Book Review

CRIMINAL COMMITMENTS AND DANGEROUS MENTAL PATIENTS: LEGAL ISSUES OF CONFINEMENT, TREATMENT, AND RELEASE. By David B. Wexler. United States Department of Health, Education, and Welfare, National Institute of Mental Health Crime & Delinquency Monograph Series, Rockville, Md., 1976. Pp. 94. $1.35.

High security psychiatric facilities are not pleasant places. Because of the perceived need for security and the resulting fences and similar equipment, they often resemble prisons more than the hospitals they purport to be. The resident[1] population resembles a prison population more than the patients of so-called "civil" hospitals, although the lethargy produced by medication and the absence of organized activities often creates what some regard as a more oppressive—or oppressed—atmosphere than that found in correctional facilities. Society's rejection of the residents is often carried through to a demand that the facilities be located at maximum distances from large population centers. The cultural and social isolation of these facilities and the acknowledged difficulty of accomplishing therapeutic results with the type of person incarcerated in these institutions creates staff recruitment problems, and staff members are likely to be less able and enthusiastic than mental health professionals working in other contexts.

These institutions have had publicly-aired problems. *Titicut Follies*, Frederick Wiseman's graphic film of life in Massachusetts' Bridgewater State Hospital, laid bare how depreciating to human dignity life in such a facility can be.[2] After the United States Supreme Court in *Baxstrom v.*

1. The word "resident" is used to avoid the dispute as to whether such facilities are sufficiently "therapeutic" to justify calling those housed in them "patients" rather than "inmates."

2. *See* Cullen v. Grove Press, Inc., 276 F. Supp. 727 (S.D.N.Y. 1968); Commonwealth v. Wiseman, 356 Mass. 251, 249 N.E.2d 610, *cert. denied*, 398 U.S. 960 (1969). Conditions at Bridgewater are discussed in Nason v. Superintendent of Bridgewater State Hosp., 353 Mass.

Herold,[3] found that New York's summary procedure for "commitment" of prison inmates whose prison terms had expired to high security hospitals operated by the Department of Corrections violated equal protection, a followup study of those patients who had been detained under the procedure left no question that the need for security had been vastly overrated. One year after the 967 patients had been transferred to civil hospitals, only seven had been determined to present such management or security problems as to require recommitment to a high security correctional facility.[4] Approximately 15% of these so-called "Baxtrom patients" had been discharged to the community;[5] several years later, this figure was increased to 27%.[6] The use of apomorphine—which stimulates up to an hour of vomiting—to discourage such rule infractions as swearing or even talking, condemned by the Eighth Circuit in *Knecht v. Gillman*,[7] took place at the Iowa Security Medical Facility. The similar use of anectine, which creates a period of muscle paralysis during which the conscious resident is unable to breathe, occurred in two California high security psychiatric facilities, Atascadero State Hospital, operated by the Department of Health, and the California Medical Facility in Vacaville, under the control of the Department of Corrections.[8] There is a growing recognition that these facilities are overused and that the quality of life in them makes such overuse a serious medical-legal problem.

In addition, the administration of the programs and procedures that bring patients to these facilities involves working with one of the most dynamic areas of developing law. Even matters that are somewhat solidified in the mental health and correctional area become uncertain when applied to the no man's land in between.[9] Almost all of the patients in high security psychiatric facilities fall into one of the following intermediate categories: persons institutionalized following an acquittal by reason of insanity or a determination of incompetency to stand trial in a criminal proceeding; persons convicted of a criminal charge but regarded as psychologically abnormal and dangerous; patients hospitalized through civil commitment proceedings but thought to pose exceptional security or management difficulties; civilly committed individuals against whom criminal charges are

604, 233 N.E.2d 908 (1968). Like some other high security psychiatric facilities, Bridgewater is administratively within the state correctional agency rather than the mental health agency. *Id.* at 608, 233 N.E.2d at 911.

3. 383 U.S. 107 (1966).

4. Hunt & Wiley, *Operation Baxstrom After One Year*, 124 AM. J. PSYCH. 974, 976 (1968).

5. *Id.*

6. Steadman & Keveles, *The Community Adjustment and Criminal Activities of the Baxstrom Patients: 1966-70*, 129 AM. J. PSYCH. 304, 304 (1972).

7. 488 F.2d 1136 (8th Cir. 1973).

8. Morris, *"Criminality" and the Right to Treatment*, 36 U. CHI. L. REV. 784, 798-800 (1969).

9. *See* text & notes 13-15 *infra*.

pending; and persons sentenced to prison terms following criminal convictions who develop what is perceived to be a need for psychiatric hospitalization during imprisonment. Typically, however, there is little or no day-to-day legal advice available to the staffs of these institutions concerning the appropriate way to avoid litigation or how to respond to litigation already begun. Despite the increasing attention that is being paid to the problems posed by isolated aspects of the procedures that bring residents to these facilities, there has been little focus upon high security psychiatric facilities as a separate type of institution[10] and little effort has been made to examine the issues posed by these programs as they relate to each other and to the institutions in which the programs are implemented.

Professor Wexler's monograph[11] responds to this void and does so well. Throughout, he is concerned with the desirable institutional context for programs designed to accommodate "dangerous mental patients." He recognizes that the solution to this problem will depend in part upon the answers to specific problems posed by the various programs. These problems are considered in light of developing trends in mental health law, what can reasonably be expected of institutional programs for dangerous mental patients, and how these expectations can best be realized.

The monograph begins by noting that programs in high security psychiatric facilities must be examined in light of developing trends of legal and medical concern.[12] Chapter II is an effective presentation of those trends and their special relevance to high security psychiatric facilities. Professor Wexler recognizes that both legal and therapeutic authorities are realizing the need to increase reliance upon community based programs, and that institutional programs must take into account this trend towards decreasing utilization of the institutional context.[13] He also notes the increasingly critical scrutiny such programs' therapeutic claims are receiving, and points out that application of the right to treatment to residents of high security facilities must be considered in planning programs.[14] Moreover, *Criminal*

10. In A. DEUTSCH, THE MENTALLY ILL IN AMERICA 411-13 (2d ed. 1949), the author reports that in colonial times "insane offenders" were disposed of in the same fashion as "sane" criminals, often by shipping or execution. When state hospitals were first constructed, beginning in the 1830's, provision was often made for the confinement of the insane criminals therein. The development of separate high security facilities for the criminally insane was primarily a response to objections raised to the enforced association of the civilly insane with persons of criminal tendencies. The State Lunatic Asylum for Insane Convicts, opened at Auburn, New York in 1859, was apparently the first such facility. It was moved to Matteawan in 1892 and the following year its name was changed to Matteawan State Hospital. Dannemora State Hospital was opened in 1900 at Dannemora, New York, for persons declared insane while serving a prison sentence. In addition, Deutsch, writing in 1949, notes the existence of separate institutions for the criminally insane and insane criminals in Illinois, Indiana, Kansas, Massachusetts, Michigan, Ohio, Pennsylvania, Wisconsin, and "other states." *Id.* at 413.

11. D. WEXLER, CRIMINAL COMMITMENTS AND DANGEROUS MENTAL PATIENTS: LEGAL ISSUES OF CONFINEMENT, TREATMENT, AND RELEASE (1976).

12. *Id.* at 1-2.

13. *Id.* at 4-6.

14. *Id.* at 9-12.

Commitments and Dangerous Mental Patients emphasizes that the developing right against intrusive, experimental, or unproven methods of treatment may render a significant number of current or anticipated techniques unavailable.[15] Finally, Wexler finds open-ended (or "indeterminate") commitment processes subject to attack on both legal and therapeutic grounds, and concludes that it should not be included as part of future programs in high security psychiatric facilities.[16]

In Chapter III, Professor Wexler discusses specific problems posed by the various categories of residents who often end up in maximum or high security psychiatric facilities. In regard to criminal defendants found incompetent to stand trial,[17] for example, he discusses the potential impact of *Jackson v. Indiana*,[18] condemning on constitutional grounds indefinite hospitalization of an incompetent defendant on the basis of the incompetency determination alone. Also evaluated is the Burt-Morris proposal to abolish incompetency as a bar to trial and substitute a 6-month continuance at the end of which the defendant must either be tried (with special safeguards to offset any remaining incapacity) or the charges must be dismissed.[19] Proposals for abolishing the insanity defense are discussed in relation to persons committed following an acquittal by reason of insanity.[20]

Perhaps the most interesting questions raised by this book concern the procedure for release of persons so acquitted and committed. Professor Wexler suggests that using the same release procedures for such persons as are used for civilly committed patients—generally discharged at the discretion of the institution—may result in discouraging discharges because of the reluctance of the institutions to assume responsibility for release of a potentially dangerous and highly visible resident.[21] Sharing responsibility for discharge by involving courts in the release decision, Professor Wexler suggests, may in fact lead to earlier discharges and might inure to the benefit of such persons. Equal protection doctrine, he urges, should not be developed so as to bar such differential processing of persons acquitted by reason of insanity. Stressing the need to distinguish among residents based upon the reasons for which they were institutionalized, Professor Wexler suggests that provision for such shared responsibility for discharge might reasonably be considered for all persons institutionalized under the government's police power, as contrasted with those compelled to submit to treatment by the state in the exercise of its parens patriae authority to assume responsibility

15. *Id.* at 12-16.
16. *Id.* at 18-32.
17. *Id.* at 38-42.
18. 406 U.S. 715 (1972).
19. *See* Burt & Morris, *A Proposal for the Abolition of the Incompetency Plea*, 40 U. CHI. L. REV. 66 (1972).
20. D. WEXLER, *supra* note 11, at 49-52.
21. *Id.* at 52-56.

for citizens no longer able to make acceptable decisions regarding their own welfare.

Probably the most significant of Professor Wexler's conclusions, however, is that no new separate high security psychiatric facilities should be constructed.[22] It is argued that efforts should rather be channeled into the development and upgrading of security units at so-called civil psychiatric facilities and mental health programs in the correctional area. Several considerations lead to this conclusion. To some extent, Wexler predicts a declining demand. He anticipates that fewer criminal defendants found incompetent to stand trial will be subject to high security hospitalization.[23] More careful scrutiny of the risks posed by civil patients with criminal detainers, and efforts to resolve the problems causing the issuance of the detainers may also result in a smaller number of such persons being regarded as appropriate for high security institutionalization.[24] Further, he asserts that the needs of prison inmates may be more efficiently met within the correctional system itself, and therefore that fewer transfers of such persons to psychiatric facilities may be desirable.[25] For those residents for whom high security institutionalization remains appropriate, however, Professor Wexler concludes that placement in units on the premises of civil mental institutions would best assure treatment that would meet reasonable legal, humanitarian, and therapeutic standards. The conclusion that the need to provide more effective treatment for a substantially reduced resident population can best be served by abandonment of separate high security institutions and at least partial integration of high security units into civil hospital programs is of obvious importance in planning future mental health facilities and programs.

Several factors need to be considered as possibly arguing against this approach, however, particularly in regard to certain categories of persons now institutionalized in separate high security facilities. One such factor is the possible impact upon the civil facilities. State hospitals and their patients have never been well received by communities, and current efforts to expand community based programs have resulted in increased friction between the public mental health system and local citizens.[26] If the criminally insane are even partially integrated into other programs, community resistance to those other programs may increase. The potential benefits to the

22. *Id.* at 2, 69-70.
23. *Id.* at 41.
24. *Id.* at 46-48.
25. *Id.* at 57. *Criminal Commitments and Dangerous Mental Patients* also concludes that more persons acquitted by reason of insanity are likely to reach the mental health system, although these are likely to involve acquittals of less serious charges than is now generally the case. Therefore, this expected increase is said to present a less uniform need for high security confinement. *Id.* at 49.
26. *See* Article, *Exclusion of the Mentally Handicapped: Housing the Non-Traditional Family*, 7 U. CAL. D.L. REV. 150 (1974) (discussing restrictive zoning ordinances).

criminally insane must be considered in light of damage that may be done to the programs for civil patients.

Second, it is necessary to consider whether abandonment of separate high security psychiatric facilities might result in an undesirable reduction of efforts to develop programs for dangerous repeat criminal offenders. This becomes of special importance in light of the possibility that the death penalty may be called into play to meet the need created by psychologically abnormal, dangerous offenders. A Danish penologist recently noted with dismay the lack of interest on the part of the psychiatric profession and members of the general public in the development of institutional programs for violent offenders. "More commonly," he observed, "we hear in the mass media demands for public violence, in the form of executions."[27] Some efforts have been successfully made to convince American juries to impose the death penalty on the basis that certain offenders are psychologically abnormal, therefore dangerous, and not amenable to treatment.[28] But there is increasing indication that the conventional wisdom that "psychopaths" or "antisocial personalities" are not receptive to therapeutic intervention is at least without firm support in the scientific evidence. When, in 1972, LeVine and Bornstein[29] examined the literature for controlled studies of the effectiveness of treatment for such persons, they found none that met their original requirements for methodological acceptability. Of the ten that met their "minimal" criteria, eight reported "positive" results. The authors commented, however, upon the absence of efforts to evaluate the effectiveness of organic treatment such as medication, psychosurgery, aversion therapy techniques, and institutional programs being utilized in Holland and Denmark.[30] Recent evidence that persons labeled psychopaths may differ from normal persons in their physiological reaction to threatening situations[31] and that there may be a genetic factor contributing to their antisocial behavior[32] suggests that efforts to develop and evaluate

27. Stürup, *Institutional Treatment of Violent Offenders*, 1 INT'L J. CRIM. & PENOLOGY 99, 100 (1973).

28. *See* Dix, *The Death Penalty, "Dangerousness," Psychiatric Testimony, and Professional Ethics*, 5 AM. J. CRIM. L. 151 (1977) (discussing the use of psychiatric testimony to establish that a convicted defendant is "dangerous" within the meaning of TEX. CODE CRIM. PROC. ANN. art. 37.071 (Vernon Supp. 1976) and therefore comes within the Texas death penalty statute).

29. LeVine & Bornstein, *Is the Sociopath Treatable? The Contribution of Psychiatry to a Legal Dilemma*, 1972 WASH. U.L.Q. 693.

30. *Id.* at 704-05.

31. *See* S. SCHACTER, EMOTION, OBESITY AND CRIME 166 (1971) (finding that sociopaths were able, after being injected with adrenaline, to learn more quickly to perform tasks in such a way as to avoid painful errors). *See also* Goldman, Lindner, Dintiz, & Allen, *The Simple Sociopath: Physiological Characteristics*, 3 BIOLOGICAL PSYCH. 77 (1971).

32. *See* Crowe, *An Adoptive Study of Psychopathy: Preliminary Results From Arrest Records and Psychiatric Hospital Records*, in GENETIC RESEARCH IN PSYCHIATRY 95 (R. Fieve, D. Rosenthal, & H. Brill eds. 1975); Crowe, *An Adoption Study of Antisocial Personality*, 31 ARCHIVES GENERAL PSYCH. 785 (1974). *See generally* Robins, *Discussion of Genetic Studies of Criminality and Psychopathy*, in GENETIC RESEARCH IN PSYCHIATRY, *supra* at 117.

organic treatment methods are a reasonably based undertaking.[33]

Such efforts may be discouraged by deemphasis of separate high security psychiatric facilities. Experimentation and evaluation might, of course, take place at high security units placed in civil facilities. This combination may, however, depreciate the importance of the high security unit programs, and traditional pessimism concerning violent offenders may result in such programs being denied a fair allocation of the institution's financial support and staff efforts. Few civil hospitals are likely to be enthusiastic about developing a reputation as a psychopath treating facility. It is also possible that such programs might be developed in correctional facilities, but the traditional animosity between mental health professionals and correctional programs suggests that is not a fertile locale for development of programs of this sort. Correctional settings are not generally attractive to mental health personnel, and their involvement is likely to be discouraged by requiring them to work in the correctional setting.

If such facilities are to remain available for the limited purpose of developing programs for criminal offenders who pose special dangers and who might otherwise be dealt with more harshly, the need would still remain to consider the extent to which the institutions should be available for the other categories of persons that have traditionally been incarcerated in high security psychiatric facilities. It may well be that security units at local civil facilities and improved correctional programs could meet all other needs, and separate facilities should be utilized for dangerous offenders only if a jurisdiction was willing to underwrite a vigorous effort to develop programs for dangerous offenders.

Professor Wexler's monograph clearly provides much needed focus upon high security psychiatric institutions as a unique category of mental health facilities. Future planning of mental health and correctional programs must recognize this and address the question of the future of such institutions with awareness of their distinct nature. *Criminal Commitments and*

33. Other programs for psychologically abnormal, dangerous offenders have made claims to therapeutic success, based largely upon comparisons of recidivism of persons released as "cured" with that of others released upon court demand. Hodges, *Crime Prevention by the Indeterminate Sentence Law*, 128 AM. J. PSYCH. 291 (1971) (concerning Maryland Defective Delinquency program); Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972) (Massachusetts sexually dangerous persons program). The methodology and conclusions of these studies, however, has been subjected to criticism. *See* Wilkins, *Treatment of Offenders: Patuxent Examined*, 29 RUTGERS L. REV. 1102 (1976). But the claims cannot be entirely ignored, especially if the alternative is to put the offenders to death or to incarcerate them for long periods of time with no sustained effort to develop behavior changing methods. Although indeterminate commitment may create the possibility of long term confinement, there is evidence that institutional staffs may avoid this danger by discharge practices. *See* Dix, *Differential Processing of Abnormal Sex Offenders: Utilization of California's Mentally Disordered Sex Offender Program*, 67 J. CRIM. L. & CRIMINOLOGY 233, 238 (1976) (suggesting that sex offenders processed under California's sex offender program probably spent less time behind bars than offenders processed through the correctional system).

Dangerous Mental Patients not only encourages this desirable focus but is an invaluable aid to understanding the numerous issues raised by programs in such institutions as these issues relate to prevailing and developing trends in mental health law.

*George E. Dix**

* Professor of Law, University of Texas. B.S. 1964, J.D. 1966, University of Wisconsin. Member of the Arizona, Texas, and Wisconsin bars.