Part II

THE CRIMINAL COMMITMENT PROCESS

Part I dealt extensively with the "normal" process of commitment. Yet the mental health legal system is sometimes entered through other channels principally related to the criminal process. Accordingly, Part II will explore some of the criminal commitment routes available under Arizona law. These include the "not-guilty-by-reason-of-insanity" route, the "incompetent-to-stand-trial" route, and the "prison-to-hospital" transfer route. The prison-to-hospital transfer is actually a form of civil commitment, but it is of a sufficiently specialized and "criminal" variety to merit separate attention here.

THE COMMITMENT AND RELEASE OF CRIMINAL DEFENDANTS FOUND NOT GUILTY BY REASON OF INSANITY

The verdict of not guilty by reason of insanity[1] (NGRI) carries two meanings in this country. In one-half the states, a verdict of NGRI means that the defendant has been actually found to have been insane

1. Arizona adheres to an unmodified *M'Naghten* test of insanity. *See* Lauterio v. State, 23 Ariz. 15, 201 P. 91 (1921). *See also* 12 ARIZ. L. REV. 149 (1970). The defense in general is explored thoroughly in A. GOLDSTEIN, THE INSANITY DEFENSE (1967).

The Supreme Court of Arizona has not been persuaded to expand its purely cognitive insanity rule (which looks only to whether the defendant knew what he was doing or knew that it was wrong) to include also a volitional element. The doctrine applying the latter element, sometimes mislabeled an "irresistible impulse" rule, exempts from criminal liability those unable to "control" their criminal behavior. Yet, there are some thoughtful arguments that a rule ignoring volition offends constitutional requirements of due process and cruel and unusual punishment. *See* Robinson v. California, 370 U.S. 660 (1962). *Cf.* Powell v. Texas, 392 U.S. 514 (1968). *See generally* Dubin, *Mens Rea Reconsidered: A Plea For a Due Process Concept of Criminal Responsibility*, 18 STAN. L. REV. 322 (1966); Comment, *Addiction, Insanity and Due Process of Law*, 3 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 125 (1967); Comment, *Cruel and Unusual Punishment and the Durham Rule*, 59 J. CRIM. L.C. & P.S. 227 (1968).

Curiously, however, the Arizona court may recently have introduced indirectly the related doctrine of "diminished" or "partial" responsibility (which permits the negation of specific intent by the introduction of evidence of mental condition

at the time of the crime.[2] In the other states, including Arizona,[3] and in the federal courts, however, an NGRI verdict means simply that the finder of fact could not determine beyond a reasonable doubt that the defendant was sane at the time the criminal act was committed.[4] In the latter jurisdictions, assuming the existence of a *M'Naghten* rule of criminal responsibility, the defense need only raise a reasonable doubt whether the defendant knew the difference between right and wrong or whether he knew the nature and quality of his act at the time of the commission of the act.[5] Thus, in one-half the state courts and in the federal courts, insanity at the time of the criminal act is not proved.[6] Moreover, in no jurisdiction does an NGRI verdict in itself have any bearing on the defendant's mental condition at the *time of trial*—presumably an important consideration in determining the defendant's present need for treatment or hospitalization.

But an acquittal by reason of insanity does not necessarily result in the defendant's release from custody. As of 1967, when Dean Goldstein published *The Insanity Defense*, the situation was as follows:

> In at least twelve states, acquittal by reason of insanity is followed by mandatory commitment to a mental hospital. In most others, the trial judge (or a jury) must determine whether the acquitted defendant is presently in need of commitment and may, in discharging this function, commit the defendant for a limited period for observation and diagnosis. In the remaining handful of jurisdictions where no explicit provision is made for

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falling short of legal insanity), a doctrine previously rejected outright in State v. Narten, 99 Ariz. 116, 407 P.2d 81 (1965) and in State v. Schantz, 98 Ariz. 200, 403 P.2d 521 (1965). The recent decision of State v. Shaw, 106 Ariz. 103, 471 P.2d 715 (1970), overturning on constitutional grounds the state's bifurcated insanity trial statute, drew heavily on the law of California—where diminished responsibility is well-recognized—and used language in parts of its opinion implying that a rule of partial responsibility may be constitutionally compelled. Thus, at one point the *Shaw* court asked, "Can this Court say that it is just to pass upon the guilt and innocence of a defendant without allowing *all* of the evidence available to determine whether he had the *mental capacity* to commit the crime?" 106 Ariz. at 112, 471 P.2d at 724 (emphasis added). And *Shaw's* progeny have not dispelled the notion. *See* State v. Andrews, 106 Ariz. 372, 378, 476 P.2d 673, 679 (1970), where the court stated:

> We would call attention to the fact that in the instant case the defendants were permitted to introduce evidence as to their mental capacity . . . using this as evidence to negative their ability to form an intent to commit the crime for which they were charged. They were not deprived of due process in the presentation of this evidence. . . . [In any event] . . . State v. Shaw . . . was not retroactive.

For a discussion of the diminished responsibility doctrine, see A. GOLDSTEIN, *supra* note 1, at 194-202. *See also* Dix, *The Effect of* State v. Shaw *on Arizona Criminal Law*, 7 ARIZ. B.J. 18 (June 1971); Comment, *A Punishment Rationale for Diminished Capacity*, 18 U.C.L.A.L. REV. 561 (1971).

2. A. GOLDSTEIN, *supra* note 1, at 111-12 & n.8, *citing* H. WEIHOFEN, MENTAL DISORDER AS A CRIMINAL DEFENSE 219-28, 241 (1954).

3. State v. Blazak, 105 Ariz. 216, 462 P.2d 84 (1969), *noted in* 12 ARIZ. L. REV. 156 (1970).

4. A. GOLDSTEIN, *supra* note 2.

5. M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1843). *See* 12 ARIZ. L. REV. 149 (1970).

6. A. GOLDSTEIN, *supra* note 1, at 111.

commitment within the criminal process, the prosecutor will consider whether to initiate civil commitment proceedings.[7]

COMMITMENT FOLLOWING AN NGRI VERDICT IN ARIZONA

Arizona provides for discretionary, as opposed to mandatory, commitment following an NGRI verdict. At one time, the state initiated separate civil commitment proceedings for all persons found NGRI.[8] Since under that procedure an acquitted defendant would obtain the same hearing that a person facing civil commitment would obtain,[9] that NGRI commitment scheme did not raise the troubling legal questions, discussed later,[10] that often plague NGRI hospitalization law. In 1968, however, the procedure was changed when the Arizona Legislature passed a comprehensive statute governing administration of the insanity defense and establishing a bifurcated trial of the guilt and sanity issues.[11] The statute provided that the issue of guilt would be tried first; only if the defendant was found to have committed the act in question would his mental responsibility be litigated, and that would be done in a second trial. Among the provisions of that comprehensive 1968 statute was one which gave the jury—or the judge when sitting without a jury—the duty of determining the present mental condition of a defendant found NGRI at the second stage.[12]

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7. *Id.* at 143.

Problems similar to those discussed in this section arise under so-called "sexual psychopath" statutes, which provide for the commitment of convicts to mental hospitals in lieu of prisons. As the project went to press, it was learned that the United States Supreme Court will hear argument in such a case in November. Humphrey v. Cady (7th Cir.) (unreported), *cert. granted*, 91 S. Ct. 1202 (1971). In *Humphrey*, the petitioner was convicted of contributing to the delinquency of a minor under WIS. STAT. ANN. § 947.15 (1958), *as amended*, (Supp. 1971-72), for which the maximum sentence is $500 and 1 year in the county jail. He was sentenced, however, under the "sexual psychopath" statute, *id.* § 959.15 (1958), which not only applies to the specifically referenced crimes of rape, adultery and sexual participation with minors, but extends to "*any crime* except homicide or attempted homicide if the court finds the defendant was *probably* directly motivated by a desire for sexual excitement in the commission of the crime." *Id.* § 959.15(2) (emphasis added). Moreover, the discretion lies not with the court, but with the department of public welfare: "If . . . the department recommends specialized treatment . . . the court *shall* . . . either place him on probation . . . [and require outpatient care], or commit him to the department under this section." *Id.* § 959.15 (6) (emphasis added).

Humphrey sought habeas corpus in district court and the Seventh Circuit; both courts denied both the writ and a certificate of probable cause for appeal. Telephone interview with Irvin B. Charne, Esq., petitioner's counsel, Milwaukee, Wis., Aug. 30, 1971. For the violation of a crime carrying a maximum penalty of 1 year, Humphrey can be committed indefinitely to a mental hospital because he *probably* was sexually motivated, in the opinion of nonjudicial personnel. *See* the discussion of doctors' criteria for incarceration in the civil commitment process, pp. 64-65 & notes 207-09, p. 90 & note 312 *supra*. *See also* "Prison-to-Hospital Transfers, pp. 174-88, and the discussion of commitment following a finding of incompetency to stand trial, pp. 165-73 & note 109a *infra*.

8. ARIZ. R. CRIM. P. 288; *see, e.g.*, State v. Bates, Nos. A-14744 & A-14840 (Pima Co. Super. Ct., Mar. 4, 1966).

9. *See* ARIZ. REV. STAT. ANN. §§ 36-505, -509 (Supp. 1970-71).

10. Pp. 154-59 *infra*.

11. ARIZ. REV. STAT. ANN. §§ 13-1621, -1621.01 (Supp. 1970-71).

12. *Id.* § 13-1621.01(D).

The jury apparently made the determination of present mental condition during the later trial on the insanity defense, and on the basis of that determination ordered the acquitted defendant's release or commitment to a mental institution. There was no explicit provision for a separate hearing on present sanity, and there was no certain standard to be followed in determining committability.[13]

In June 1970, however, the Supreme Court of Arizona, in *State v. Shaw*,[14] held the bifurcated trial system established by the new insanity defense statute[15] violative of due process. *Shaw* spawned much confusion in the NGRI commitment area, for it was unclear whether the opinion sought to vitiate the entire 1968 statutory scheme—and thus restore the older procedure of ordinary civil commitment in NGRI cases—or whether it sought simply to excise as unconstitutional the bifurcated determination of guilt and sanity. The later opinion of the *Haletky* case,[16] however, soon resolved the point, restricting *Shaw* to the bifurcation procedure and holding the NGRI commitment provision severable and intact.[17]

Consequently, the same provisions and shortcomings remain: A single jury determines both criminal responsibility and present sanity; no certain statutory standard exists by which the jury can measure the defendant's present mental condition vis-à-vis the propriety of commitment; and if the court, without express statutory authorization, should choose to have the jury deliberate separately on the defendant's present mental condition, the court is not required, during the earlier proceeding on guilt and criminal responsibility, to instruct the jury on the consequences of finding a defendant not guilty by reason of insanity.

NGRI v. Civil Commitment

In an involuntary civil commitment a person cannot be committed before he receives a court hearing at which testimony of at least two examiners and at least two lay witnesses is given.[18] The judge must then find that the patient is mentally ill to such an extent that he is dangerous to himself or

13. *Id.* §§ 13-1621, -1621.01. Subsection 13-1621.01(C), among others, has been judicially extirpated. State *ex rel.* Berger v. Superior Court, 106 Ariz. 365, 371, 476 P.2d 666, 672 (1970) [referred to herein as the *Haletky* case, by the name of the real party in interest].

14. State v. Shaw, 106 Ariz. 103, 471 P.2d 715 (1970).

15. ARIZ. REV. STAT. ANN. § 13-1621.01(A)-(C) (Supp. 1970-71). For a discussion of the procedural aspects of *Shaw*, *see* Dix, *Mental Illness, Criminal Intent, and the Bifurcated Trial*, 1970 L. & SOC. ORDER 559.

16. State *ex rel.* Berger v. Superior Court, 106 Ariz. 365, 476 P.2d 666 (1970). *See* note 13 *supra.*

17. *Id.* at 371-72, 476 P.2d at 672-73. The court further held that *Shaw* would only apply to cases which began after that decision. *Id.* at 369, 476 P.2d at 670. Though some semblance of sense can be made of section 13-1621.01 when it is read in connection with *Shaw* and *Haletky*, a legislative revamping is very much in order. See the *Haletky* opinion for the Arizona court's redrafting efforts.

18. ARIZ. REV. STAT. ANN. § 36-514(B) (Supp. 1970-71).

to the person or property of others.[19] He must release the patient if he determines the patient is not dangerous because of mental illness.[20]

The question then arises whether the differences between a person found NGRI and a patient facing a civil commitment hearing justify the different methods for judicially disposing of the two classes of persons. Phrased in a legal framework, do the differences in disposition methods unfairly discriminate against the acquitted criminal defendant and offend equal protection?

The Test of Bolton v. Harris

Bolton v. Harris[21] laid the foundation for analysis of the problem and has catalyzed awareness of the issue. In an opinion by Judge Bazelon, the Court of Appeals for the District of Columbia Circuit held the equal protection clause required that "persons found not guilty by reason of insanity must be given a judicial hearing with procedures substantially similar to those in civil commitment proceedings."[22] The court reasoned that the differences in District of Columbia procedures between civil commitment hearings and those resulting from a verdict of NGRI violated equal protection as defined by the Supreme Court case of *Baxstrom v. Herold.*[23]

In *Baxstrom,* the Supreme Court held that equal protection was denied to New York prisoners who at the expiration of their penal sentences were civilly committed without the safeguards available to non-prisoners facing civil commitment. Equal protection was also offended in *Baxstrom* because mentally ill prisoners were confined in an area for the dangerously insane past the expiration of their penal sentences without a judicial determination of their "special dangerousness"—a procedure required by New York law before anly civilly committed patient can be confined in an area for the dangerously insane.[24] The Court found the discrimination to be irrational because while

> [c]lassification of mentally ill persons as either insane or dangerously insane of course may be a reasonable distinction for purposes of determining the type of custodial or medical care

19. *Id.* § 36-514(C).
20. *Id.* §§ 36-514(C), -515.
21. 395 F.2d 642 (D.C. Cir. 1968); *accord,* People v. Lally, 19 N.Y.2d 27, 224 N.E.2d 87, 277 N.Y.S.2d 654 (1966). *See generally* Note, *Bolton v. Harris: Equal Protection in Insanity Proceedings,* 56 GEO. L.J. 1191 (1968); Note, *Commitment Following Acquittal by Reason of Insanity and The Equal Protection of the Laws,* 116 U. PA. L. REV. 924 (1968).
22. 395 F.2d at 651.
23. 383 U.S. 107 (1966).
24. N.Y. MENTAL HYGIENE LAW § 85 (McKinney 1971). The law requires a judicial finding that confinement in a civil hospital would endanger the safety of other patients, employees, or the community at large. Arizona should consider the adoption of such a statute with regard to transfers of civil patients from general hospital population wards to far more restrictive ones—such as the Maximum Security Unit.

> to be given, . . . it has no relevance whatever in the context of the opportunity to show whether a person is mentally ill *at all.*[25]

Prior criminal conduct can therefore properly affect the certainty, the duration, and the quality of involuntary hospitalization, but not, consistent with equal protection, the very procedures for the determination of mental illness itself.

The Arizona insanity defense statute, which, as was noted earlier, does not itself specifically provide for a separate hearing on the present mental condition of a defendant found NGRI, establishes a procedure which is patently vulnerable under the *Baxstrom-Bolton* equal protection theory.[26] The embellishing *Haletky* decision, however, contains the following possibly significant language: "Where the defendant is found not guilty by reason of insanity there would *then* be submitted to the jury the interrogatory . . . [whether the defendant's present mental condition justifies commitment to a mental institution] . . . ."[27] In contrast to the former Arizona procedure, which consisted, at one deliberation, of a joint consideration of the insanity defense and the defendant's present mental condition, *Haletky*, by its use of the term "then", may be read to contemplate a separate consideration of present mental condition *after* a verdict of NGRI. *Bolton*, moreover, would seem to command not only that a separate deliberation on present mental condition be had, but also that a separate hearing be held to provide an opportunity for the introduction of evidence on that condition.[28] If, for example, a jury only considered evidence of insanity at the time of the crime in finding a defendant presently committable, equal protection would be violated, for a person must be found presently dangerous before he may be civilly committed.[29] Nor should the Constitution permit the prosecution to prejudice the defendant by introducing, at the criminal trial itself, evidence of his present mental condition.

Even a separate hearing, however, would not place the NGRI defendant in as advantageous a position as his counterpart in the civil commitment process, for the NGRI defendant, at his subsequent hearing on present mental condition, will probably have thrust upon him the same

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25. 383 U.S. at 111. *Accord*, Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968); Cameron v. Mullen, 387 F.2d 193 (D.C. Cir. 1967).

26. ARIZ. REV. STAT. ANN. § 13-1621.01(C)-(D) (Supp. 1970-71). And to the extent that the statute contemplates the jury rendering a decision on present mental condition based solely on evidence relating to the defendant's criminal responsibility at the time of the crime, it would seem also to offend due process. Specht v. Patterson, 386 U.S. 605 (1967); Bolton v. Harris, 395 F.2d 642, 650-53 (D.C. Cir. 1968) (discussing *Specht*).

27. 106 Ariz. at 371, 376 P.2d at 672 (emphasis added).

28. Bolton v. Harris, 395 F.2d 642, 651-52 (D.C. Cir. 1968). In State v. Atwood, No. A-16066 (Pima Co. Super. Ct., May 28, 1970), the trial judge held a hearing on the day following an NGRI verdict in order to receive testimony in regard to the defendant's present mental condition. But questionnaires sent to Arizona judges indicate that the practice of holding separate hearings is not uniformly followed.

29. For the due process implications of the textual example, see *Specht* and its discussion in *Bolton, supra* note 26.

jury that pondered over the facts of his case and found him insane at the time of the crime.[30] Though the standards for criminal responsibility and for hospital commitment are legally distinct,[31] other portions of this project have clearly shown that even judges and lawyers have great difficulty in distinguishing the various legal concepts of mental illness.[32] Obviously, then, a jury's earlier finding of NGRI will weigh heavily—no doubt too heavily—in its later hospitalization determination.[33] Add the ingredient of a very serious offense, which often triggers the insanity defense,[34] and the jury's knowledge that the NGRI defendant will freely roam the streets if not committed, and a jury determination that the defendant still suffers from a mental disorder which justifies commitment seems easily predictable.

The project's field findings—such as the 1970 Pima County Superior Court case of *State v. Atwood*[35]—demonstrate, if they do not actually prove, the disadvantages sometimes suffered by NGRI defendants facing jury commitment. In *Atwood*, the jury acquitted the defendant of first degree murder because of insanity. After a separate hearing on the present mental conditon of the defendant, at which the only evidence introduced was evidence of a present lack of dangerousness, the jury found his condition justified commitment. The trial judge, however, set aside the jury order and released the defendant. *Atwood* should be contrasted with *State v. Soto*.[36] There, after the prosecution and defense stipulated that the defendant committed the physical acts constituting the crime,[37] the judge, sitting without a jury, found the defendant NGRI. The judge further ordered his release on the basis of a psychiatric report that the defendant's condition did not justify his commitment.[38]

Recommended Procedure for NGRI Commitment

The statutory provisions for adjudication of a defendant's present mental condition after a verdict of NGRI seem unwise, unfair, and un-

30. The bifurcated trial statute permits waiver of the jury at the first trial (guilt or innocence) or the second trial (insanity at the time of the crime and present mental condition), but does not address itself to the possibility of waiving a jury only for the determination of present mental condition. Further, even if the present mental condition determination could be severed, for jury waiver purposes, from the basic criminal trial, consent of both the state and the court is required in order for the jury "waiver" to take effect. ARIZ. REV. STAT. ANN. § 13-1621.01(L). *Cf.* Singer v. United States, 380 U.S. 24 (1965).

31. *See* pp. 150-51 *supra.*

32. *See generally* pp. 19-23, 77-78 *supra. See also* pp. 64-65, 90 & n.312 *supra.*

33. Jackson v. Denno, 378 U.S. 368 (1964). *See also* Bruton v. United States, 391 U.S. 123 (1968).

34. A. GOLDSTEIN, *supra* note 1, at 24.

35. No. A-16066 (Pima Co. Super. Ct., May 28, 1970).

36. No. A-17375 (Pima Co. Super. Ct., Aug. 18, 1970).

37. The crime charged was drawing a check on a nonexistent account. *See* ARIZ. REV. STAT. ANN. § 13-316(A)(4) (Supp. 1970-71).

38. On occasion, however, it is beneficial for the defendant to insist on consideration of both his plea of NGRI and his present mental condition by a jury.

constitutional. To overcome those objections within the existing legislative framework would require considerable alterations. First, the standard of commitment would, of course, have to be clarified and made explicit in order to avoid confusion in determining whether the defendant's current mental condition justifies commitment. Second, the jury should be instructed prior to deliberating guilt or innocence that a person found NGRI will not simply be released, but that his condition and need for hospitalization will be considered at a separate hearing. Third, a separate hearing to determine present mental condition should be held after a verdict of NGRI, and the hearing, like an ordinary civil commitment proceeding, should require the testimony of at least two medical and two lay witnesses. Finally, the judge should consider the present committability of a defendant found NGRI unless the defendant elects to be judged by the jury which found him NGRI.

Upon analysis, it is obvious that the wholly "rebuilt" NGRI commitment statute would closely resemble the civil commitment provisions, albeit with some additional frills. But rather than redraft the *Shaw*-damaged bifurcated insanity defense statute to accommodate the above goals, the legislature, with far greater ease, could simply repeal the insanity defense statute in its entirety—including the NGRI commitment portion "salvaged" by *Haletky*.[39] Such a course of action would revive the old procedure—Rule 288 of the *Arizona Rules of Criminal Procedure*—which provides for a separate *civil* commitment hearing after a verdict of NGRI,[40] and would solve the multitude of problems presented in this section. In the NGRI commitment area, progress, it seems, can best be obtained by regression.

RELEASE AFTER NGRI COMMITMENT IN ARIZONA

Following the commitment of a person found NGRI, the question arises as to how he can obtain release when he is no longer dangerous to himself or to society. In Arizona, two psychiatrists must first certify that the defendant is no longer a danger to himself or to others.[41] Second, the court must hold a trial, at which the defendant has the burden of proof, to determine whether he should be released.[42] A jury, presumably

In State v. Palacios, No. A-17444 (Pima Co. Super. Ct., Oct. 2, 1969), for example, a lower middle-class jury found the admitted killer of two "hippies" not guilty by reason of temporary insanity, and the defendant was promptly released.

39. State *ex rel.* Berger v. Superior Court, 106 Ariz. 365, 476 P.2d 666 (1970); *see* p. 150 & n.13 *supra.*

40. The rule reads as follows:

> If the jurors acquit the defendant on the ground that he was insane or mentally defective at the time of the alleged commission of the offense charged, their verdict shall so state. In such event the court shall immediately direct a petition to be filed for the examination of the defendant as a mentally ill person in accordance with the provisions of A.R.S. § 36-502 [now, under the 1968 civil commitment law, ARIZ. REV. STAT. ANN. § 36-509].

41. ARIZ. REV. STAT. ANN. § 13-1621.01(I) (Supp. 1970-71).

42. *Id.*

of the county where the criminal act occurred,[43] must decide the question unless the state consents to the defendant's waiver of trial by jury.[44] There is no express statutory provision for assigned counsel to represent the patient at the release proceeding.[45] This release procedure has the advantage, according to *Haletky*,[46] of preventing quick, unsupervised releases following NGRI verdicts;[47] but it has the distinct disadvantage of imposing a heavy and seemingly unconstitutional procedural and substantive burden on the NGRI committed defendant.

By contrast, a patient seeking release from confinement under a civil commitment order faces a different and far less convoluted procedure. He most frequently is released without any affirmative effort on his part: the superintendent of the Arizona State Hospital simply discharges him, completely or conditionally, upon unilaterally finding him no longer dangerous.[48] A patient can also obtain a judicial hearing on the need for his continued commitment once each year, regardless of the superintendent's diagnosis of the patient's condition.[49] A petition prepared by the patient or another and submitted to the Maricopa County Superior Court[50] is the sole prerequisite for triggering such a hearing. And at the hearing, as at the initial commitment hearing, the patient will be represented by coun-

43. *See* State v. McWilliams, No. A-15924 (Pima Co. Super. Ct., May 28, 1969) (both trial and release trial held in Pima County).

44. The court apparently need not now concur in the waiver, although such concurrence was required under the statute before *Haletky*. *See* ARIZ. REV. STAT. ANN. § 13-1621.01(L) (Supp. 1970-71). Since, under section 1621.01(I), the trial is conducted as a civil proceeding, the constitutional provision for waiver of trial by jury in civil cases (ARIZ. CONST. art. 6, § 17) apparently controls. See State *ex rel.* Berger v. Superior Court, 106 Ariz. 365, 371-72, 476 P.2d 666, 672-73 (1970).

45. Counsel is, of course, statutorily provided at civil commitment hearings. ARIZ. REV. STAT. ANN. § 36-514(A) (Supp. 1970-71). Curiously, the Public Defender Act provides for appointed counsel at civil commitment hearings but not at NGRI release hearings. *See id.* § 11-584(2). Apparently, public defender representation in felony cases, where it is available, extends only to trials and appeals. *Id.* § 11-584(1). In fact, however, despite the statutory vacuum, patients have been represented by counsel at the two NGRI release trials with which the project is familiar, both of which were held in populous counties (Maricopa and Pima).

46. 106 Ariz. at 371; 476 P.2d at 672.

47. *See, e.g.*, State v. Bates, Nos. A-14744 & -14840 (Pima Co. Super. Ct., June 10, 1966) (defendant found NGRI released from hospital without restrictions two months after verdict).

48. ARIZ. REV. STAT. ANN. § 36-524(D) (Supp. 1970-71):

> The superintendent, as frequently as necessary, shall examine or cause to be examined, every patient. When the superintendent determines that the conditions justifying hospitalization under § 36-514 no longer obtain, he shall give the patient a complete discharge. A copy of the complete discharge shall be sent to the clerk of the court where such proceedings were held.

Conditional discharge is provided for by *id.* § 36-524(A).

49. *Id.* § 36-516. An interview with the superintendent of the hospital disclosed, however, that the rehearing provision is in practice rarely invoked. Interview with Willis H. Bower, M.D., May 5, 1971. Perhaps that result is to be expected in the absence of a needed legal services program at the hospital to assist the patients.

50. A patient hospitalized at the Arizona State Hospital, which is located in Maricopa County, must petition the superior court in that county. ARIZ. REV. STAT. ANN. § 36-516 (Supp. 1970-71).

sel[51] and the court must affirmatively find the patient mentally ill and dangerous or he will be released.[52] That is to say, society has the burden of proving the patient remains dangerous.

Bolton v. Harris *and Release Procedures*

If the NGRI release procedures must be substantially similar to those for one civilly committed, as must the NGRI commitment procedures,[53] NGRI defendants seeking release may be deprived of equal protection. Measured by the *Bolton* holding on the constitutionality of the District of Columbia release provisions, as well as by the standard of substantial similarity, the Arizona NGRI release provisions seem to offend equal protection.

Under the District of Columbia NGRI release provisions operative at the time of the *Bolton* decision, the decision of the superintendent of a mental institution to discharge an NGRI patient was reviewed by a court *de novo*.[54] Under the District's civil commitment release provisions,[55] however, a civilly committed patient could be discharged solely on the order of the superintendent.[56] The civilly committed patient could obtain a court hearing on the need for continued commitment if one physician—a member of the hospital staff or an outside psychiatrist (who could be requested by a patient)—informed the court that he believed the patient to be no longer dangerous. Moreover, periodic examinations of civilly committed patients were performed. NGRI patients, however, were not entitled to periodic examinations, to examination by outside physicians, or

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51. *Id.* § 36-514(A).

52. *Id.* § 36-516, incorporating by reference *id.* § 36-514(C). Because of a provision for further observation when the court "cannot definitely determine" whether a patient is dangerous to self, others or property of others, *id.* § 36-515, the court may have to be convinced beyond a reasonable doubt of the patient's dangerousness to order his confinement for more than a temporary 30-day period. *In re* Winship, 397 U.S. 358 (1970) (applying a reasonable doubt test to juvenile delinquency adjudications because of the possible loss of liberty involved), may also have a bearing on commitment hearings. If it does, there will be no question but that the court must find a person dangerous beyond a reasonable doubt to order him committed.

53. Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968). See note 7, p. 149, and text accompanying note 22, p. 151 *supra*.

54. The review is discretionary unless the government objects to the discharge. Then the review is mandatory. D.C. CODE ANN. § 24-301(e) (Supp. IV, 1971):

> [T]he court in its discretion, or upon objection of the United States or the District of Columbia shall, after due notice, hold a hearing at which evidence as to the mental condition of the person so confined may be submitted, including the testimony of one or more psychiatrists from said hospital. The court shall weigh the evidence and, if the court finds that such person has recovered his sanity and will not in the reasonable future be dangerous to himself or others, the court shall order such person unconditionally released from further confinement in said hospital. If the court does not so find, the court shall order such person to be returned to said hospital.

55. *Id.* §§ 21-546 to -548 (1967).

56. *Id.*

to court hearings on the need for continued commitment unless the superintendent recommended discharge.

Speaking for the *Bolton* court, Judge Bazelon approved, as an acceptable exercise of legislative caution, the statutory requirement for a court review of the superintendent's decision to discharge an NGRI patient, even though there was no review of a similar release decision for a civilly committed patient. He proceeded, however, to construe the NGRI release statute to require the remaining safeguards given to civilly committed patients; there was, he felt, a lack of a "rational justification"—equal protection language—for the former distinctions.[57] *Bolton* also equalized the burden of proof for NGRI patients and civil patients in habeas corpus release proceedings.[58]

Under the standards laid down in *Bolton*, the existing Arizona NGRI release provisions are unconstitutional. The requirement, for example, that the NGRI patient has the burden of proof at the release hearing is at odds with *Bolton's* language that "[w]hile the criminal acts committed by a[n] [NGRI] patient may be evidence indicating whether or not the burden has been met, they do not justify a different burden."[59] Also, although a judical review of the superintendent's decision to release an NGRI committed patient may be upheld as an acceptable precautionary measure, the provision that an NGRI patient in Arizona must, in effect, be released by a *jury* (unless the state consents to a trial without a jury) is of questionable equal protection validity, particularly when the jury is from the county in which the patient committed the criminal act. A significantly greater burden is placed on the NGRI patient than on the civilly committed patient, whose release is determined by a judge in Maricopa County, if it is determined judicially at all. The potential for meting out community vengeance by an unforgiving jury is unfortunate but apparent.[60] Finally, by any interpretation of equal protection, an NGRI patient is denied that constitutional right if he is denied counsel at a release trial.[61]

That NGRI patients in *Bolton* were held entitled to release procedures generally corresponding to those of civilly committed patients supports an argument, moreover, that NGRI patients in Arizona should, if they so desire, be given release hearings as often as once a year.[62] And Arizona's

57. 395 F.2d at 652.
58. *Id.* at 653.
59. *Id. But see* Dixon v. Jacobs, 427 F.2d 589, 601-05 (D.C. Cir. 1970) (Leventhal, J., concurring).
60. *But see* State v. McWilliams, No. A-15924 (Pima Co. Super. Ct., May 28, 1969), in which jury ordered an NGRI-committed patient released after four months of hospitalization. A possible explanation for this readiness to recognize restoration to sanity is the size of the county in which the release trial occurs. If the *McWilliams* release trial had occurred in one of the outlying counties (that is, a county other than Maricopa or Pima), and if the original trial had also taken place there, the result might have been different. But that is a matter for empirical investigation.
61. *See* note 45 *supra.*
62. *See* ARIZ. REV. STAT. ANN. § 36-516 (Supp. 1970-71).

provision that NGRI patients must shoulder the burden of proof in their release trials similarly offends equal protection.[63]

Field Findings

At the time of this writing, the project is aware of only two NGRI release trials having been held in Arizona since the enactment of the insanity defense statute in 1968. One resulted in release; the other in a hung jury. Both were jury trials, and both involved female NGRI patients.

In *State v. McWilliams*[64] the defendant was found NGRI of the charge of murder and attempted murder and was committed to the Arizona State Hospital on January 20, 1969.[65] On April 10, 1969, the defense counsel moved for a release trial, and on May 28, 1969, the defendant was found by a jury to be no longer dangerous and was ordered released.

In the other case,[66] the patient, charged with assault with a deadly weapon, had originally been found NGRI on October 9, 1969 and was committed to the Arizona State Hospital. On July 30, 1970, two psychiatrists filed certificates to the effect that the patient was no longer a danger to herself or others. The release trial occurred on December 7-9, 1970, but the patient failed to meet her burden of proof, and the jury hung six-six. Thus, despite being hospitalized for fourteen months, being certified as recovered by two staff psychiatrists, and obtaining the favorable votes of half the jurors, she was retained at the hospital.

CONCLUSION

Shaw set the stage for reconsideration of the release provisions by voiding bifurcation; *Haletky*,[67] however, separated and retained the NGRI commitment and release provisions. A complete invalidation of the insanity defense statute may have been the better course for the *Haletky* court to follow. The revitalization of rule 288[68] for NGRI commitments, which might have been accomplished had *Haletky* interpreted *Shaw* as going all the way, would have meant a return to civil commitment and release proceedings for the NGRI patient.

By leaving the statute partially intact, however, *Haletky* kept alive the equal protection problems spawned by the 1968 insanity defense statute. Since that statute is quite specific in its invidious treatment of NGRI-

63. *See* Bolton v. Harris, 395 F.2d 642, 653 (D.C. Cir. 1968).
64. No. A-15924 (Pima Co. Super. Ct., May 28, 1969).
65. One of two psychiatric reports submitted to the court following examination of, among other things, defendant's mental capacity to stand trial, see ARIZ. REV. STAT. ANN. § 13-1621(F)(7) (Supp. 1970-71), stated that the defendant's present mental condition did *not* justify a commitment to a mental institution. The other written report contained the opposite conclusion: commitment was justified.
66. State v. Haletky, No. 10169 (Maricopa Co. Super. Ct., Dec. 9, 1970).
67. State *ex rel.* Berger v. Superior Court, 106 Ariz. 365, 476 P.2d 666 (1970).
68. ARIZ. R. CRIM. P. 288 (1956).

committed patients, it is unlikely that it could now be read judicially, as the *Bolton* court did with the District of Columbia Code, to "incorporate" the release procedures of the civil commitment statutory section. Instead, judicial rectification will have to come about through constitutional invalidation of the pertinent NGRI sections. And, of course, the legislature could itself act to repeal its 1968 error. Once again, the past provides the more enlightened route to progress.

INCOMPETENCY TO STAND TRIAL

The vast field of incompetency to stand trial, "by far the most frequent issue leading to the hospitalization of persons in the criminal justice system,"[69] could, of course, constitute an entire project in its own right.[70] Obviously, such full-scale treatment of the topic falls beyond the scope of the present work. Instead, this section will focus on the Arizona criminal competency statute and the problems raised by it, some of which were brought to the project's attention through interviews, questionnaires, and examinations of court files.

Strange as it may seem, there is even some uncertainty in the competency-to-stand trial area concerning the operative local statute or rule. In 1968, the Arizona legislature passed a new comprehensive criminal incompetency statute[71] which was plainly intended to replace the older rule, *Arizona Rule of Criminal Procedure* 250.[72] But if rule 250 is dead, its post-mortem convulsions have taken on a life-like quality, for now, over two years after its purported demise, the Supreme Court of Arizona still refers to rule 250 as being quite alive.[73] The issue is not without significance, for some important consequences can turn on whether rule 250 or section 13-1621 governs,[74] including perhaps whether the in-

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69. Rosenberg, *Competency for Trial—Who Knows Best?*, 6 CRIM. L. BULL. 577 (1970) (quoting unpublished paper by Lipsett & Lelos).

70. *Cf.* A. MATTHEWS, JR., MENTAL DISABILITY AND THE CRIMINAL LAW: A FIELD STUDY (1970); ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS, DUE PROCESS, AND THE CRIMINAL DEFENDANT (1970) [hereinafter cited as CRIMINAL DEFENDANT].

71. ARIZ. REV. STAT. ANN. § 13-1621 (Supp. 1970-71).

72. Telephone interview with John Flynn, Esq., a Phoenix attorney who was a chief architect of ARIZ. REV. STAT. ANN. § 13-1621 (Supp. 1970-71).

73. State v. Makal, 106 Ariz. 591, 480 P.2d 347 (1971) *(passim)*; State v. Davis, 106 Ariz. 598, 480 P.2d 354 (1971) *(passim)*. In *Davis*, the court curiously referred *both* to rule 250 and to ARIZ. REV. STAT. ANN. 13-1621 (Supp. 1970-71).

For some insight into the resolution of conflicting court made rules and legislative enactments, *see* State *ex rel.* Conway v. Superior Court, 60 Ariz. 69, 131 P.2d 983 (1942); Burney v. Lee, 59 Ariz. 360, 129 P.2d 308 (1942); ARIZ. REV. STAT. ANN. § 12-111 (1956). *See also* the recent discussion in State v. Blazak, 105 Ariz. 216, 462 P.2d 84 (1969). *Blazak*, moreover, seems to hold that section 12-1621 *does* replace rule 250, at least until the court promulgates new rules.

74. For example, section 13-1621(H)(4) specifies that after a defendant found incompetent to stand trial is released from the state hospital on the ground that he has regained his competency, the court must hold another competency

competency procedure can be used by the state as a sword against unwilling defendants,[75] a practice seemingly permissible under the decisional law construing rule 250,[76] but arguably improper according to the terms of section 13-1621.[77]

Actually, whichever provision governs, it seems, from interviews with prosecutor and defender offices within the state, as well as from file checks[78] and judicial questionnaires,[79] that in practice the prosecutor in Arizona rarely if ever petitions for a competency hearing or examination. Instead, incompetency is in this state used principally as a defense shield, sometimes invoked sincerely and for use in mitigation of punishment, but also used as a delaying tactic, with the hope that witnesses will

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hearing. *See also* State v. Blazak, 105 Ariz. 216, 462 P.2d 84 (1969). But under rule 250, the court under such circumstances could, in limited situations, rely solely on the superintendent's restoration certificate, and could proceed to trial without holding a second competency hearing. State v. Bradley, 102 Ariz. 482, 433 P.2d 273 (1967).

75. The prosecutive use of the incompetency device as a sword—and as the final disposition of a criminal case—is discussed in Lewin, *Competency to Stand Trial: Legal and Ethical Aspects of an Abused Doctrine*, 1969 L. & SOC. ORDER 233, 257-68. *See also* United States v. Barnes, 175 F. Supp. 60 (S.D. Cal. 1959); Foote, *A Comment on Pre-Trial Commitment of Criminal Defendants*, 108 U. PA. L. REV. 832 (1960). An interesting case study is portrayed in Rosenberg, *Treatment Denied—The Case of Arnold H. Marman*, 57 GEO. L.J. 702 (1969).

76. State *ex rel.* Ronan v. Stevens, 92 Ariz. 227, 375 P.2d 717 (1962) (lower court erred in denying state's request to order defendant examined regarding competency to stand trial).

77. Section 13-1621(B) permits a defendant to request an incompetency examination and hearing, and 13-1621(D) permits the superior court on its own motion to appoint medical experts to inquire into the accused's mental competency, but adds a provision that "the defendant shall not be committed without his consent." The statute may well be interpreted to mean that no competency inquiry is permissible without a defense provision permitting a prosecution-initiated examination further supports such an interpretation. *See also* Note, *Incompetency to Stand Trial*, 81 HARV. L. REV. 454, 467 (1967):

> In some situations it is clearly in the defendant's interest to serve a relatively short prison sentence rather than to face indeterminate commitment at an institution followed by a trial at some future time if and when found competent by hospital authorities. Even where the relative benefits of asserting incompetency and being tried are unclear, it would seem that the defendant's interests would best be served by allowing his counsel, or perhaps a court appointed guardian, to make the decision. The rule allowing the prosecution or the court to inquire into the defendant's competency arose at a time when indigent defendants had no constitutional right to appointed counsel, as they now have in all felony cases. Where counsel is provided, the rule is not essential both because the participation required of the defendant at trial is less active, and because counsel can intelligently decide when it will be in the defendant's interest to raise the incompetency issue though the defendant himself cannot. Moreover, if only the defendant or someone acting on his behalf were permitted to insist upon his incompetency, the possibility of the court or prosecution using the issue for purposes detrimental to the defendant would be eliminated. (footnotes omitted)

78. In a project survey of criminal case files, it was learned that in approximately 50 examined cases where incompetency to stand trial was raised, defense counsel raised the issue 46 times and superior court judges raised it four times. As might be anticipated, the incompetency issue generally arose only where prison terms of greater than 5 to 15 years could be expected.

79. None of the state judges who responded to the project's criminal ques-

become unavailable during the defendant's stint at the Arizona State Hospital.

Even if it cannot be used as a sword against criminal defendants, the harshness and uncertainty of the Arizona law of criminal competency should operate to dissuade many informed defense lawyers from asserting it even when it would be perfectly legitimate for them to do so. It is to those troubling issues of criminal competency law that we will now turn.

STANDARDS

It is now well recognized that the trial of an incompetent defendant offends due process,[80] and that federal constitutional standards should ultimately be used to gauge the constitutionality of state standards.[81] The federal standard has been pronounced by the United States Supreme Court in *Dusky v. United States*:[82]

> '[T]he test must be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.'[83]

And the District Court for the Western District of Missouri, particularly expert and influential in competency matters because of its location near—and caseload from—the Medical Center for Federal Prisoners at Springfield, has embellished the federal standard with a series of questions relevant to the capacity of a defendant to stand trial. In *Wieter v. Settle*,[84] that court held that when it appears:

> (1) that [the defendant] has mental capacity to appreciate his presence in relation to time, place and things; (2) that his elementary mental processes are such that he apprehends (i.e. seizes and grasps with what mind he has) that he is in a Court of Justice, charged with a criminal offense; (3) that there is a Judge on the Bench; (4) a Prosecutor present who will try to convict him of a criminal charge; (5) that he has a lawyer (self-employed or Court-appointed) who will undertake to defend him against that charge; (6) that he will be expected to tell his

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tionnaire had ever adjudged a defendant incompetent to stand trial when the defendant or his lawyer denied that the defendant was incompetent.

80. Pate v. Robinson, 383 U.S. 375, 378 (1966). To the extent that a defendant mentally incapable of assisting his counsel is forced to trial, he may also be deprived of his sixth amendment right to the effective assistance of counsel. *See* Wilson v. United States, 391 F.2d 460, 463 (D.C. Cir. 1968). *See also id.* at 467 (Fahy, J., dissenting). *But see* note 109a *infra*.

81. Noble v. Sigler, 351 F.2d 673 (8th Cir. 1965), *cert. denied*, 385 U.S. 853 (1966). *Cf.* Malloy v. Hogan, 378 U.S. 1, 11 (1964) ("the same standards must determine whether an accused's silence in either a federal or state proceeding is justified").

82. 362 U.S. 402 (1960).

83. *Id.* at 402.

84. 193 F. Supp. 318 (W.D. Mo. 1961).

> lawyer the circumstances, to the best of his mental ability, (whether colored or not by mental aberration) the facts surrounding him at the time and place where the law violation is alleged to have been committed; (7) that there is, or will be, a jury present to pass upon evidence adduced as to his guilt or innocence of such charge; and (8) he has memory sufficient to relate those things in his own personal manner—such a person, from a consideration of legal standards, should be considered mentally competent to stand trial under criminal procedure, lawfully enacted.[85]

Though not nearly as elaborate as *Weiter*, Arizona's criminal competency test[86] seems on its face to comply with the *Dusky* rule. But in the context of its administration, the Arizona standard may fall out of line with *Dusky*. That is because Arizona law requires medical experts, appointed to examine an accused with respect to competency, to file reports with the court containing their opinion on the following matters:

> 1. Whether the defendant presently suffers from a mental illness or defect.
>
> 2. The defendant's present ability to understand the nature of the proceedings against him.
>
> 3. The defendant's present ability to assist in his own defense.
>
> 4. Whether the defendant suffers from a condition which is diagnosed solely as a sociopathic or psychopathic personality disorder.
>
> 5. Whether the defendant's ability to reason or to control his conduct is substantially impaired.

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85. *Id.* at 321-22. A guide for psychiatrists conducting competency examinations can be found in Robey, *Criteria for Competence to Stand Trial: A Checklist for Psychiatrists*, 122 AM. J. PSYCHIATRY 615 (1965). The Laboratory of Community Psychiatry at the Harvard Medical School has recently prepared a Competency Screening Test, which is a paper and pencil test consisting of twenty-two sentence completion items. The answers to each item can receive a score of from zero to two, with higher scores indicating competency. For example, one question reads "When I go to court the lawyer will . . . ." An answer comparable to "defend me" will receive two points, while "be there" will receive one, and "put me away" will earn none. A total score less than 20 is said to raise the question of competency. *See* Department of Psychiatry, Harvard Medical School, Competency Screening Test (1970) [hereinafter cited as Harvard Competency Screening Test] [copy on file with the *Arizona Law Review*]. If used principally for sorting out persons who are *not* incompetent to stand trial (as opposed to identifying those who *are* incompetent), the Competency Screening Test would seem particularly useful, for even if a defendant is mentally disturbed, a high score on the test will indicate that his disturbance is not affecting his ability to understand and cope with court processes. On the other hand, for *low* scorers, mental incompetency to stand trial would appear to be but one of many possible conclusions that could be inferred from the test results: a low score could also be attributable to a naiveté about the judicial system or, in some cases, to a realistic assessment of its shortcomings, neither of which are appropriate mental grounds for rendering one incompetent or for committing him.

86. A person is incompetent if "as a result of mental illness or defect, he is unable to understand the proceedings against him or to assist in his own defense." ARIZ. REV. STAT. ANN.§ 13-1621(A) (Supp. 1970-71).

6. The defendant's potential for violent or dangerous behavior.

7. Whether the defendant's present mental illness or defect justifies his commitment to a mental institution.[87]

The apparent rationale for requiring these various findings is expediency—giving the defendant a full psychiatric workup on various issues so long as he must be examined for competency.[88] But the problem with this sort of economizing is that factors not at all relevant to the defendant's ability to stand trial may enter into, confuse, and prejudice the ruling on competency. The judicial confusion is well illustrated by the responses to a questionnaire sent to various superior court judges in Pima and Maricopa Counties, which indicate that factors 4, 6, and 7 of section 13-1621(F)—factors relating to sociopathy, violence and civil committability but not at all relevant to the *Dusky* standard—are considered by some judges in their determination of the defendant's competency to stand trial.[89] The result, of course, is that an incompetent defendant may be unwillingly and unconstitutionally forced to trial because he is not violent or because his mental condition does not justify hospitalization.[90] Similarly, a defendant who once successfully invoked the incompetency procedure but who is now competent and desires to return for trial may, be-

87. *Id.* § 13-1621(F).

88. Interview with John Flynn, Esq., *supra* note 72. Interestingly, the Arizona law does not require that the reports contain an opinion on the accused's criminal responsibility under the Arizona *M'Naghten* rule. If, however, the factors listed in ARIZ. REV. STAT. ANN. § 13-1621(F), if considered in other jurisdictions, might have a bearing on responsibility. Yet in other states, obtaining that information indirectly often becomes a defense motive for invoking pre-trial competency procedures, especially in jurisdictions which do not authorize appointed attorneys to employ experts at state expense. *See generally* Lewin, *Incompetency to Stand Trial: Legal and Ethical Aspects of an Abused Doctrine*, 1969 L. & SOC. ORDER 233.

89. The judges were provided with a list of items 4, 6, and 7 of section 13-1621 (F) and were asked whether each of them related to criminal competency. It has been documented that, even without the added confusion provided by the Arizona statutory scheme, lawyers, too, are often unclear about the criminal incompetency standard. Rosenberg, *Competency for Trial—Who Knows Best?*, 6 CRIM. L. BULL. 577, 585-87 (1970). And psychiatrists seem bewildered by it. *Id.* at 581-85. *See generally* Vann & Morganroth, *Psychiatrists and the Competence to Stand Trial*, 42 U. DET. L.J. 75, 84 (1965); note 32 *supra*.

90. An area where Arizona is seemingly applying an erroneous standard in theory as well as in practice relates to the rather narrow but important problem of competency to plead guilty. Simply stated in *In re* Williams, 165 F. Supp. 879, 881 (D.D.C. 1958) (history detailed, *infra* note 117):

> The issues involved in the plea of guilty and the consequences which attach to a plea require a greater degree of awareness than competency to stand trial. The Court may reasonably find, as it did in this case, that the latter competency may exist and still not feel justified in accepting a plea of guilty on the defendant's behalf.

Even apart from *Williams*, a rule that the standards for competency to plead guilty should be higher than the standards for competency to stand trial would seem compelled by a conjunctive reading of Westbrook v. Arizona, 384 U.S. 150 (1966), holding that a mere finding of competence to stand trial is not determinative of the difficult question of a defendant's competence to waive counsel, and of Boykin v. Alabama, 395 U.S. 238 (1969), which acknowledged that "[s]everal federal constitutional rights," including the privilege against self-incrimination, the right to trial by jury, and the right to confrontation, "are involved in a waiver that takes

cause he is believed to be potentially violent,[91] be retained at the Arizona State Hospital.[92]

COMMITMENT FOR EXAMINATION AND TREATMENT

A criminal defendant released on bond or on his own recognizance[93] retains his liberty unless and until he is convicted and sentenced. But under the pertinent statutory provisions, such is not the case with respect to an Arizona criminal defendant who opts to call into question his competency to stand trial. First of all, if the superior court grants a defense request for a competency examination and hearing, the applicable statute requires the court to "order the defendant committed to a mental health facility for a period of thirty days or less for the examinations."[94] Moreover, if after the examination and hearing the court finds the defendant incompetent to stand trial, "it shall commit the defendant to an institution authorized to receive him,"[95] and "bail shall be exonerated by the court if the defendant so requests."[96]

In other words, local law seems to require a forfeiture of freedom by any defendant seeking to establish his due process right[97] not to be tried while incompetent, and requires further that, if he be found incompetent,

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place when a plea of guilty is entered in a state criminal trial." 395 U.S. at 243. Yet, in the recent case of State v. Makal, 106 Ariz. 591, 480 P.2d 347 (1971), the Supreme Court of Arizona found that a competency to stand trial hearing sufficiently adjudicated the defendant's competency to plead guilty, at least where the court questioned the defendant to determine that his plea was entered into knowingly and voluntarily.

91. Such a situation seems ideally suited for the defendant's lawyer to have administered to his client the Harvard Competency Screening Test, *supra* note 85.

92. Interestingly, perhaps because of the crowded conditions of its Maximum Security Unit, the Arizona State Hospital often apparently uses different—and less stringent—competency standards than do the superior courts. This often results in an inefficient "ping pong" process, where a defendant will be committed to the hospital as incompetent, returned to court by the hospital as competent, recommitted by the court to the hospital, *ad infinitum*. One example found in an examined file is of a defendant found incompetent in May 1967, released by the hospital in January 1968, returned to the hospital by the court in March 1968, and released again by the hospital in July 1968. Even more poignant are the facts from State v. Blazak, 105 Ariz. 216, 462 P.2d 84 (1969). There the defendant was ordered committed to the hospital on June 14, 1967 and was released on July 19, 1967. "Subsequently, on August 22, 1967, and October 16, 1967, two more rule 250 hearings were held. At both of these hearings the court determined that Blazak was unable to stand trial and ordered him recommitted to the state hospital. Each time he was released shortly thereafter by the authorities of the hospital." *Id.* at 217, 462 P.2d at 85.

93. *See* Ares, Rankin & Sturz, *The Manhattan Bail Project: An Interim Report on the Use of Pre-Trial Parole*, 38 N.Y.U.L. REV. 67 (1963). *But see* ARIZ. R. CRIM. P. 48, 56, 57 (1956).

94. ARIZ. REV. STAT. ANN. § 13-1621(C) (Supp. 1970-71).

95. *Id.* § 13-1621(H)(2). In practice, the receiving institution is, of course, the Arizona State Hospital, although one judge responding to a project questionnaire noted that he once committed a criminally incompetent defendant to a private psychiatric hospital.

96. *Id.*

97. Pate v. Robinson, 383 U.S. 375, 378 (1966).

he forfeit his freedom until his competency is restored. But those provisions of local law are out of tune with the recommendations made by various organizations that have carefully studied similar legal situations in other jurisdictions.

With respect to commitment during the examination period, for instance, a committee of the Judicial Conference of the District of Columbia Circuit, recognizing the importance of the right to bail and the propriety in many cases of an outpatient psychiatric examination, recommended:

> The status of the accused who has been enlarged on bail should not be changed because of a pre-trial mental examination being ordered for him, and an accused who is otherwise eligible for bail should not be denied bail because a pre-trial mental examination is ordered for him; if, however, the examining psychiatrists report that the accused's confinement is necessary for an effective examination the court should be empowered to commit to a mental hospital.[98]

A similar—but somewhat more cautious—recommendation was made by a special committee of the Association of the Bar of the City of New York, which suggested that

> psychiatric examinations ordered by courts should expressly be allowed to be conducted on an out-patient basis without mandatory incarceration or hospitalization in any case in which there is no reason to suspect the defendant to be dangerously mentally ill or in need of immediate hospitalization, providing the director of the examining hospital or clinic or other appropriate official agrees and providing the defendant is otherwise entitled to release on bail.[99]

Arizona law should, at the least, be brought into compliance with that recommendation.[100]

Considerably more important to a defendant than the examination period, no doubt, is his fate subsequent to a judicial finding of incompetency. Though Arizona law calls for the automatic hospitalization of all

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98. JUDICIAL CONFERENCE OF THE DISTRICT OF COLUMBIA CIRCUIT, REPORT OF THE COMMITTEE ON PROBLEMS CONNECTED WITH MENTAL EXAMINATION OF THE ACCUSED IN CRIMINAL CASES BEFORE TRIAL 104 (1966).

99. CRIMINAL DEFENDANT, supra note 70, at 90-91.

100. It is possible, though not without considerable straining, to construe existing Arizona law to provide for outpatient competency examinations. For instance, ARIZ. REV. STAT. ANN. § 13-1621(C) (Supp. 1970-71), after providing that the defendant be committed for examination to a mental health facility for up to thirty days, proceeds to state that "the period of commitment or the place of examinations may be altered by the court upon a showing of good cause." Conceivably, that language could be read to permit the examination to occur at an outpatient clinic. But it may, on the other hand, just as easily be read as a provision enabling the court, for good cause, to detain a defendant for examinaiton in a non-medical facility—such as a jail. In any case, the statute is sufficiently ambiguous to deserve legislative clarification.

defendants found incompetent to stand trial,[101] sound reasons exist for rejecting such an inflexible approach. Community mental health[102] is, of course, a treatment alternative preferable to the often anti-therapeutic public hospital,[103] whether applied to purely "civil" patients or to many patients somehow involved in the criminal process. Moreover, since a finding of incompetency to stand trial does not in itself have any necessary bearing on whether an accused is dangerously mentally ill,[104] there appears to be no valid reason, at least in the absence of such a showing of dangerousness, for detaining a defendant otherwise eligible for bail. An obvious hypothetical illustration would be a defendant charged with car theft who, following an automobile accident shortly after the alleged theft, has developed a condition of amnesia sufficient to render him incompetent to stand trial.[105]

The impropriety of involuntarily hospitalizing all defendants found incompetent to stand trial has been well recognized by various authorities. Accordingly, the federal rule appears to be that federal criminal defendants determined to be incompetent to stand trial shall not be committed absent a showing of dangerousness equivalent to the test for ordinary civil commitment.[106] And, again somewhat more cautiously than the federal

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101. ARIZ. REV. STAT. ANN. § 13-1621(H)(2) (Supp. 1970-71). In practice, according to responses to a project questionnaire, Arizona judges always hospitalize a defendant found incompetent to stand trial.

102. See "Community Mental Health: Social Impact and Legal Implications," pp. 118-46 *supra*.

103. See "General Conclusion," pp. 237 *et seq. infra*.

104. *Cf.* State v. Sheriff of Pima County, 97 Ariz. 42, 396 P.2d 613 (1964), dealing with the other side of the coin, *i.e.*, that a person civilly committed because of his supposed dangerousness is not necessarily incompetent to stand trial.

105. The Arizona law of incompetency with respect to amnesia is well stated in State v. McClendon, 103 Ariz. 105, 437 P.2d 421 (1968), *noted*, 11 ARIZ. L. REV. 119 (1969). See also the earlier *McClendon* case at 101 Ariz. 285, 419 P.2d 69 (1966). In short, Arizona law is more likely to find a defendant with amnesia incompetent if his prospects are good for overcoming the condition in the short-run. But as the condition is diagnosed as approaching permanence, the chances of the court finding the accused incompetent diminish substantially. The Arizona approach to amnesia is virtually identical to the approach taken to the question of incompetency in general in Note, *Incompetency to Stand Trial*, 81 HARV. L. REV. 454, 459 (1967):

> If the disability is permanent, a finding of incompetency means that the defendant can never be brought to trial and often, under present law, that he will be confined for life. In such cases there may be good reason to proceed with the trial though the defendant's level of effectiveness is below the usual minimum. Likewise, if the disorder impairing the defendant's abilities appears easily curable within a brief time, a higher standard of effectiveness than the norm may be appropriate. (footnote omitted).

Another interesting approach to the amnesia issue is taken in Wilson v. United States, 391 F.2d 460 (D.C. Cir. 1968), where the central inquiry seems to be whether the defendant's loss of memory precludes a defense reconstruction of the facts surrounding the alleged offense, or whether those facts can somehow—perhaps aided by liberal discovery—be extrinsically reconstructed. *See also* Note, *Amnesia: A Case Study in the Limits of Particular Justice*, 71 YALE L.J. 109 (1961).

106. *See* United States v. Curry, 410 F.2d 1372 (4th Cir. 1969); United States v. Gorobetz, 156 F. Supp. 808 (D.N.J. 1957). *See also* J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, PSYCHOANALYSIS, PSYCHIATRY AND LAW 687 (1967).

authorities, the special bar association committee investigating New York procedures recommended that:

> courts should be granted discretion, where appropriate, to order suitable alternatives to hospitalization of defendants mentally unfit to be tried. The decision should be based upon a complete evaluation of the defendant's circumstances and the public interest, and should contain such terms and conditions as are necessary to protect against malingering.[107]

Arizona law clearly needs to be revised to make possible, in appropriate cases, community care for persons found incompetent to stand trial.

LENGTH OF CONFINEMENT

Current Arizona law provides not only that a defendant found incompetent to stand trial be confined, but provides further, as do many other jurisdictions,[108] that the confinement last indefinitely—until the defendant's competency has been restored.[109] In some jurisdictions, this type of theoretically "pre-trial" commitment is clearly recognized as constituting, in practice, a final disposition of the criminal case.[109a] A study conducted in 1965 at New York's Matteawan State Hospital, for example, uncovered the frightening fact that one fifth of Matteawan's 1,062 "pre-trial" commitments had been hospitalized in excess of twenty years, and that 645 of the total number of patients had been "awaiting trial" for longer than five years.[110] In Arizona, perhaps because of the overcrowded conditions at the public hospital and the corresponding pressure to return patients to court quickly,[111] the length-of-confinement figures for incompetent defendants at the Arizona State Hospital are fortunately not nearly as striking.[112] Nonetheless, even a cursory look at Table XIII, prepared by the project from data supplied by the Arizona

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107. CRIMINAL DEFENDANT, *supra* note 70, at 123. Checks against malingering are discussed *id.* at 122.

108. *See* F. LINDMAN & D. MCINTYRE, THE MENTALLY DISABLED AND THE LAW 362 (1961).

109. ARIZ. REV. STAT. ANN. § 13-1621(H)(3-5) (Supp. 1970-71).

109a. The United States Supreme Court has recently granted certiorari in an Indiana case involving pre-trial commitment of a criminal defendant who will probably never be found competent to stand trial. Jackson v. State, — Ind. —, 255 N.E.2d 515 (1970), *cert. granted*, No. 5703, 91 S. Ct. 1203 (1971). According to the dissent to the Indiana court's opinion, the commitment constitutes lifetime incarceration and is a denial of due process of law. *See also* Lang v. Briggs, — Ill. 2d —, — N.E.2d —, 8 CRIM. L. RPTR. 2033 (Sept. 22, 1970) (deaf-mute allowed trial on merits where evidence showed defendant likely never to be competent to stand trial; note 7 *supra*; text & note 129 *infra*.

110. CRIMINAL DEFENDANT, *supra* note 70, at 214-215.

111. See note 92 *supra*.

112. One negative feature of the proposed construction at the Arizona State Hospital of an additional maximum security facility may be the reduction of pressure to return patients to trial, and a corresponding closer approximation of the New York situation. For other possible detrimental features of building the new facility, see the section on prison-to-hospital transfer, pp. 183-88 *infra*.

State Hospital, will illustrate the uncomfortable fact that several Arizona defendants have spent considerable periods of time, often in the Maximum Security ward, purportedly awaiting trial on criminal charges.[113]

TABLE XIII: PATIENTS COMMITTED TO THE ARIZONA STATE HOSPITAL AS INCOMPETENT TO STAND TRIAL

Year Committed	Residing in Maximum Security Unit	Residing Among General Hospital Population
1971	15	2
1970	10	4
1969	5	5
1968	6	2
1967	3	2
1966	1	1
1965	—	1
1964	1	—
1955	—	1

If a defendant held for a considerable period of time is eventually returned to trial, he may be severely disadvantaged. First of all, unlike the statutes of some other jurisdictions,[114] Arizona law does not provide that time spent in a mental hospital while regaining competency must be credited against any subsequent sentence imposed, and in practice credit seems only sometimes to be granted.[115] Apart from the possible prejudice with respect to sentencing, the defendant may be handicapped by having to defend a stale case.[116] Unless the speedy trial provision of

113. In addition, four patients are hospitalized awaiting sentencing. *See* ARIZ. REV. STAT. ANN. § 13-1621(F) (Supp. 1970-71). One of them, committed in 1967, is housed in the Maximum Security Unit. The other three, residing among the general hospital population, were committed in 1966, 1967 and 1970.

114. *See* MICH. STAT. ANN. § 28.966(11)(9) (Supp. 1971).

115. None of the superior court judges responding to the project questionnaire reported granting credit in all cases, but all except one judge—who claims never to grant credit—reported that they at least sometimes credit a defendant with hospital time. One of those judges specified that he accords credit unless he believes the defendant's hospitalization was the result of malingering.

116. *See, e.g.*, Dickey v. Florida, 398 U.S. 30 (1970) (defendant's chief witness died during delay preceding trial). Even if the defendant should have a perfectly valid defense to the prosecution—such as a void information or the running of the statute of limitations—it is unclear under Arizona law whether such an objection could properly be made by defense counsel while the case is still fresh. Though most Arizona judges surveyed said they would entertain such a motion if it could be litigated without the defendant's personal participation, some judges felt such a motion by an incompetent defendant would be improper. A striking textbook-type example of the problem is presented in United States v. Barnes, 175 F. Supp. 60 (S.D. Cal. 1959), where three of four co-defendants were permitted to quash an indictment on speedy trial grounds, but the fourth defendant, who had been found

the Constitution protects a defendant against such a prosecution and against an incompetency commitment of inappropriate length, which at the moment is at best unclear,[117] local statutory devices are needed to provide such safeguards.

Since the entire rationale for an incompetency commitment is to restore the defendant to competency and return him to trial, it follows that the theoretical basis for that type of commitment evaporates when it becomes clinically apparent that restoration is highly unlikely. When that occurs, the criminal charges should be dismissed[118] and the defendant should be released from custody or, if appropriate, committed civilly. The recently prepared draft legislation of a Justice Department committee, proposing an overhaul of the federal law of incompetence to stand trial,[119] provides a thoughtful model.[120]

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incompetent to stand trial, was ruled incapable of making a similar motion until restored to competency. The *Model Penal Code* would specifically permit the making of such a motion. MODEL PENAL CODE, § 4.06(3) (Prop. Off. Draft 1962).

117. *Compare* Williams v. United States, 250 F.2d 19 (D.C. Cir. 1957) (sixth amendment speedy trial provision applicable under the circumstances) *with* United States v. Davis, 365 F.2d 251, 255 (6th Cir. 1966) (sixth amendment speedy trial provision inapplicable to delays occasioned by defendant's mental incompetency). Justice Brennan, concurring in *Dickey*, 398 U.S. at 39, demonstrates the uncertainty of the contours of the speedy trial provision in general, let alone as applied to the narrow area of incompetency to stand trial.

The Mr. Williams of the cited case has had a long and varied experience with the courts. A partial history: Mr. Williams was indicted for assault with a deadly weapon in 1949, tried and convicted, *rev'd*, Williams v. United States, 188 F.2d 41 (D.C. Cir. 1951), (new trial unreported), *rev'd*, No. 11,006 (D.C. Cir., May 3, 1952) (unreported), (new trial unreported), *rev'd*, No. 12,349 (D.C. Cir., Apr. 21, 1955) (unreported), (new trial unreported), *rev'd*, 250 F.2d 19 (D.C. Cir. 1957) (indictment dismissed). Mr. Williams had managed in the times between trials to get himself involved in a number of other actions which are not reported here, as a result of which he was committed, but released on a writ of habeas corpus. *In re* Williams, 157 F. Supp. 871 (D.D.C.), *aff'd sub nom.* Overholser v. Williams, 252 F.2d 629 (D.C. Cir. 1958). He was again committed and released. Williams v. Overholser, 162 F. Supp. 514 (D.D.C.), *mod. & aff'd*, 259 F.2d 175 (D.C. Cir. 1958). After trial on a new offense, he was again committed, brought habeas corpus, *In re* Williams, 165 F. Supp. 879 (D.D.C. 1958) (jurisdiction refused), and appealed the order of commitment, which was reversed. Williams v. District of Columbia, 147 A.2d 773 (D.C. Mun. App. 1959).

In 1961, Williams committed a new crime and was convicted. Trial judgment unreported, *aff'd*, Williams v. United States, 312 F.2d 862 (D.C. Cir. 1962), *cert. denied*, 374 U.S. 862 (1963). *See generally* 250 F.2d at 21 n.3; 312 F.2d at 863 & n.5, 865 & nn.9-11. *Cf.* note 90, p. 164 *supra.*

118. MODEL PENAL CODE § 4.06(2) (Prop. Off. Draft 1962), provides that if "the court is of the view that so much time has elapsed since the commitment of the defendant that it would be unjust to resume the criminal proceeding, the Court may dismiss the charge and may order the defendant to be committed . . . or discharged." Another possibility is to try the defendant, even though incompetent, rather than to detain him any longer at the hospital—at least if the defendant or his counsel requests such a disposition. *Cf. Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. 283 & n.58 (1970) [hereinafter cited as *1970 Hearings*] (statement of Bruce J. Ennis Esq., relating in part to the constitutional and common law propriety, in certain instances, of trying incompetent defendants).

119. 18 U.S.C. §§ 4241 *et seq.*

120. Intra-Department Committee to Revise Chapter 313, Title 18, *United*

The proposal permits a federal court to commit an incompetent defendant to the custody of the Secretary of Health, Education and Welfare, but specifies that, within one year of the initial commitment, the court must hold a second hearing to determine not only the accused's present competency, but also the likelihood of his regaining competency within a reasonable time. If the court at the second hearing concludes that the accused remains incompetent and is not likely to regain competency within a reasonable time, it is required to dismiss the criminal charges, and, unless the Secretary files a petition within 60 days to civilly commit the defendant under a proposed federal civil commitment law,[121] the defendant must be discharged from custody at the end of the 60-day period. Though the "reasonable time" concept should probably be quantified[122] to insure against abuse, the overall proposed scheme seems worthy of serious consideration within Arizona.

CONCLUDING REMARKS

As suggested above, it is theoretically more sound to civilly commit an incompetent defendant, assuming he meets civil commitment standards, than to hold him indefinitely awaiting a trial that seems unlikely ever to materialize. A recent empirical study[123] strongly suggests, moreover, that civil commitment is, psychologically speaking, generally preferable to criminal incompetency commitment, and should be used more than it now is as the first and only dispositional device for many mentally ill offenders.

The study consisted of the authors following up a group of persons who had been accused of crime, sent to the Boston State Hospital for pretrial observation and recommendation, and for whom the hospital recommended further hospitalization. Though the hospital had not recommended whether the further hospitalization should take the form of a civil

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States Code, Department of Justice, Report (undated, unpublished) [hereinafter cited as Intra-Department Report] [copy on file with the *Arizona Law Review*].

121. Basically, the proposal is designed to permit federal civil commitment of the patient while the Secretary seeks, if possible, a suitable state or local placement.

122. Michigan law with respect to a defendant committed as criminally incompetent provides that if "the department of mental health believes that the defendant cannot recover competence to stand trial within 18 months from the entry of the order of commitment, or if by the expiration of 18 months from the entry of the order of commitment the defendant has not regained competence to stand trial," a procedure comparable to civil commitment (but rather convoluted in practice) should be initiated. MICH. STAT. ANN. § 28.966(11)(7) (Supp. 1971). But the Michigan law does not call for the dismissal of criminal charges at that time. Yet, presumably to curtail the possibility of a prosecution after an extremely long period of hospital confinement, Michigan does provide that the statute of limitations on the criminal charge commence to run at the time the accused is adjudicated incompetent to stand trial. *Id.* § 28.966(11)(9).

123. McGarry & Bendt, *Criminal vs. Civil Commitment of Psychotic Offenders: A Seven-Year Follow-Up*, 125 AM. J. PSYCHIATRY 1387 (1969).

or a criminal commitment, the courts, unaware that they were aiding the design of a natural experiment, neatly divided the group into halves and committed an equal number civilly and criminally. The authors concede, of course, that judicial discretion rather than randomization played an important role in determining the civil or criminal nature of the various commitments, and that the study accordingly cannot be viewed as the equivalent of a controlled experiment. Nevertheless, after comparing the two groups on such variables as type of offense and finding no crucial distinctions, the authors felt satisfied that the study provided an "acceptable ex post facto research design."[124] Thus, the two groups could be properly compared with respect to matters of subsequent history, and any differences in subsequent history could probably be attributed to the difference in the nature of the two types of commitments.

The results of the study are rather striking. During the study period, virtually all of the criminally committed male patients remained hospitalized, with an average length of hospitalization totaling 61 months, while all civilly committed male patients were discharged after averaging only 5.8 months in the hospital.[125] And while the small number of criminally committed patients released to the community did have repeated subsequent arrests, the civilly committed patients, when released, did not constitute a serious danger to the community.

The moral seems clear: if an offender is mentally ill and meets both the standards of incompetency and civil committability, he and society may both be better served by his entering the mental health system through the civil commitment route.[126] Indeed, if the "civil-criminal" distinction has merit beyond the area of criminal incompetency, it would seem that an offender would be better advised to attempt to enter the state hospital by civil commitment rather than by successfully invoking the defense of insanity. And surely, considering the unavailability of psychiatric help at the prison, the difficulty of getting transferred from the

124. *Id.* at 1388.

125. The authors do not attempt to explain the sharp contrast, but persons looking for plausible explanations might well concentrate on difference in staff perceptions and stigmatization of the two types and on the anti-therapeutic effect of the security conditions under which the criminally committed patients probably had to live.

126. From the project's study, it appears that this procedure is often followed in the outlying counties. Moreover, the county attorney may be encouraged to follow the civil commitment route because of a practical reason rather unrelated to psychiatric theory: the cost of hospitalizing an incompetent criminal defendant falls by statute on the county in question, ARIZ. REV. STAT. ANN. § 13-1622 (1956), while the comparable cost of maintaining a civilly committed patient is of course shouldered by the state. During their interview with a judge in one outlying county, project members were told of how, in the case of a defendant who had been committed as incompetent to stand trial and who had already been in the state hospital for a few months at county expense, the County Board of Supervisors visited the judge and urged him to dismiss the criminal charges and to commit the patient civilly. The request was complied with.

prison to the hospital, and the inadequate treatment given transferred prisoners at the hospital—all discussed in the section immediately following—a mentally ill offender would probably find civil commitment to be far preferable to a pure criminal conviction.

PRISON-TO-HOSPITAL TRANSFERS

When the topic of prison-to-hospital transfers is mentioned, mental health lawyers almost instinctively focus their attention on the Supreme Court case of *Baxstrom v. Herold*[127] and on the Second Circuit case of *United States* ex rel. *Schuster v. Herold.*[128] Those cases, bottomed on equal protection theory, hold that a prisoner cannot constitutionally be involuntarily committed to a mental hospital during or at the expiration of his criminal sentence unless he is afforded the same protections available to patients undergoing ordinary civil commitment. In *Baxstrom*, for example, the prisoner-patient nearing expiration of his penal sentence was accorded a judicial hearing before being ordered detained indefinitely in a Department of Corrections mental hospital, but the Court found Baxstrom's commitment constitutionally objectionable because, for no satisfactory reason, New York law did not provide Baxstrom with the same safeguards afforded in normal commitment cases:

> We hold that petitioner was denied equal protection of the laws by the statutory procedure under which a person may be civilly committed at the expiration of his penal sentence without the jury review available to all other persons civilly committed in New York. Petitioner was further denied equal protection of the laws by his civil commitment to an institution maintained by the Department of Correction beyond the expiration of his prison term without a judicial determination that he is dangerously mentally ill such as that afforded to all so committed except those, like Baxstrom, nearing the expiration of a penal sentence.[129]

In Arizona, the *Baxtrom-Schuster* problem seems, for two reasons, to be virtually non-existent.[130] First of all, the applicable statute, while not wholly free from doubt, seems to accord prisoners the same protections as are available in ordinary civil commitment proceedings. Secondly, as will be discussed more fully later, very few if any prisoners are transferred against their will to the Arizona State Hospital.

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127. 383 U.S. 107 (1966).
128. 410 F.2d 1071 (2d Cir.), *cert. denied*, 396 U.S. 847 (1969).
129. 383 U.S. at 110. *See* the discussion of continued incarceration of mentally ill prisoners, pp. 147-70 & notes 7, 109a *supra.*
130. *But see* note 164, p. 182 *infra,* for a possible *Baxstrom* problem in Arizona regarding practices within the prison itself.

The pertinent provisions of the Arizona transfer law are as follows:

> A. When a prisoner confined in the state prison discloses symptoms of mental illness, the prison physician shall examine him, and if he is determined to be so afflicted, the physician shall report the fact in writing to the superintendent of the prison, describing the condition found, together with any recommendations he has. Upon receipt of the report, the *superintendent shall file a petition as provided in § 36-509 and thereafter the proceeding shall conform to article 1 of chapter 5, title 36* [the civil commitment chapter].
>
> . . . .
>
> C. *If the prisoner is determined to be mentally ill, the court shall order and direct that he be confined in the Arizona state hospital* in the legal custody of the superintendent of the prison. The transfer of the prisoner to the state hospital shall be made by the superintendent of the prison.[131] (emphasis added).

If the transfer statute is interpreted, as subsection C might suggest, to permit involuntary transfer of a prisoner upon a simple showing of "mental illness" alone, the provision would undoubtedly run afoul of *Baxstrom*, for pure civil commitments cannot be ordered in Arizona short of a finding that the patient is mentally ill *and* dangerous to himself, others, or property.[132] But the statute surely does not command that unconstitutional construction. Instead, its incorporation by reference (in subsection A) of the regular civil commitment chapter[133] should lead to the inference that civil standards of committability must be met before a prison-to-hospital transfer will be judicially authorized. An interview with the judge who conducts all Pinal County commitment proceedings[134] confirmed that, in practice, identical committability standards are employed in civil commitments and in prison-to-hospital transfers. For that reason alone, *Baxstrom* has not proven problematic in Arizona in the context of prison-to-hospital transfers.

Further, because of the severely overcrowded conditions in the Maximum Security Unit of the Arizona State Hospital,[135] prisoners have rarely if ever been transferred against their will from the prison to the hospital. Indeed, the principal problem in Arizona has been quite different—since psychotherapy at the prison is totally unavailable[136] because of the ab-

131. ARIZ. REV. STAT. ANN. § 31-224 (Supp. 1970-71).
132. *Id.* § 36-514(C).
133. *Id.* §§ 36-501 *et seq.*
134. The state prison is located in Pinal County.
135. *See* note 138 *infra.*
136. The absence of treatment at the prison was brought home by a touching letter written by an inmate sex offender to the Post-Conviction Legal Assistance Clinic at the University of Arizona. The Clinic was assisting this inmate in the preparation of a habeas corpus petition unrelated to the issue of treatment when it received the following letter:

> You mentioned in your letter that you were about to complete the Writ of Habeas Corpus that you and the other students have been working on for me. I have been looking for you almost every day in regard to this, and I hope that you will soon be bringing it down.

sence of staff psychiatrists and psychologists,[137] mentally ill prisoners desiring treatment have had to fight vigorously to get *into* the hospital.[138] Against this backdrop, we may begin to examine in greater detail the process of prison-to-hospital transfers in Arizona.

The Process of Prison-to-Hospital Transfer in Arizona

Although they are now on the increase, there have to date been very few prison-to-hospital transfers in Arizona.[139] For a variety of reasons, the Arizona State Prison and the Arizona State Hospital apparently have not developed a truly cooperative relationship, and, as a result, there is very little psychiatric care given to mentally ill prisoners, who both institutions admit are in desperate need of care.[140] But understanding on the

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> There is something that I would like to bring up, and it is this: I have been locked up now almost continually since 1957 for offenses of this nature and I would like to do something while I am incarcerated this time to help cure me of this sickness. It would be a terrible wrong to get me out of here on any kind of legal loophole if I were to just go and repeat my crimes. That would not be fair to society or to me. While I have been here I have done everything possible I know of to get mental help, but to no avail.
> I have had some talks with ———— [a nondegree prison psychologist] and he told me he thought I was in fine shape but I would like to be surer than that. It is one thing to have a few pleasant talks with an extremely overworked prison official and it is quite a different matter to go up to the State Hospital and get some kind of treatment. If it takes a couple of years so what? It would be far better to be sure than sorry. I have never, since I first got into this kind of trouble had any kind of treatment for it. All I have had were a few psychological tests to see if I was sane enough to stand trial or not. Do you think that the school could help me in this problem? I want help for this problem and I am willing to go to any length to get it.

137. *See* Maxwell v. McBryde, 12 Ariz. App. 269, 469 P.2d 835 (1970). Nor does the state hospital send any professional to the prison to conduct therapy.

138. *Id.* The current Maximum Security Unit was built for 50 patients but now houses about 80. Arizona State Hospital, 1969-70 Annual Report 9 (Aug. 14, 1970). Even in the light of a legislative appropriation for a new maximum security facility, it is unlikely that the number of involuntary transfers will increase markedly, nor is it likely that many mentally ill offenders desiring treatment will be able to obtain it:

> Original plans presented to the legislature were for the care of 200 patients, with an expectation that this number would need to be increased to 300. It was expected that a significant number would be mentally ill persons referred from the Department of Correction which does not have a facility to treat them. The actual appropriation of $2,750,000 enabled planning for a 110-bed structure, and it appears that only about twenty-five cases under the jurisdiction of the Department of Corrections most direly needing help can be accommodated in a facility of the size. 1969-70 Annual Report at 6.

139. Prison officials stated that there was generally no use in trying to transfer prisoners to Arizona State Hospital as the hospital, because of its crowded conditions, would usually oppose commitment, and even if the inmate were to be committed, he would in all likelihood be returned rather rapidly to the prison. In that regard, the project came across a Pinal County commitment file where the court committed an inmate only to have the hospital discharge him for return to the prison 15 days later.

140. Every person interviewed agreed that there were many prison inmates who were desperately in need of psychological care.

part of the two institutions seems now to be increasing, attributable largely to the recent "ice-breaking" litigation of *Maxwell v. McBryde*.[141]

The history of prison-to-hospital transfers in Arizona can conveniently be divided into the pre- and post-*Maxwell* eras. The pre-*Maxwell* era was characterized largely by inaction on the part of both hospital and prison officials. The inaction was made possible by a statutory provision which makes the initial step in the process of inmate transfer exactly opposite from the initial step for ordinary involuntary civil commitments.[142] With a civil commitment, the filing of a petition for commitment precedes the psychiatric examination,[143] but with a prison-to-hospital transfer, the inmate is first examined by the prison doctor, and only thereafter may a petition for commitment be filed.[144] If the prison doctor does not feel that the inmate is mentally ill, or if for policy reasons he does not want to press for commitment, the petition is simply never filed.[145]

A look at the history of the Jesse Maxwell case[146] brings into focus the system which had developed over the years during the pre-*Maxwell* era. During an appeal, Maxwell's appointed attorney began to realize that his client might be mentally ill. Maxwell wanted to receive psychiatric care, so on advice of counsel he got a tank order, which is a method by which an inmate requests something of the prison officials. In his tank order, Maxwell asked that he be given a psychiatric examination. This request was ignored.

When Maxwell's request for an examination was not granted, his attorney filed a petition for commitment with the Pinal County probate court. Enclosed with the petition was a letter which stated in part that both Maxwell and his attorney had requested the prison officials to give Maxwell a psychiatric examination and that their requests had been ignored.[147] The court held a hearing on the petition, during which the basic policy reasons for not transferring inmates to Arizona State Hospital were openly discussed.[148]

The prison had two reasons for not initiating the petition as required by statute. First, one of the prison physicians felt that he could

141. 12 Ariz. App. 269, 469 P.2d 835 (1970).
142. Mathis Becker, Esq., attorney for inmate Jesse Maxwell (who was successfully transferred to Arizona State Hospital) stated that, in his view, the different initial step was the crucial factor in preventing prisoners from being transferred to the Arizona State Hospital.
143. ARIZ. REV. STAT. ANN. § 36-510 (Supp. 1970-71).
144. *Id.* § 31-224.
145. This practice was widespread during the pre-*Maxwell* era.
146. The history of the Jesse Maxwell case comes from conversations with Maxwell and his attorney, Mathis Becker, Esq.
147. The letter was not on file at the Pinal County courthouse, but a copy of it is in the possession of Maxwell's attorney.
148. The prison physician at the time of Jesse Maxwell's transfer reiterated these policy reasons during an interview.

provide better treatment for the prisoner than could the hospital because the prisoner was more at home in the prison where he knew the informal code. Secondly, the prison physician said there is a very low "cure" rate for insane prisoners in the hospital, particularly because "recovery" at the hospital will result not in release, but simply in return to the prison.

The view of the prison physicians was buttressed by the Arizona State Hospital. A representative of the Arizona State Hospital stated that there are too many people in the prison who need care and that it would be physically impossible for the hospital to take care of criminals.[149] A separate facility for the criminally insane was needed. The lower court found that:

> 1. All the testimony indicates that Jesse Ray Maxwell is suffering from a mental illness.
>
> 2. That due to the mental illness, Jesse Ray Maxwell is in danger of injuring himself or the person or properties of others.
>
> 3. That although there are no psychologists or psychiatrists on the prison staff, the prison physicians feel that they can adequately treat Jesse Ray Maxwell at the Arizona State Prison.
>
> 4. That both of the prison physicians feel that they can perhaps give Jesse Ray Maxwell better treatment at the State Prison then [sic] he can receive at the Arizona State Hospital.
>
> 5. That the prison physicians state that the Arizona State Hospital has requested that criminally insane inmates not be sent to the State Hospital.[150]

On the basis of those findings, the lower court dismissed the petition.

Maxwell's attorney challenged this inert system by petitioning for a special action to order Maxwell's transfer to the hospital. The court of appeals ordered the respondent superior court to comply with the statute, pointedly stating, "[i]t is not for the prison physician, the prison superintendent or even the court to determine where the prisoner is to be treated, nor are the wishes of the hospital staff of the state hospital of weight against the clear statutory mandate."[151] If that language stood alone, it could have done much to shatter the system of inaction. The court, however, went on to state that *Arizona Revised Statutes Annotated* section 31-224—requiring a preliminary examination by a prison physician and permitting only the prison superintendent to file the petition—is the only statute under which the commitment of a mentally ill prisoner may be instituted, and that:

> It cannot be permitted that the attorney or friends of an inmate may, by filing of an ordinary mental health petition, re-

149. A representative of the state hospital stated during an interview that the hospital did not want prisoners because there was no room for them in the Maximum Security Ward, and that a separate facility for the criminally insane was needed.

150. Maxwell v. McBryde, 12 Ariz. App. 269, 270, 469 P.2d 835, 836 (1970).

151. *Id.* at 837.

> move a prisoner from the custody of the prison superintendent and have him treated as an ordinary patient.[152]

According to the court, the remedy for an inmate who believes that he is entitled to treatment for mental illness, and for whom the prison superintendent will not initiate a petition, is to institute a special action against the prison officials to compel them to institute a transfer proceeding under section 31-224.[153] Since this remedy usually requires that the prisoner have an active lawyer or a concerned family, the prisoner who is forgotten will generally not be able to get psychiatric care unless the prison agrees to file the petition. By thus limiting the "class" of possible petitioners under section 31-224 to the prison superintendent, the *Maxwell* court left the door open to perpetuating a system of nearly total inaction.

Nevertheless, in the post-*Maxwell* era, prison-to-hospital commitment procedures have changed considerably. There seem to be three basic reasons for the changes. First, *Maxwell* "broke the ice."[154] There simply had never before been a prison-to-hospital transfer like this one—where a prisoner was sent to the mental hospital despite firm hospital resistance and opposition. Secondly, in light of *Maxwell*, prison officials felt the hospital would at least have to accept some mentally ill prisoners, and the officials became bolder in seeking transfers. Finally, a change in medical and social personnel at the prison has resulted in a growing realization that a mentally ill prisoner can receive treatment at the hospital superior to that in a prison cell. Accordingly, in the last few months there have been three prison-to-hospital transfers and two more are currently being planned.[155]

Interestingly (though not surprisingly), the transfers are not complying strictly with the chronological sequence set out in the transfer statute.[156] Under the statutory scheme, it will be recalled, a mentally ill prisoner is first examined by the prison doctor, and, if the doctor feels commitment is in order, he sends a report to the superintendent of the prison. Once the superintendent receives the report, he must file the petition. There is no room for compromise with the hospital. And under *Maxwell*, the mentally ill prisoner must be transferred if he is found dangerous to himself, to others, or to property.[157]

The statutory transfer method is not in current use, primarily because the prison officials feel it is futile to transfer prisoners to Arizona State Hospital when the hospital will send them "right back."[158] The

152. *Id.*
153. *Id.*
154. This expression was used repeatedly by prison officials.
155. These figures come from interviews with prison personnel.
156. ARIZ. REV. STAT. ANN. § 31-224 (Supp. 1970-71).
157. These are the civil standards as well. *Id.* § 36-514. *See* pp. 16-25, 96-117 *supra.*
158. One prison official stated that Arizona State Hospital gave the prison no

statute was originally written so that prisoners could receive psychiatric care if the prison officials felt it warranted. The hospital was to be passive in the selection process, as the statute implies and as the *Maxwell* case reaffirms. But the hospital's overcrowded condition has altered its theoretically passive role. Presumably to permit some transfers of prisoners and yet to avoid as much as possible friction and hostility between the prison and the hospital, the post-*Maxwell* era is marked by an informal arrangement for determining transfers, and this informal procedure is, according to interview data, the only one presently utilized in transfer cases.

The informal method gives the hospital a large degree of control over the transfer process, for the hospital in effect controls which prisoners will be selected for transfer. The transfer process begins when a prison official calls the state hospital and discusses the inmate's problem with a psychiatrist, who sets up an appointment if he feels it is necessary. Once the appointment is made, the prison obtains a travel order so that the prisoner may receive his psychiatric evaluation. The prisoner is then sent to the Arizona State Hospital for his mental examination, and is returned the same day with the psychiatrist's evaluation and recommendations. If the psychiatrist feels that treatment for mental illness is needed, a petition for commitment is then filed by the prison, finally bringing into play the statutory transfer method.

This informal system of commitment has several major effects on the process of prison-to-hospital transfers in Arizona. First, Arizona State Hospital is given an inordinate amount of control over the process of transferring inmates to the hospital. The hospital can select which prisoners shall be examined, and can select which prisoners it desires to keep at the hospital. In effect, this method of transfer allows the hospital to veto the commitment of any prisoner it finds undesirable. Another important function served by the informal transfer system is the avoidance of "embarrassments" such as the *Maxwell* case. Embarrassment is avoided, of course, by the prison filing commitment petitions only in cases where the hospital has already agreed to take the prisoner. This avoids legal battles between the prison and hospital and allows for a decrease in tension between the two institutions.

THE SELECTION OF PRISONERS FOR COMMITMENT

The method of selecting which prisoner will be suggested to the Arizona State Hospital as a candidate for commitment is an attempt by the prison to accommodate itself to the standards of the overcrowded hospital and at the same time to obtain psychological care for some mentally

warning of the discharge of prisoner-patients. The hospital would simply notify the prison to "come and get him."

ill prisoners.[159] As will be seen, however, the selection system has developed in such a way that the few mentally ill prisoners who are transferred are probably by no means the ones most direly in need of treatment.

The prison's selection system seems to have three basic components. First, for any prisoner to be considered as a candidate for transfer to the mental institution, he must be thought of as being mentally ill. In a prison, as in a small town, certain persons develop a reputation for being mentally ill. Once an inmate develops such a reputation, he is ordinarily examined by the prison doctor.[160] Secondly, there must be a need to transfer the prisoner away from his fellow inmates. For example, a mentally ill inmate who is likely to be beaten by his fellow inmates[161] is a far better candidate for psychiatric care, from the prison's point of view, than is a mentally ill inmate who gets along with the other prisoners. This step in the selection system is an accommodation to the need of the prison to avoid disturbances. The final factor in the prison's selection system is that the prisoner must not be violent. The prison believes this requirement to be imposed by the state hospital, presumably because of the hospital's inadequate facilities. The ideal candidate for transfer to the hospital, then, when considered from the points of view of both the prison and the hospital, is a non-violent, mentally ill inmate who is about to be murdered by his cellmate.[162] In the view of the prison officials, however, a demonstration of violence by an inmate ends any chance of his receiving psychiatric care.[163]

The consequences of not being selected for transfer depend on the ability of the mentally ill prisoner to get along with his fellow convicts. If the mentally ill inmate indulges in exotic behavior, he will probably be

159. The workings of this selection system were deduced from interviews at Arizona State Prison.

160. It is possible for a prisoner without a reputation for mental illness to be examined, but it appears that in such a case the prisoner must seek the doctor out.

161. Some mentally ill prisoners are ridiculed severely by other inmates.

162. One prison official mentioned, as a prime candidate for transfer to the Arizona State Hospital, a mentally ill prisoner who banged his pan against the prison bars at night, thereby keeping many of his fellow inmates awake.

163. One prison official stated that, in his opinion, there was no chance of the hospital accepting a violent prisoner. A close analogy to that situation can be provided by the striking Arizona case of State v. McFord, 13 Ariz. App. 273, 475 P.2d 758 (1970), which involved a *"hospital-to-prison"* transfer. While on probation for an assault charge, McFord was committed to the Arizona State Hospital. In the commitment order, the court continued McFord's probation, but added an additional condition that McFord comply with all rules and regulations of the state hospital. As a patient at the state hospital, however, McFord managed to escape and to arm himself with a gun. He also attempted suicide on several occasions (once by breaking a light in the hospital and trying to cut himself), both as a patient and as an escapee. When McFord was again taken into custody, a probation revocation hearing was held. At that hearing, two hospital doctors testified (in a manner that would probably seem unusual in an ordinary civil commitment proceeding involving a suicidal patient) that McFord probably suffered only from a personality disorder and surely did not have a mental illness requiring hospitalization. In revoking probation and sentencing McFord to the state prison, the

mocked and teased by his fellow inmates, who may even encourage him to do acts harmful to himself. If the mentally ill prisoner is violent, his fellow inmates will fight with him. Prison officials are forced to provide makeshift care for such mentally ill inmates. Because the hospital has not assisted the prison doctor with suggestions relating to the treatment of individual patients, the prison has on its own developed methods of treating non-transferred mentally ill prisoners. From interviews with various inmates and prison officials, it was learned that there are apparently two such methods.[164]

First, the inmate can be put in an isolation cell. Seemingly, isolation is resorted to only if the inmate is very violent or hard to get along with. Because isolation is normally a means of punishment, administered only for major infractions of the rules, this form of "treatment" is used sparingly. One inmate who was in isolation because his fellow inmates encouraged his aberrant behavior and because the prison felt isolation was the only way of protecting him from the other prisoners, described the experience as one where "they check on me with flashlights every hour to see if I'm dead."

The second—and by far the most pervasive—method by which the prison cares for mentally ill inmates is to put the disturbed prisoner in the segregation block. This area is normally reserved for inmates who fear for their lives, but it doubles as a place whereby mentally ill prisoners can be protected from their fellow inmates.

If necessary to calm him, the inmate in isolation or segregation is given medication, but there are no visiting psychiatrists and no other therapy to speak of. Yet, whether or not he is in isolation or segregation, the mentally ill prisoner himself may not wish to be transferred from his penal setting to the state hospital, and such an attitude may well have a rational foundation. The prisoner himself, therefore, has a "selection" system which must be examined to round out the picture of prison-to-hospital transfers in Arizona.

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lower court, in an action affirmed on appeal, found

> that you have breached and broken the conditions of probation. It is a further finding and order of the Court that the probation be revoked . . . you just haven't abided by the provisions of the probation. *You have apparently antagonized everybody at the State Hospital.* You have escaped and armed yourself. *You have attempted to commit suicide.* You have done nothing to cooperate and assist in their supposed treatment of you. *And it's their testimony that you shouldn't be allowed to be free on the streets.* And I don't plan to let you out on the streets then. *Id.* at 275-76, 475 P.2d at 760-61 (emphasis added).

164. Insofar as these methods involve, as they do, separation from the general prison population, additional restrictions on liberty, and stigmatization, they may well be likened to informal, non-judicial "commitment proceedings" which, if involuntarily thrust upon an unwilling inmate, might easily raise due process questions or questions of equal protection under Baxstrom v. Herold, 383 U.S. 107 (1966). See pp. 174-75 & notes 127-136 *supra.*

THE PRISONER'S PERSPECTIVE[165]

There are two major considerations which a prisoner or his lawyer must ponder before deciding whether to seek a transfer to the Arizona State Hospital. First, the prisoner must consider the effect the transfer will have on the length of his incarceration—a multi-faceted problem. Secondly, the prisoner must consider the type of treatment he will receive at the Arizona State Hospital, an inquiry relating not only to the type of psychiatric treatment he can expect, but also to how he will be treated day to day, such as with respect to security restrictions on his liberty.

Length of Incarceration

Unfortunately, since no treatment is provided at the prison, and since Arizona law permits transfers from the prison to the state hospital only pursuant to the regular judicial commitment route, a mentally ill inmate desiring treatment and contemplating the possibility of transfer ought to weigh in his decision the fact that a commitment to the hospital could conceivably result in his confinement beyond the expiration of his penal sentence. That is because a commitment to the state hospital, unlike a prison sentence, is not for a term certain, but is instead for a period ending only when the hospital (or a reviewing court) finds the patient no longer "mentally ill to such a degree that he is in danger of injuring himself of the person or property of others"[166] if given his freedom.

Requiring a mentally ill inmate in effect to renounce a definite release date in order to qualify for needed therapy seems too high a price to ask of any inmate, and is probably a price that would not too readily be paid by an inmate with only a short term remaining to serve. To ameliorate that unfair situation—and that built-in disincentive to seek therapy —the state, through the Department of Corrections or through the state hospital, should strive to make meaningful treatment available at the prison itself, thus reducing the need for resorting to hospital commitment of prisoners. Even for those prisoners needing the hospital facilities, means ought to be devised—administratively or legislatively—for placing prisoners in the state hospital in the custody of the superintendent of the prison without the necessity of a judicial commitment and its accompanying possibility of indefinite confinement.[167]

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165. This information regarding the prisoners' selection system was gathered from interviews with prisoners, prison officials and judges.

166. ARIZ. REV. STAT. ANN. § 36-514(C) (Supp. 1970-71), incorporated by *id.* § 36-524(D). Note that *id.* § 31-224(D) states that upon expiration of a transferred inmate's prison term, the prison superintendent shall send the inmate a legal discharge from prison; presumably, however, his hospital term would continue until the patient meets the requirements for hospital discharge.

167. Under the Western Interstate Corrections Compact, which Arizona recently joined, ARIZ. REV. STAT. ANN. § 31-471 (Supp. 1970-71), an Arizona inmate can under certain circumstances be placed in a penal institution of any member state. Among other things, the Compact can be used to make available to an Arizona

It may be, of course, that some prisoners are not totally deterred by the spectre of infinite hospitalization. Many of them might well recognize that—statistically at least—most commitments do not in fact last terribly long.[168] Even so, those inmates may decide against seeking hospitalization because of the seemingly uncertain effect that the period of hospitalization will have on their penal sentences. In short, there is a legal question regarding various time credits while in the hospital. Prison inmates in Arizona do not ordinarily serve their sentences "flat"—that is, receive only one day's credit for each day served. Rather, almost all prisoners are eligible to take advantage of the rather liberal "good time" provisions in Arizona law. Those provisions, which can operate to reduce substantially the length of a penal term, are of two types: ordinary good behavior credits—known colloquially as "copper time," which allows the prisoner extra credit of 2 to 5 months per year for time served,[169] and "double time," which allows a prisoner two days credit for each day served while performing certain jobs.[170] Most prisoners earn both "copper time" and "double time" simultaneously.

As noted earlier, however, it is not perfectly clear to the prison timekeepers whether the good-time provisions apply to an inmate transferred to the state hospital. In practice, it seems that transferred prisoners receive simply one for one "flat" time, although the prison seems to feel that it has the discretion to credit a prisoner who returns from the hospital with "back good time." But, during interviews, no one at the prison could point out a specific instance where a committed prisoner received his "back time."[171]

Yet, there seem to be persuasive legal and policy considerations to compel the operation of those time credits as a matter of right for transferred inmates. With respect to "copper time" credits, there is a case virtually in point. In *Walsh v. State* ex rel. *Eyman*,[172] the Supreme Court of Arizona held an Arizona inmate entitled to "copper time," as well as

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inmate needed training or treatment (including mental treatment) which may be non-existent in Arizona. The prison has tried to transfer some inmates out of state to receive psychiatric treatment but, for various reasons, has seemingly been generally unsuccessful. It is anomalous, however, that it is theoretically possible for an inmate to be sent out of state and to receive psychotherapy without being committed for an indefinite term, but that it is not possible under current law and practice for that same inmate to be sent 65 miles to the Arizona State Hospital under a similar arrangement. *Cf.* MASS. GEN. LAWS ANN. ch. 123, § 18(b) (Supp. 1970) (voluntary admission procedures available).

168. Prisoners serving long sentences—such as life—may of course not care if they are hospitalized for a lengthy period, but our principal concern in this section is with prisoners serving ordinary terms.

169. ARIZ. REV. STAT. ANN. § 31-251(B) (Supp. 1970-71).

170. *Id.* § 31-252(A) (1956). For a general discussion of time credits in Arizona, see 12 ARIZ. L. REV. 171 (1970).

171. The process of keeping a record of a prisoner's various time credits is a complicated operation even in the absence of a hospital transfer. With respect to transferred inmates, it is even difficult to keep physical tabs on the prison records.

172. 104 Ariz. 202, 450 P.2d 392 (1969).

to day-to-day time, for the period he spent away from the Arizona State Prison while being tried for an offense in California for which he had demanded a speedy trial. *Walsh* provides ample authority for requiring "copper time" credits to be accorded an inmate transferrred to the hospital.

The question of a transferred prisoner's right to "double time" is a slightly more difficult one, but even here the granting of the time credit seems in order. Since a prisoner is statutorily entitled to receive "double time" only when he performs certain services,[173] the *Walsh* court, while granting the extradited inmate "copper time" for the period spent in California, denied "double time" credits because he had not performed the requisite services.

It is noteworthy, however, that if services are in fact performed, they need not necessarily be performed within the prison walls in order for "double time" credits to properly accrue. The pertinent statute provides, in part, that "[a] prisoner in the state prison . . . performing any . . . assignment of confidence and trust *either within or without the prison walls*, shall be allowed double time while so employed.[174] Reading that statute in conjunction with the *Walsh* decision, the Department of Corrections has allowed both "copper time" and "double time" credits to qualified inmates serving Arizona sentences out of state concurrently with sentences of other jurisdictions.[175]

There appears to be no statutory or policy reason, then, why a prisoner in Arizona State Hospital could not receive double time for performing assignments of confidence at the hospital. One inmate who had been transferred to the hospital, for example, served as president of the patient's governing council, a position probably useful to the day-to-day functioning of the hospital and its therapeutic community, but did not receive "double time" for those services, even though he had received "double time" credits at the prison prior to his hospital transfer. Many patient-held positions which serve the hospital may be considered assignments of trust, and may at the same time foster the social and psychological development of the patient-employees. A program of cooperation between the prison and the hospital with respect to placing transferred prisoners in those positions could eliminate any doubt as to the "double time" status of transferred inmates.

Finally, even if positions of trust are not readily available at the state hospital, or even if they could not suitably be filled by transferred inmates, "double time" credits should nevertheless be made available—by statute if necessary—to prisoner-patients. Such a course of action would

173. ARIZ. REV. STAT. ANN. § 31-252 (1956).
174. *Id.* (emphasis added).
175. Wexler, *Counseling Convicts: The Lawyer's Role in Uncovering Legitimate Claims*, 11 ARIZ. L. REV. 629, 635 n.34 (1969).

eliminate an unnecessary deterrent to seeking treatment and would recognize that a prisoner ought not to be penalized for his mental problems. It is noteworthy, in that regard, that prisoners who undergo treatment for *physical* problems are not deprived of "double time" credits for the period of time they spend at the county general hospital.[176] Mental patients should be dealt with no differently.

The final "length of incarceration" consideration of a prisoner contemplating a transfer is his opportunity for parole. Though the parole statute[177] would in no way seem to bar the granting of parole to prisoner-patients, prison officials stated unequivocally that so long as a prisoner is committed to the state hospital, he could not appear before the parole board and could not be granted parole.

It is unclear whether the apparent unavailability of parole to transferred prisoners is attributable to the fact that the parole board meets only at the Arizona State Prison, or whether there is a more fundamental policy objection to granting parole to committed inmates. In either case, however, the practice seems unwarranted. If the problem is simply one of logistics—of bringing the prisoner-patient and the parole board together—it can be readily solved either by transporting the inmate to the prison for his appearance before the board or by having the board sit occasionally at the state hospital. And if parole is denied for broader reasons of policy, the policy itself would seem ill-founded. Granting the prisoner-patient parole would not in this setting be equivalent to setting him free. Rather, the parole from his penal sentence would signify simply that, when he is discharged by the hospital, he will be released rather than returned to the prison—a fact that should surely provide a powerful incentive for the patient to take full advantage of the psychiatric care available and thus to regain his liberty.[178]

Treatment

The final consideration which a prisoner or his lawyer must make when deciding to seek psychiatric care is the type of treatment he

176. *See also* Sawyer v. Sigler, 320 F. Supp. 690 (D. Neb. 1970) (equal protection violation to deny good time credits to a prisoner medically unable to perform prison labor).

177. ARIZ. REV. STAT. ANN. § 31-412 (Supp. 1970-71):

> If it appears to the board of pardons and paroles, from a report by the department of corrections, or upon the application by the prisoner for a release on parole, that there is reasonable probability that the applicant will live and remain at liberty without violating the law, then the board may authorize the release of the applicant upon parole . . . .

178. In this connection, it is important to note that transferred prisoners are placed automatically in the Maximum Security Unit of the state hospital and—for security reasons—are usually retained in that unit during their entire stay at the hospital. Arizona State Hospital, 1969-70 Annual Report 6, 9-10 (Aug. 14, 1970). If a prisoner-patient were granted parole, however, he would seemingly no longer constitute a "special" security or escape risk, and might well be transferred to the general hospital population, where living conditions are less restrictive

will receive at the Arizona State Hospital, both in terms of psychiatric care and in terms of day-to-day living. Although some inmates obviously believe a stay at the hospital would wholly rebuild their psychic structures,[179] prisoners who have actually spent time in the hospital have consistently complained that no one at the mental hospital gave them any treatment.[180] One prisoner complained that he saw a psychiatrist only once during a stay of over a month. The hospital freely admits this lack of psychiatric treatment. In its Annual Report, the Arizona State Hospital noted:

> Finally guaranteed a new facility by the legislative appropriation this year, maximum security nonetheless continued to labor with the realities of obsolete crowded buildings, lack of proper treatment facilities, critical staff shortages, and the pressure of time. Idealistic program planning had to be put second to the demands for processing; mere management took precedence over treatment because of the dual problems of the patients who are, for the most part, mentally ill and under criminal charges.
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> . . . [O]verall, conditions must be reported as discouraging. Staff turnover has been high in the face of frustrating obstacles. Recreation for patients is limited, industrial therapy is not available, and an educational effort proved abortive due to improper facilities. Court testimony consumes psychiatrists' time away from the unit. Under these conditions the primary medical treatment is chemotherapy. Appropriate rehabilitation, counseling, and education cannot even be attempted. Added to this, the population of the division reached 80 during the year in facilities barely suitable for less than 50.[181]

The prisoner deciding whether to seek a transfer must realize, then, that he will receive very little, if any, psychiatric attention. In addition, he should recognize that transferred prisoners are not ordinarily integrated with the general hospital population but are instead placed in the Maximum Security Unit—itself a rather anti-therapeutic environment.[182]

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and more pleasant and where the chances for psychiatric recovery seem substantially greater. Morris, *"Criminality" and the Right to Treatment*, 36 U. CHI. L. REV. 784 (1969). The possibility of leaving the Maximum Security Ward and entering the general hospital population is raised not only by the granting of parole, but also by the expiration of a transferred inmate's penal sentence—which is another reason why prisoners contemplating transfer to the hospital ought to be concerned with the computation of their "good time" credits. See pp. 184-85 & notes 168-74 *supra*.

179. See the inmate's letter reproduced *supra* note 136.

180. Prison officials, during interviews, repeatedly conveyed these complaints.

181. Arizona State Hospital, 1969-70 Annual Report 9 (Aug. 14, 1970).

182. Morris, *supra* note 178. Although, as Morris reports, it has been demonstrated empirically that the so-called "criminally insane" can be mingled successfully and uneventfully with the general hospital population, the Arizona State Hospital—apparently because of fear of adverse public reaction—has been extremely hesitant to implement a policy of "mingling." The hospital's attitude can be gleaned from its Annual Report, where it noted apologetically that:

> [T]he population of the [Maximum Security] division reached 80 during the year in facilities barely suitable for less than 50. This necessitated transferring ten patients into the general hospital population and caused

Accordingly, a prisoner contemplating transfer must balance the situation at the prison with that at the hospital. A prisoner locked in isolation (particularly if he has a long sentence) may have little to lose by a transfer to the state hospital, while a prisoner in the general population or on outside trusty status may consider a transfer to the hospital's Maximum Security Unit far too great a loss of liberty to endure in return for only an outside chance of receiving some psychiatric treatment.

CONCLUSION

From the prisoner's perspective, then, a multitude of factors should militate against seeking needed treatment except in very special circumstances. The fact that, upon transfer, he will be committed indefinitely, will probably not receive "good time" credits, will be ineligible for parole, will not receive adequate treatment, and will be placed in the Maximum Security Unit, should discourage most informed prisoners from seeking hospital commitment. The result is that, at best, only prisoners with little to lose, or those who are uninformed, wholly irrational or severely mentally ill will even seek care. The irony, however, is that the prison, convinced that the Arizona State Hospital will not accept violent prisoners or those prisoners who are absolutely psychotic,[183] will not even refer those types of prisoners to the hospital. With the prison trying to accommodate the needs of the hospital, the intermeshing of the three selection systems—the prison, hospital, and prisoner selection systems—leads to the transfer of a very select prisoner. One thing is certain, this select prisoner is not transferred solely because he is "most direly needing help."[184] He is in all respects nothing more than a compromise candidate, surrounded by many losers—or winners.

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some public reaction. It might be noted that we publicly reported this move to be the least harmful, least inhumane, and least dangerous—not as most therapeutic, most humane, and most safe. Arizona State Hospital, 1969-70 Annual Report 9-10 (Aug. 14, 1970).

The hospital's announced attitude of extreme hesitance, which flies in the face of scientific studies, raises the question whether it is really desirable to increase the hospital's maximum security capability, thereby insuring the continued anti-therapeutic isolation of mentally ill patients who happen also to be somehow involved in the criminal process. Interestingly, a recent project interview with the superintendent of the state hospital disclosed that the patients transferred by necessity from maximum security turned out, to the hospital's surprise, to be among the *best patients* of the general population units—a result that could have been predicted from the research described in Morris' article. Also, a maximum security psychiatrist estimated that at least 25 percent of those in the unit could clearly be transferred out without incident, but that anoher 25 percent should clearly remain under tight security. He was uncertain about the remaining 50 percent. Perhaps the gratifying results of the hospital's "forced experiment" will contribute to a change in its unduly restrictive security policy.

183. The words "absolutely psychotic" were used by a prison official.

184. Arizona State Hospital, 1969-70 Annual Report 6 (Aug. 14, 1970).