Imprisonment Without Trial

Judge Tom R. Blaine (Retired)

In the United States today thousands of people are deprived of their freedom through the process known as civil commitment of the mentally ill. They have not been convicted of crime; in fact, they have had no opportunity for any kind of hearing in court or before a judicial official.

More than 20 states have laws authorizing preventive incarceration of allegedly mentally ill persons who are likely to injure themselves or others. The decision of what future harms justify confinement is never made by the legislature or by a court but by an unelected and unappointed expert—a physician—whose opinion as to what harms do, or do not, justify detection, has proven to be of no greater value than that of an intelligent layman.

To illustrate, a Connecticut statute provides that one suddenly in need of care and treatment in a mental hospital may be confined in such hospital, either public or private, for not more than 30 days, without a court order, if a physician certifies that he has examined the person within three days prior thereto, and in his opinion he needs immediate treatment.

Statutes of many other states are either identical or similar.

Reprinted with permission from *Trial*, Vol. 7, No. 2, 1971, pp. 50-51.

Why have a majority of states enacted laws giving physicians authority to send persons to mental hospitals without hearings, sometimes in the most arbitrary manner?

Historically, the encounter between law and psychiatry is a process of usurpation of power on the part of psychiatrists and abdication on the part of the courts.

In the seventeenth century one was held irresponsible if he "doth not know what he is doing, no more than an infant or a wild beast." In the eighteenth century the "wild beast" test was abandoned and "right and wrong" became "good and evil."

Near the middle of the nineteenth century the House of Lords in the famous McNaughten case restated what had become the accepted "right-wrong" test in a form followed in England and in most American jurisdictions as an exclusive test of criminal responsibility until 1954, when it was overthrown in the case of *Durham v. United States* (214 F. 2d [D.C. Cir. 1954]).

Attempts to overthrow the "right-wrong" test and to establish medical criteria of symptomatic description continued from 1838 with publication of Dr. Isaac Ray's now classic *Medical Jurisprudence of*

Insanity, through the nineteenth century and well into the twentieth. Knowledge of right and wrong was a fallacious test of criminal responsibility, Dr. Ray contended, "based on an entirely obsolete and misleading conception of the nature of insanity."

In *Durham v. United States,* Former Supreme Court Justice Abe Fortas, counsel for Durham, argued that substitution of a new rule for the McNaughten case would permit psychiatrists to testify in "the terms of their own discipline, and not in the terminology of an irrelevant formula."

The court was not told *why* the "right-wrong" formula was irrelevant for legal purposes and did not even consider the possibility that the terms of the physicians' discipline might be antagonistic to a perfectly rational legal rule. The Fortas argument was accepted and the medical model of insanity adopted.

At last the issue of responsibility was where Isaac Ray thought it belonged—in the therapeutic hands of the physicians. Madness, as Dr. Ray had contended, was to be regarded as a mental disease to be defined by physicians with little or no interference by courts.

The criminal law purports to punish those who have committed harmful acts, while civil commitment is supposed to *prevent* people from doing harm.

The increased involvement of physicians' administration of justice has, without doubt, resulted in needless deprivation of liberty based on erroneous opinions of "experts" in those states that follow the medical model of confinement of the mentally ill to prevent harmful acts were crime is not involved.

Can one, for a moment, imagine the people allowing a criminal code to stand which authorizes an expert, say a criminologist, to cause a person to be incarcerated because the expert believes the person might commit a crime if allowed his freedom?

Our penal codes are explicit and certain that one charged with crime can only be imprisoned after his guilt has been established beyond a reasonable doubt and dozens of other legal safeguards have been followed. But the criteria for the confinement of the mentally ill to prevent injury to themselves or to others are so vague and indefinite that effective judicial review is not possible.

We have virtually turned over to the physicians the civil commitment process— a legal policy never approved by any authorized decision-maker.

But how accurate are the predictions of physicians on the future antisocial conduct of those they say should be confined?

To justify preventive incarceration at the hands of physicians, it would appear that the predictions of antisocial conduct should be nearly 100% perfect. However, after a survey of all published literature on psychiatrists' prediction of antisocial conduct, Harvard Law Professor Alan M. Dershow-itz reported in 1968:

". . . these studies strongly suggest that psychiatrists are rather inaccurate predictors; inaccurate in an absolute sense, and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials; and when compared to actuarial devices such as prediction or experience tables."

Psychiatrists are particularly prone to one type of error—overprediction, Professor Dershowitz continued. "They tend to predict antisocial conduct in many instances where it would not, in fact, occur . . . Our research suggests that for every correct psychiatric prediction of violence, there are numerous erroneous predictions."

Of course the psychiatrist never learns about his erroneous predictions of violence, since predicted assailants are nearly always incarcerated and have no opportunity to prove or disprove the prediction.

The rule in criminal cases is: It is better

Judge Tom R. Blaine
(Retired!
Box 1343
Enid, Oklahoma 73701

to free ten criminals than to imprison one innocent man. The legal policy in civil commitment seems to be: It is better to confine ten men who would not assault than to let free one man who would.

The psychiatrist may, and often does, define danger to include all kinds of minor social disruptions. Harm to self is placed on the same basis as harm to another, although many people believe otherwise. Conversations with psychiatrists reveal wide discrepancies as to just what threatened harms justify incarceration.

If those physicians who qualify as psychiatrists are less accurate in their prediction of the anti-social behavior of persons suspected of doing possible harm to other people, or to themselves, than nonmedically trained professionals, how can we justify laws which permit *any* physician to participate in the medical model of confinement where there is no criminal charge?

Too often a physician, called on to determine whether one should be placed in a mental institution "to protect himself or others," adopts the easy way out, shifting the responsibility to psychiatrists in the mental hospital.

Again, the examining physician may be under pressure from relatives to send the alleged mentally ill person to the hospital.

And the statutes of the several states do not prescribe what kind of examination shall be given before "preventive" commitment. A study of reported cases in the appellate courts indicates that the examinations actually given have generally been perfunctory.

It does not take a lawsuit to show that damages will result if one is wrongfully confined in a mental hospital for a few days or a few weeks.

A *case in point is Mayben v. Rankin, (Cal.) 358 P. (2) 681, which indicates how one may be damaged when involuntarily confined as an alleged mentally ill person. The plaintiff recovered a judgement of $78,000 for false imprisonment and assault and battery against a psychiatrist, J. H. Rankin, and the Beverly Hills Medical Clinic, a partnership of physicians of which Dr. Rankin was a member. In delivering his opinion, Chief Justice Gibson said:*

"The evidence established without conflict that Dr. Rankin caused plaintiff to be taken, without her consent, to the psychiatric ward of St. John's Hospital, a private institution, and to be detained there while he gave her electroshock treatments.

"Plaintiff testified that she was examined by Dr. Rankin at her husband's request, that she was not mentally ill but was upset because of infidelity and other objectionable conduct on the part of her husband, that she refused to be hospitalized but that Dr. Rankin forcibly administered an injection.

"The next thing she remembered was that a week later she found herself in the hospital, where she remained against her will for 15 days. There was also expert testimony that she had not been mentally ill"

It is expensive for the patient to employ a lawyer to take legal action for release.

Most employers do not look favorably on taking back an employee who "has been confined in a mental institution," even for a short while. Moreover, mental humiliation to the patient may be so great as to actually injure his health.

Involuntary detention in a penal or mental institution is too serious under our form of government to be permitted without some form of judicial hearing. Before commitment on the opinion of a physician (or even two) that he will harm himself or others, an alleged mentally ill person should be provided these statutory safeguards to his rights:

1. He should be taken before a judge of a court of record, who, in the absence of all relatives, should advise him that he has a right to a trial in court to determine whether he should be sent to the mental hospital.
2. If the supposedly mentally ill person appears without an attorney, and the judge is of the opinion that he is unable to secure counsel, an attorney should be appointed for him.
3. Should a trial be requested, the matter should be set for an early hearing, at which time introduction of evidence should be permitted both for and against commitment to a hospital.
4. If the examining doctor's conclusion that such person should be hospitalized to protect himself or others is sustained, the subject should be committed to a mental institution, public or private, *on the order of a judge or court, rather than on the certificate of a physician.*

If the examiner's opinion is not approved, the person in question should be ordered released.

AMERICAN SCHIZOPHRENIA ASSOCIATION PUBLISHING POLICIES

SCHIZOPHRENIA is the professional journal owned by the American Schizophrenia Association and published quarterly as a service to its members. Participating and sustaining memberships in the Association include annual subscriptions to SCHIZOPHRENIA, a quarterly Newsletter, and booklets on schizophrenia. To become a member, write to American Schizophrenia Association, 56 West 45th Street, New York, N.Y. 10036. A nonprofit corporation—membership contribution is tax deductible.

Annual subscription rate for SCHIZOPHRENIA to doctors and libraries is $15.00 in the United States and Canada; $18.00 overseas.

Articles appearing in SCHIZOPHRENIA do not necessarily reflect the attitude of the Association or the Co-Editors.

 Direct editorial material to one of the following: Abram Hoffer, M.D., Ph.D., 1201 CN Towers, First Avenue South, Saskatoon, Saskatchewan, Canada; J. Ross MacLean, M.D., Medical Director, Hollywood Hospital, 515 Fifth Avenue, New Westminster, British Columbia, Canada; or Humphry Osmond, M.D., Director, Bureau of Research in Neurology and Psychiatry, Princeton, New Jersey.

Send correspondence relating to published issues and annual subscription orders to the publishers: Lowrie Associates, Inc., 6950 France Avenue, Minneapolis, Minnesota 55435.