PM-5:00 PM. Tours by appointment.

Folger Shakespeare Library -- 201 E. Capitol St., SE 20003: (202) 544-7077. The Folger Shakespeare Library houses the world's largest collection of Shakespeare's printed works, as well as a large collection from the continental Renaissance. The Great Hall, reminiscent of an Elizabethan long gallery, contains exhibits from the collection, and the theatre is styled to suggest an Elizabethan innyard theatre. The library sponsors performances of music and drama, readings of poetry and prose, and lectures. Open daily, 10:00 AM-4:00 PM. Tours available Mon.-Fri., 11:00 AM-1:00 PM.

Octagon House -- 18th and New York Ave., NW. One of the first townhouses built after the District of Columbia became the federal capital. Restored 18th century with period furniture, and actually built in an octagonal shape.

National Geographic Building -- 17th and M Streets, NW. METRO exit: Farragut North (red line).

## MONUMENTS AND MEMORIALS

Arlington National Cemetery -- Arlington, VA 22211: (703) 692-0931. Here lie the remains of 175,000 American soldiers who fought from the Revolutionary War to the present. Among the thousands of white headstones are the graves of William Howard Taft, John F. Kennedy, Robert Kennedy, boxer Joe Louis, Oliver Wendell Holmes, and astronaut Virgil Grissom. A moving sight is also the hourly changing of the guard at the famous Tomb of the Unknown Soldier. On the hill see Arlington House, a memorial to Robert E. Lee and the final resting place of Washington's architect: Pierre Charles L'Enfant. Open daily, 8:00 AM-7:00 PM.

Iwo Jima Statue (Marine Corps Memorial) -- On Route 50, near Arlington National Cemetery, Arlington, VA. The largest bronze statue ever cast, this 78-foot memorial commemorates all the Marines who have died in battle since 1775. Felix W. deWeldon created the piece from a famous war photograph showing the flag being raised on Mt. Suribachi during WWII. Open daily, 24 hours.

Jefferson Memorial -- Tidal Basin (South Bank), West Potomac Park. Dedicated in 1943, the classical dome and colonnade of this memorial to the third U. S. president is in the style he most preferred. Inside is a 19-foot bronze statue beneath a simple rotunda, and the walls are filled with quotations from the Declaration of Independence and other writings. Open daily, 24 hours.

Lincoln Memorial -- West Potomac Park at 23rd St, N.W.: (202) 426-6841. This simple, grand memorial to Abraham Lincoln is shaped like a Grecian temple, overlooking the massive Reflecting Pool on the National Mall. A 19-foot statue of the 16th President is inside, and surrounding the seated figure on the walls are some of Lincoln's most famous speeches. Open daily, 24 hours.

Vietnam Veterans' Memorial -- Constitution Ave. between Henry Bacon Dr. and 21st St. N.W. (202) 426-6841. Modern V-shaped memorial designed by Maya Ying and inscribed with the names of 58,131 people who died or remain missing in the Vietnam War. Built with the private contributions of American citizens. Large books help to locate names on the walls. Open daily, 24 hours. Handicapped accessible.

Washington Monument -- On National Mall at 15th St., N.W.: (202) 426-6841. The tallest masonry structure in the world, stretching 555 feet into the sky. This majestic obelisk was dedicated to the memory of the first U. S. President in 1885. From the top one can get the best view of the District of Columbia and environs. The elevator ride is free! Open daily, 9:00 AM-Midnight.

## MUSEUMS AND GALLERIES

Ford's Theatre & Lincoln Museum -- 511 10th St., N.W. 20004: (202) 426-6924. The place President Lincoln was assassinated on April 14, 1865. Lincoln Museum downstairs contains objects related to the Lincolns



and assassin John Wilkes Booth. Open daily, 9:00 AM-5:00 PM.  
Tours on the half hour except 12:30 PM.

Smithsonian Institution Museum Group -- The Smithsonian Institution is the world's largest museum complex with thirteen museums and the National Zoo. About one percent of the museum's 100 million objects is on display at any one time. All museums are open daily, 10:00 AM-5:30 PM. Admission to all Smithsonian Museums is free. Free walk-in "highlights" tours available to the public in most museums. Visitor information, (202) 357-2700 daily, 9:00 AM-5:00 PM. TDD for hearing impaired (202) 357-1729; recorded information, (202) 357-2020.

#### PARKS AND GARDENS

Botanic Garden -- Maryland Ave. & 1st St., S.W. 20024: (202) 225-8333.  
This glass building houses an extraordinary collection of exotic and familiar plants, including orchids, cacti and huge palm trees. The fountain and gardens in front are by Frederick Bartholdi. Open daily, 9:00 AM-9:00 PM.

Dumbarton Oaks -- 32nd and R Streets, N.W. Byzantine and pre-Columbian art in a pavilion designed by Philip Johnson. Decorative arts and extensive gardens.

East Potomac Park -- Ohio Drive, access by Maine Avenue or Rock Creek Parkway by Lincoln Memorial. At the end, Haines Point has a view of the Anacostia and the Potomac Rivers and the airport, sculptures, and playground.

Tidal Basin -- Independence and Maine Avenue.

Constitution Gardens -- Between 17th and 23rd Streets, Independence and Constitution Avenues.

#### THEATRE AND STAGE

The Arena Stage -- 6th & Main Ave., S.W. 20024: (202) 554-9066. Box office: (202) 488-3300. Arena Stage features classics as well as contemporary and new plays.

John F. Kennedy Center for the Performing Arts -- New Hampshire Ave. at Rock Creek Parkway, NW 20566: (202) 254-3600. All types of performances from opera and symphony concerts to Broadway musicals and classical drama. Three restaurants, lobby concession stands during performances. METRO exit: Foggy Bottom-GWU (orange/blue line).

**Restaurants near the Ramada Renaissance Hotel  
Ballston Metro Center**

Nam Viet Restaurant  
1127 N. Hudson Street  
Arlington, VA 22201  
(703) 522-7110

The Pines of Italy  
237 N. Glebe Road  
Arlington, VA  
(703) 524-4969

Maiko Super Sushi  
3155 Wilson Blvd.  
Arlington, VA 22201  
(703) 522-4787

Jeannies Chinese  
5221 Wilson Blvd.  
Arlington, VA  
(703) 524-1988

Queen Bee Restaurant  
3181 Wilson Blvd.  
Arlington, VA 22201  
(703) 527-3444

Sizzler Steak House  
2130 N. Glebe Road  
Arlington, VA  
(703) 525-6316

Vietnam Clarendon  
3211-3213 N. Washington Blvd.  
Arlington, VA 22201  
(703) 527-7208

El Tazunal Mexican  
1227 N. Hudson St.  
Arlington, VA  
(703) 243-4800

Hunan Number One Restaurant  
3033 Wilson Blvd.  
Arlington, VA 22201  
(703) 528-1177

El Ranchero  
4617 Wilson Blvd.  
Arlington, VA  
(703) 524-1010

Fuji Restaurant  
77 North Glebe Road  
Arlington, VA 22203  
(703) 524-3666

Red Hot and Blue  
1600 Wilson Blvd.  
Arlington, VA  
(703) 276-7427

Hunan Gate  
4233 N. Fairfax Drive  
Arlington, VA 22203  
(703) 243-5678

MY AN 2  
6785 Wilson Blvd.  
Falls Church, VA  
(703) 538-7110

Jacques' Cafe  
4001 N. Fairfax Drive  
Arlington, VA 22203  
(703) 528-8500 or 528-7548

**Ballston Common Shopping Mall**  
Wilson Blvd. and Glebe Road  
Arlington, VA 22203

American Cafe  
(703) 522-2236

Slade's  
(703) 243-8830

Boardwalk Fries  
(703) 528-8522

Cisco's  
527-5308

Everything Yogurt  
528-3070

Frank & Stein  
522-4070

Greek Gourmet  
527-5308

Inside Scoop  
525-8955

Kabuki Sushi & Steak  
522-2464

McDonald's  
525-2980

Manchu Wok  
522-0854

Sbarro's

Steak Escape  
525-6171

Texas Cattle Corp  
527-3332

Wingmaster  
524-2449

**FOOD SPECIALTIES  
AT THE  
BALLSTON COMMONS SHOPPING MALL**

Cheese & Bottle  
524-0112

Coffee Bean  
522-1650

Dallas Candies  
522-4411

Fannie May Candies  
522-5636

Ms. Fielery  
527-6844

General Nutrition Center  
528-9257

Mais Oui  
525-1231

The Original Cookie Company  
841-0528

T.J. Cinnamons  
524-0400

**DIRECTIONS TO  
RAMADA RENAISSANCE HOTEL BALLSTON METRO CENTER**

- NORTH**      Take 95 south over the Wilson Bridge to 395 North. Exit off at number 7B Glebe Road. Proceed 3.28 miles to North Fairfax Drive. There is a light at North Fairfax. Turn right. Proceed through the next stop light. The first street after the light will be North Stafford. Turn right.
- SOUTH**      Head north on 395 to exit number 7B (Glebe Road). Proceed 3.28 miles to North Fairfax Drive (there is a traffic light). Turn Right on to North Fairfax. Proceed through the next stop light. The first right after the light is North Stafford.
- EAST**        Take Route 66 west to exit number 23 (Glebe Road). At the top of the exit is a stop light. Turn left (Glebe Road). At the second stop light (north Fairfax) turn left. Proceed through the next stop light and turn right onto the first street. This is North Stafford.
- WEST**        Take Route 66 east to exit 23 (North Fairfax/Glebe Road). After the third (3rd) stoplight make your first right onto North Stafford.
- FROM  
DULLES**      Take Dulles Access Road (follow signs for I-66 east Washington). Get on I-66 east. Take Route 66 east to exit 23 (North Fairfax/Glebe Road). After the third (3rd) stoplight make you first right onto North Stafford.
- FROM  
NATIONAL**    Follow signs for 66 West. Take Route 66 west to exit number 23 (Glebe Road). At the top of the exit is a stop light. Turn left (Glebe Road). At the second stop light (north Fairfax) turn left. Proceed through the next stop light and turn right onto the first street. This is North Stafford.

# RAMADA RENAISSANCE HOTEL BALLSTON METRO CENTER

## PROFILE

### Special Guest Room Features:

All guest rooms feature: remote control television, Skylink in-room movies, AM/FM clock radio, touchtone telephones with call waiting, state of the art fire protection system, guest room card key lock system, and individual control for heating and air conditioning.

### Guest Rooms:

<u>Type</u>	<u>Number of Rooms</u>
Double Double Rooms	75
King Rooms	129
Suites	5
Total Guest Rooms	209

### Concierge Floor:

The top floor of the hotel has been designated as our concierge floor. We provide complimentary continental breakfast every morning, and hors d'oeuvres and cocktails for social hour in the concierge lounge. Each room will have a special amenities package for the discriminating travelers.

### Food & Beverage Outlets:

#### Mezzanine Level

A CUT ABOVE Restaurant, elegant yet casual, seating - 132

#### Mezzanine Level

A CUT ABOVE Lounge, inviting and congenial with soothing piano music, seating - 46

#### Plaza Level

METRO'S Bar, a popular watering hole with emphasis on Happy Hour and lunchtime periods, seating - 77

### Meeting Rooms:

Gallery Ballroom	4,000 Sq. ft.
Masters Ballroom	1,400 Sq. ft.
Pre-function Area	1,680 Sq. ft.
Conference Room	416 Sq. ft.
Board Room	310 Sq. ft.

### Hotel Facilities and Services:

Guest laundry, gift shop, complimentary parking for hotel guests, room service, fax service, and valet service.

### Available in Ballston Metro Center Complex:

Florist, Colorfax, health food store, bank, beauty salon, Landini Brothers, and Tivoli Gourmet Deli.

### Recreation:

Extensive health club facility featuring indoor lap pool, steam room, and exercise room. Ballston Common Shopping Mall.

### Location:

Located directly above the Metrorail station and one-quarter mile from Interstate 66, the hotel site offers easy access to downtown Washington, D.C., National Airport, and Dulles International Airport, Tyson's Corner, the Pentagon and various points around the greater Washington, D.C. area, including the national monuments and historical attractions.

DINING, BRUNCHING, MUNCHING, AND GRAZING

"What's To Eat On Capitol Hill"

AMERICAN

The Adams Room -- The Hay-Adams Hotel, One Lafayette Sq., NW 20006: (202) 638-6600. Cobb's salad, Maryland crab cakes, London broil. Daily 6:30 AM-2:00 PM \$3.75-18.50 (B), \$10.50-17 (Br), \$10.00-\$18.50 (L). Res. req. Coat and tie. AE, MC, VS, DC, JCB.

The American Cafe -- Fresh seafood and meat over mesquite logs, and fresh baked breads. Days and hours vary by location, many open late serving lunch and dinner. Capitol Hill: 277 Massachusetts Ave., NE. 20002: (202) 547-8500. Res NN, casual. AE, MC, VS, DC.

Board & Bottle Dining Room -- Best Western Skyline Inn, 10 Eye St., SW 20024: (202) 488-7500. American-French cuisine with daily specials. Daily, 11:30 AM-2:00 PM & 5:30 PM-10:00 PM. \$4-\$12 (L), \$5-18 (D). Casual. AE, MC, CB, VS, DC, GR.

Bullfeathers Restaurant -- 410 1st St., SE 20003: (202) 543-5005. Exciting American cuisine catering to a wide range of tastes and pocket books. Besides having the best hamburger on Capitol Hill, Bullfeathers is known for well-prepared fresh fish and prime beef dishes. Sun, 10:00 AM-2:00 AM, Mon.-Thurs., 11:30 AM-2:00 AM, Fri., 11:30 AM-3:00 AM, Sat., 10:30 AM-3:00 AM. \$5-\$8 (Br), \$5-\$10 (L), \$9-\$15 (D). DJ on Saturday nights. Seasonal outdoor cafe. Res. req. Coat and tie or casual. GR, AE, MC, CB, VS, DC, Choice.

The Cafe -- The Sheraton Grand on Capitol Hill, 525 New Jersey Ave., N.W. 20001: (202) 628-2100. Cobb salad, she-crab soup, progressive American. Daily, 7:00 AM-11:00 PM. \$4.50-\$8.95 (B), \$17.95 (Br), \$5.95-\$13.95 (L), \$5.95-\$15.95 (D). Res. rec. Casual. AE, MC, CB, VS, DC.

Coach and Parlor Restaurant -- Quality Inn, 415 New Jersey Ave., N.W., 20001: (202) 638-1616. Regional American seafoods, Italian veal and pasta, fresh seafood daily. Daily, 6:30 AM-10:00 PM. \$3.95-\$6.95 (B), \$4.35-\$8.95 (L), \$8.95-\$17.95 (D). Res NN. Coat and tie or casual. Handicapped accessible (no stairs), including restrooms. GR, AE, MC, CB, VS, DC, Discover.

The Monocle on Capitol Hill -- 107 D St., N.E., 20002: (202) 546-4488. Regional fresh fish and shellfish prepared in light sauces, aged beef, and innovative salads. Mon.-Fri., 11:30 AM-Midnight; Sat., 6:00 PM-11:00 PM. \$6-\$12 (L), \$12-\$18 (D). Live jazz piano and bass player, Fri.-Sat. evenings. Res. rec. Coat and tie. GR, AE, MC, CB, VS.

Park Promenade -- Hyatt Regency, 400 New Jersey Ave., N.W. 20001: (202) 737-1234. Pizzas of the day, gourmet style-perfect balance fish of the day, fajita Mexican dish. Daily, 6:30 AM-Midnight. \$4-\$9 (B), \$18.50 (Br), \$10.50 (L), \$19 (D). Bar with wine dispense.

Park Promenade -- Hyatt Regency, 400 New Jersey Ave., N.W. 20001: (202) 737-1234. Pizzas of the day, gourmet style-perfect balance fish of the day, fajita Mexican dish. Daily, 6:30 AM-Midnight. \$4-\$9 (B), \$18.50 (Br), \$10.50 (L), \$19 (D). Bar with wine dispenser. Res NN, casual. Handicapped accessible (elevator and ramp). AE, MC, VS, DC.

The Signature Room -- The Sheraton Grand, 525 New Jersey Ave., NW 20001: (202) 628-2100. Aged prime beef, steaks and seafood. Mon.-Sat. 6:00 PM-11:00 PM. \$17-\$28 (D). Piano. Res. rec. Coat and tie. AE, MC, CB, VS, DC.

Smithson's -- Holiday Inn Capitol, 550 C St., S.W. 20024: (202) 479-4000. Breakfast buffet, lunch buffet. Mon.-Fri. Family menu. House specialty: pot roast. Daily, 6:30 AM-2:00 PM & 5:00 PM-10:30 PM. \$2.25-\$5.95 (B), \$4.50-\$7.50 (L). \$8.95-\$14.95 (D). Res. NN, casual. Handicapped accessible (ramps and restroom facilities).

Tiber Creek Pub -- The Bellevue Hotel, 15 E St., NW 20001: (202) 638-0900/ext. 201. House specials, BBQ rib, Texas crab toast, and deep dish pizza. Bar has yards of beer. Mon.-Fri., 7:30 AM-10:30 AM, 11:30 AM-3:00 PM, 4:00 PM-2:00 AM. Sat.-Sun., 7:30 AM-10:30 AM & 4:30 PM-2:00 AM. \$3.95-\$6.95 (B), \$3.95-\$6.95 (Br), \$3.95-\$7.95 (L), \$6.95-\$15.95 (D). Res. rec. Casual. GR, AE, MC, CB, VS, DC.

#### CONTINENTAL

Apple of Eve -- Loews L'Enfant Plaza Hotel, 480 L'Enfant Plaza, S.W. 20024: (202) 484-1000. Fresh meat, seafood and vegetables, salads, and desserts prepared table side. High quality of all menu items. Mon.-Fri., 11:00 AM-2:30 PM. Daily, 5:30 PM-Midnight. \$8-\$15 (L), \$14-\$25 (D). Piano, happy hours, live band. Res. rec. Coat and tie. GR, AE, MC, VS, DC.

Hugo's On The Hill -- Hyatt Regency, 400 New Jersey Ave., NW 20001: (202) 737-1234. Fresh lobster and seafood, variety of game and selected cuts of beef. Sweet souffles. Daily, 6:30 PM-11:00 PM. \$17.50-\$22. Piano bar for 6:00 PM-1:00 AM. Res. rec. Coat. Handicapped accessible (elevator, tables accessible with wheelchairs). AE, MC, CB, VS, DC.

The Hunt Room -- 406 1st St. S.E., 20006: (202) 488-7160. Classic continental cuisine from egg souffle to prime ribs with maderia sauce served in a stylish private dining room. \$10-\$13.50 (B, Br), \$16.50-\$21 (L), \$21-\$31.50 (D). Res. rec. Coat and tie. GR.

#### ETHNIC SPECIALTIES

The Dubliner Restaurant and Pub -- The Phoenix Park Hotel, 520 N. Capitol St., NW, 20001: (202) 737-3773. Fish and chips, generous portions,

great burgers, homemade soups, fresh daily specials. Guinness Stout on tap. Mon.-Thurs., 11:30 AM-2:00 AM; Fri., 11:30 AM-3:00 AM. Sat., 7:00 AM-3:00 AM, Sun., 7:00 AM-2:00 AM. \$3.95-\$6.95 (B, Br), \$4.95-\$8.95 (L), \$4.95-\$10.95 (D). Live Irish entertainment daily, beginning each evening at 9:00 PM. Seasonal outdoor cafe. Reservations not necessary. Casual. AE, MC, CB, VS, DC.

The Powerscourt -- The Phoenix Park Hotel, 520 N. Capitol St., NW 20001: (202) 737-3776. Elegant Irish dining -- entrecote Jameson is the house specialty. Fresh seafood daily, Irish oak-smoked salmon. Mon.-Fri., 7:00 AM-10:30 PM. Sat., 5:30 PM-10:30 PM. \$5.95-\$10.95 (B), \$7.95-\$15.95 (L), \$12.95-\$18.95 (D). Reservations recommended. Coat and tie. Handicapped accessible elevators and restroom facilities. AE, MC, CB, VS, DC.

#### FRENCH

La Colline -- 400 N. Capitol St., NW 20001: (202) 737-0400. Fresh seasonal seafood, pastries from La Colline's own pastry shop, and wine bar. Mon.-Fri., 7:00 AM-10:00 AM, 11:30 AM-3:00 PM, 6:00 PM-10:00 PM. Sat., 6:00 AM-10:00 PM. Sun., 5:00 PM-9:00 PM. \$1.25-\$3.50 (B), \$7.25-\$10.75 (L), \$7.75-\$13.50 (D). Seasonal outdoor cafe. Reservations recommended. Casual. AE, MC, CB, VS, DC.

#### SEAFOOD

Jonah's Oyster Kitchen -- Hyatt Regency, 400 New Jersey Ave., NW 2001: (202) 737-1234. Serving the finest, freshest seafood in the Washington area prepared in a variety of different ways. Mon.-Fri., 11:30 AM-2:30 PM and raw bar, 2:30 PM-5:00 PM. Daily, 6:00 PM-11:00 PM. \$7.95-\$15.75 (L), \$15.50-\$21 (D). Muzak. Reservations recommended. Coat and tie or casual. Handicapped accessible elevator. AE, MC, CB, VS, DC.



