

# Justice Is Not a Psychiatric Term\*

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The centipede had a terrible problem: he was developing a case of extremely painful arthritis. For expert help on the matter, he sought out a wise old owl. The owl pondered the problem and told the centipede that he should turn himself into a frog, since frogs do not get arthritis. The centipede was very happy until he realized that he knew no way he could turn himself into a frog. He returned to the owl for further instructions; the owl replied, "I just advance concepts; don't bother me with solutions."

## Introduction

Today, more than any other medical specialty, psychiatry is being confronted by challenges from all directions. Justice is the banner being carried by the challengers to the practice of psychiatry, and the battle lines cross all aspects of the judicial system — civil, criminal, family court, state and federal. The purpose of this paper is to utilize the traditional medical format of a case presentation for an analysis of issues in order to gain insight from past errors and, one hopes, to avoid further losses on the parts of psychiatrists, courts and patients.

## Issues

The basic issue is the role of psychiatry in providing proper input to the processing of the mentally ill offender. The case under discussion involves at least eighteen current battlefronts: fitness to stand trial, criminal responsibility, civil commitment, right to treatment, right to refuse treatment, unusual and hazardous treatments, informed consent, guardianship, release from confinement, prediction of dangerousness, duty to warn, community outrage and its effect on decision-making, impartiality of the expert, and malpractice exposure in acting as an agent of the court, just to mention a few. These issues are not new, but rather like the dormant locust, have arisen *en masse* to devour any semblance of reason in their path.

## The Case

A 21-year-old man with a juvenile record was charged with burglary. The public defender asked for a sanity commission to determine his fitness to proceed, his criminal responsibility and a recommendation for treatment. He was found not fit to proceed, not responsible and dangerous. Charges were dropped and he was civilly committed to the state hospital. He received a potpourri of treatments, ranging from isolation to placement

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\*The paper was presented at the annual meeting of the AAPL, San Francisco, October, 1976.

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in a boarding home, along with a wide variety of diagnoses. While still under commitment, he walked away from his least restrictive alternative and two months later was charged with a brutal murder/rape. At this point he was mute, and his attorney asked for, and received, the appointment of a sanity commission. Its recommendation was that the patient/defendant was not fit to proceed, but the court did not agree. A rehearing was granted and an amytal interview was done, with the appointment of a guardian *ad litem* since the defendant was unable to give informed consent. Following this procedure, three more psychiatrists recommended that he was not fit to proceed and was in immediate need of medical/psychiatric treatment. The court went ahead with a hearing until the defendant became physically assaultive in court, abruptly ending the hearing.

Since, as a matter of public record, there was no institution in the state capable of managing this defendant, requests were made of 39 other states, all of whom declined to receive this man. After remaining in jail, he was ultimately transferred to the maximum security unit at the state hospital to await some final decision.

### **Additional Problems**

Further complicating the indeterminate status of this man's criminal charges, the family of the victim of his crime has instituted a civil action against the hospital and treatment authorities for negligence/malpractice in the death. A civil liberties group has threatened action for inadequate treatment. Last, but not least, the treating physicians feel they have nothing in their armamentarium either to make him well enough to stand trial or effectively to predict his future conduct.

### **Analysis of Issues**

The economic and social costs of the eleven psychiatrists, one psychologist, one priest, and various physician-administrators and psychiatric consultants who have been involved with the meandering course of this one individual's travels through the civil and criminal psychiatric justice systems are tremendous, and there is every possibility that these costs will continue to increase. If this process should lead to a more definitive diagnosis and prognosis and a more "just" disposition of the case, then the costs might be acceptable. Yet the disposition of this case is no more certain now than it was more than two years ago. It is not clear that the patient will ever become "competent to stand trial," in terms of the understanding of that phrase by the examining psychiatrists in the sanity commissions. In fact, the commitment of the patient to the custody of the Director of the Department of Health may very well result in an indefinite incarceration at the state hospital. Therefore, in an attempt to decrease costs and ameliorate the plight of a patient/defendant caught on the mental health merry-go-round, we suggest the following alternative dispositions.

### **Alternate Methodology**

We start by noting that the criminal justice system is a legal system, with rules governing the legal rights and duties of the individuals traveling in that system. Additionally, the adversarial role of lawyers causes them to go into battle as combatants, striving for their clients' interests. Therefore, the issues of insanity and competency are settled by an adversarial method in the criminal justice system. The use of expert psychiatric testimony to aid the decision maker in settling these issues often results in confusing and usurping the decision-making function of the judge and jury. In addition, the large influx of expert opinion, as in the present case, increases the economic costs of the criminal justice system and embroils psychiatrists and other mental health professionals in a time-consuming, frustrating attempt at evaluation and treatment. A

simple way of decreasing these costs, possibly lessening this confusion and giving the decision-making power back to the judge and jury may be to prohibit the use of expert psychiatric-psychological testimony in the courtroom. This choice is buttressed by the basic observation that the criminal law attempts "... to define socially intolerable conduct and to hold conduct within limits which are reasonably acceptable from the social point of view." Hence, the criminal law is essentially applying societal judgments to individual conduct. By prohibiting psychiatric-psychological judgments from displacing these societal judgments, the essential nature of the criminal justice system may be preserved. Nevertheless, psychiatrists and other mental health professionals do have expertise in the area of mental illness, and to disregard this expertise entirely may arguably be a denial of a fair trial to the defendant. In this case, a perusal of the medical records and the trial transcripts indicate that all experts are essentially agreed that he cannot reasonably assist his counsel at the present time. Therefore, the suggestions which follow do not entirely disregard the contribution of mental health professionals to the criminal justice system.

### **Incompetency**

A defendant who is legally incompetent probably cannot be constitutionally convicted of a crime. The test for determining competency is 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." In order to test each defendant against these criteria, courts presently rely on the testimony of expert witnesses. The test for fitness to stand trial is phrased in terms of nonpsychiatric/psychological language. Furthermore, the commitment of defendants to state hospitals for the purpose of making them fit to stand trial often results in indeterminate confinement, which is constitutionally impermissible. A patient/defendant should speedily be given a fair trial, civilly committed as dangerous to himself or others, or released. He should not be allowed to languish in the never-never land of "psychiatric justice." For this reason, we suggest a time limit of at least six months within which to treat a defendant in order to make him competent to stand trial. The role of the expert will be to testify to the presence of mental illness and to fashion an individual program to treat this illness. The expert will be allowed to testify as to the legal competency of the defendant, but laymen who are familiar with the defendant will also be allowed to testify. If it appears that the defendant cannot be treated successfully within a specified period, then the court may proceed to trial with special *legal* safeguards (e.g., the primary test would be whether all relevant evidence reasonably appears to be present). If this suggestion sounds harsh, it is no more so than the disposition of the amnesic defendant who is brought to trial despite his memory loss. If later, newly discovered evidence may result in a reversal of a previous guilty verdict, the court may reopen the case and order a new trial. If the defendant is legally incompetent to stand trial, and no effective treatment can be elucidated, together with a lack of relevant evidence (e.g., no witnesses), then the charges should be dismissed and the defendant either released or civilly committed as being dangerous to himself or others.

While all psychiatrists were in agreement that the defendant in the case presented could not reasonably assist his counsel, not all lay witnesses described the defendant as unable to communicate effectively with others. Of course the lay witnesses were not asked whether or not the defendant was competent to consult with his attorney — but they should have been asked. No treatment plan was offered to make the defendant competent to stand trial. No agreement existed among the psychiatrists as to the diagnosis of the defendant. These factors indicate the confusing and time-consuming ritual, largely ineffective, in present competency hearings. Under our suggestions, the court would have considered all witnesses' testimony as to competency, asked for a diagnosis, asked for a

treatment plan based on the diagnosis, and once having decided the defendant was competent, proceeded to trial. The next stage would be to determine if special safeguards were needed at trial. Once this question was decided, the defendant should have been placed on trial unless his participation was absolutely essential to a fair trial. In that case, the charges should have been dropped, and a decision on civil commitment should have been made.

This approach would have reduced the time and number of psychiatrists involved, focused the attention of the court on the issue of proceeding to trial, and disposed of the defendant in a constitutionally sanctioned method of incarceration, instead of the commitment to the state hospital with no reasonable likelihood of regaining competency.

In the interest of conserving time, I shall summarize our recommendations on several other main issues:

1. Insanity — there needs to be explicit clarification of the legal relationship of *mens rea* and mental illness. The psychiatrist relating diagnoses to criminal responsibility converts the criminal justice system into one of psychiatric justice, allowing for exposure to liabilities which are not scientifically defensible.

2. Prediction of dangerousness — in spite of the disclaimers of the possibility of predicting dangerousness, there are instances where the probabilities are significant and overt and the basis of such predictions should be explicated. Full disclosure of the process by which one reaches a requested conclusion is the best protection against redress for an honest mistake.

3. Relying on sovereign immunity — in the past, we psychiatrists have made a series of significant, unwarranted assumptions, not the least of which has been to assume that if one is performing a function requested by the court, state agency or another type of official administrative body, then he is protected from suit if something happens. The *Donaldson* case burst that bubble, as did *Tarasoff*, and now in Hawaii, members of a court-appointed sanity commission are being sued as individuals. We believe that sovereign immunity must be established for classes of psychiatrists who are performing legally sanctioned roles. The lack of clarification of the roles and their qualifications allows for unrealistic discretion and then liability.

### **Corrective Measures**

1. Boycott — many psychiatrists feel that we should simply refuse to participate in any legal proceeding as experts, avoid state or institutional employ until adequate funding and facilities are provided, and, by and large, restrict our activities to those areas which are safe, clean and free from ambiguity. At this point in time, this position is undesirable and impossible to implement.

2. Pass the ball back to the courts and legislators — this is not as unreasonable as boycotting, but probably not workable either. Psychiatry was not handed a desirable ball, but it is very unlikely that the originators are going easily to resume the burden of re-stitching and re-inflating it.

3. Collaboration — this obviously is the key word in working toward realistic solutions. Clearly, in no way can psychiatry disentangle itself from these issues. To engage in adversarial maneuvers with well-equipped, powerful challengers is foolhardy at best and suicidal at worst. If a supreme judicial psychiatrist were appointed by a higher power to appoint a sanity commission for the profession as it engages in its current battles, I wonder if we would be found fit to proceed, responsible, dangerous to ourselves and/or others or simply gravely disabled.

Collaboration cannot be accomplished without trust, and trust, in this instance, is based on credibility derived by an open and honest expression of professional limitations on both sides.

The last question I leave you to ponder is not unlike that of the future of the

defendant in the case presented. This man is in psychiatric never-never land, neither criminally prosecuted nor civilly committed, and his future is more ambiguous than it was over two years ago. Psychiatry is in a legal never-never land. Having few, if any rights, but many duties, we find our future significantly more uncertain than at any time in the past.

This is not to say that things won't change, but rather to say that we must influence change through a wider understanding of the processes we have backed into or accepted naively. Lawyers develop a special arrogance in the practice of their profession, for in order to pursue a lawsuit, they must become rapid experts in the area under litigation. Therefore, they begin to see themselves as experts in a wide variety of arenas. Rather than denigrate this attitude, psychiatrists could learn from it. We must become experts in the areas that we are litigating. Without such knowledge nothing shall be learned and change will not be for the better.