IMPLICATIONS FROM THE BAXSTROM EXPERIENCE*

by

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At 41 years of age, Johnnie K. Baxstrom was arrested in Rochester, New York in October, 1958 and charged with Assult 2°. Two months later he was convicted and sentenced to 2½ to 3 years in Attica State Prison. In June, 1961, Baxstrom was determined to be mentally ill and was transferred to Dannemora State Hospital, a mental hospital run by the Department of Corrections for mentally ill, convicted felons. When Baxstrom's maximum sentence expired in December, 1961, he was retained in Dannemora as mentally ill (diagnosis: psychosis due to convulsive disorders, epileptic deterioration). Psychiatrists from the Department of Mental Hygiene said he was too dangerous for civil hospitalization and therefore must be detained in Dannemora, if requiring mental hospitalization.

Baxstrom's petitions for transfer and release began when he drew up a *habeas corpus* writ in May, 1962. His efforts culminated in the *Baxstrom v. Herold* (383 U.S. 107) decision of the United States Supreme Court written by Chief Justice Warren in February, 1966. The decision concluded that Baxstrom had been denied equal protection of the law by not being allowed the right of a jury trial as permitted under the corresponding section of the Mental Hygiene Law. In addition, he was denied equal protection by being detained in a Department of Corrections facility without proper review as to whether he was dangerously mentally ill at the close of his prison term. Such a determination was a judicial one and under the MHL the petitioner was afforded the right to a jury trial on the question of dangerousness.

The benefits of this decision for Baxstrom himself are debatable. One month after the Supreme Court decision, he was transferred to a civil hospital. Then under a newly enacted law, received a jury trial to determine whether he was mentally ill and required continued civil retention. The jury concluded he was not and he was released from the civil hospital in May, 1966. He moved to Baltimore where on June 6, 1966 he died in bed during epileptic seizures.

The positive effects of the Baxstrom decision on other residents of Dannemora and Matteawan State Hospital, New York's other hospital for criminally insane, are much less debatable. Beginning one month after the court's decision, the New York State Department of Mental Hygiene began the transfer of 967 patients from these two correctional hospitals to 18 civil facilities. In very few cases were these transfers detrimental to the patients or the community.

The Baxstrom decision itself appears to have been quite inconsequential outside of New York. Although this decision demanded equality in all states' procedures and protections, I am aware of only one other state (Massachusetts) requiring the transfer of any criminally detained mental patients.

At this point let me briefly outline the design of our research on the patients transferred because of the Baxstrom decision. After the research design, I will summarize our major findings. Having accomplished this, I will discuss what I see as the major implications from the Baxstrom patients' experiences.

Research Design

Our research began in 1970, four years after the Baxstrom patient transfers. We were

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concerned with what had happened to this group of patients who had been so feared by the civil hospital staffs that were required to take them. How much trouble had these Baxstrom patients caused? How many and which of them made it to the community? What problems had they caused and encountered upon subsequent community release? These were the kinds of questions that we wished to answer. In addition, we felt that the experiences of this population could provide data to help conceptualize, measure, and predict dangerousness.

With these questions in mind, we obtained the hospital records of all 967 Baxstrom patients for background data and institutional behavior. For arrest and conviction information, we accumulated crime sheets from hospital records and for current offenses received reports from the state's central data processing agency.

As it became apparent that the massive amount of data on each patient would preclude coding it for all 967, we selected a 20% random sample of the 920 males (199) and included all 47 of the females. We then abstracted and coded the data for these 246 patients. In addition, we attempted to locate all those Baxstrom patients from our sample who were in the community in 1971 to obtain community adjustment data. Of the 85 we sought, we located 71 (82%).

Major Findings

The major finding about the Baxstrom patients was that they caused much less trouble than most people expected. This can be said of them both while institutionalized and while in the community. Four and a half years after their transfers (October, 1970) 50% of the Baxstrom patients remained in civil hospitals. One third of them were in the community and 14% had died. Less than 1% were in jail or prison and 2% were back in Matteawan or Dannemora. In fact, of the 967 Baxstrom patients, only 26 (2.7%) were returned to New York hospitals for the criminally insane at any time between 1966 and 1970.

The release rate of the Baxstrom patients from civil hospitals is remarkable. Between 1966 and 1970, 49% of the Baxstrom patients were released into the community. The rate at which they were removed from the civil hospitals by both death and discharge was greater than that of *all* adult chronic civil patients (47% compared to around 30%). In fact, 17% of the 967 transferred Baxstrom patients were released or died in the *first* six months after their transfers.

All these figures on Baxstrom patient releases can be summarized simply by saying that the Baxstrom patients fared far better than anyone expected they would at the time of their transfers.

In addition to their release rates, there are at least two other areas of Baxstrom patient experiences that I think are worth pursuing here, their assault records in civil hospitals and their subsequent criminal activity.

Looking at the Baxstrom patients' behavior in civil hospitals before first release, 15% of the Baxstrom patients were involved in assaultive incidents. An additional 5% of these patients were involved in assaults during subsequent reinstitutionalizations or in the community while released. Thus in the first four years after their court ordered transfers, 20% of the Baxstrom patients had some record of assault in hospital, aftercare, or criminal records.

It is interesting to note that assaultiveness and other types of disruptive behavior statistically were not significantly related to release from civil hospitals. Patients with assaults or other disruptive behavior were released almost as frequently as those with no record of behavior problems. However, these incidents did make a difference whether patients were in hospitals at the end of our follow-up, because those readmitted because of or with assaults were less frequently re-released. As with some other recent data of civil hospital admissions (Greenly, 1972), Baxstrom patients releases were more related to having someone in the community who maintained an interest in them after their long hospitalizations. Assaults were a deterring factor in release decisions, but became a less important factor if there was someone willing to sponsor the patient's release.

Of the 121 of our sample patients released into the community some time between 1966 and 1970, 21 (17%) were arrested. These 21 had 46 arrests resulting in 54 charges, 31 misdemeanors and 23 felonies. Convictions followed on 17 counts, 14 misdemeanors and 3 felonies (Grand Larceny, Possession of Dangerous Weapon, and Robbery 1°). The 121 released Baxstrom patients between 1966 and 1970 spent over 3,400 months in the community for an average of 28.5 months/patient. In these two and a half years, only nine of the 121 (7%) were convicted of any criminal offense, while 66 of them (50%) had no subsequent institutionalizations of any type.

These data pretty much describe our picture of the Baxstrom patients during the first four years after their transfers. I would now like to turn to what I see as some of the major implications from these experiences.

Implications

1. The Baxstrom Patients Were Not Very Dangerous

I use this term "dangerous" hesitantly, yet advisedly. It is a term weighed down by imprecision and connotation, and a concept that I will discuss in detail later. I would say at this point that whatever it may mean, the Baxstrom patients were not. The data just presented dealt with their release rates, assaultiveness, and subsequent criminal activity. On none of these measures did the Baxstrom patients fare badly. Unfortunately, it is quite difficult to make very many statements about the level of success or failure of the Baxstrom patients without some reference point. We did show that their release rates were higher than those of chronic adult civil hospital patients. However, there are no data on inpatient assaultiveness of which I am aware that provide a comparison with the Baxstrom patients' assaultiveness.

We did manage some inroads into this problem of baseline data by also studying all those patients transferred with psychiatric approval from New York's same two hospitals for the criminally insane in the two years immediatedly preceding the Baxstrom transfers. These "Pre-Baxstrom" patients numbered 359 (312 males and 47 females). In comparing their first four years in civil hospitals to the Baxstroms these are two major cautions: (1) the Pre-Baxstrom patients were significantly older than the Baxstrom patients when transferred (58 males and 64 females compared to 48 and 51); and (2) the Pre-Baxstrom patients died at a much higher rate than the Baxstrom patients, limiting the number of possible discharges.

On assaults and subsequent criminal activity, the Pre-Baxstrom patients fared somewhat better than the Baxstrom patients. Of the 359 Pre-Baxstrom patients, 6% had assaults recorded compared to the 20% of Baxstrom patients. Of the released Pre-Baxstrom patients, 12% were rearrested compared to the 17% of Baxstrom patients. However, a significantly fewer number of Pre-Baxstrom patients were ever released into the community after transfer (36% compared to 49%). Thus, with this one control population the Baxstrom patients compare quite well. Even if they did not, the question would arise whether the absolute level of their subsequent behavioral problems supported psychiatric estimations of their dangerousness.

There is one implication from this discussion of the Baxstrom patients that I wish to make clear I am *not* drawing. Recently, to my surprise, the Director of Matteawan State Hospital referring to our published reports on the Baxstrom patients said, "I suppose that you think all hospitals like this one should be closed." My response was that I intended no such implication.

The Baxstrom patients are not typical of patients now entering mental hospitals through criminal procedures. They and the Pre-Baxstrom patients may be representative of chronic populations in older, traditional state correctional/mental health hospitals. However, the Baxstrom patients were a group of middle aged people when they were transferred. They had been continuously institutionalized in hospitals for the criminally insane for an average of 14 years. My current research on a group of 540 male, incapacitated felony defendants in New York shows them to have an average age of 30. I would expect this latter group to be more

representative of current treatment and custody issues than the Baxstrom patients, who are still quite important. They may not be representative of patients now being admitted, but they are representative of long term patient populations in many state hospitals for the criminally insane.

I said earlier that I used the term "dangerousness" advisedly. I did so because I think it may be the single most important concept for current issues in psychiatry and its relationships with criminal and civil involuntary commitment. I have talked of the Baxstrom patients' dangerousness in terms of their release patterns from civil hospitals, their incidents of assaults in civil hospitals, and the number and type of arrests and convictions after community release. The hospital behavior problems and arrests are nearly the same thing in different locations, in fact, release patterns were used because of their hypothesized relationship with assaults (a hypothesis you will recall that was rejected). The use of such data, as indicators of dangerousness is supported by Rubin's (1972) superb summary of definitions and measures of dangerousness. He concluded that the term dangerousness could be limited to actual injury and destruction of persons, either self or others, although he discussed mainly injury to others. I think this conceptualization can be accepted as the general definition of dangerous *behavior* and as such the Baxstrom patients were not very dangerous.

However, I think the tremendous psychiatric and legal import of *dangerousness* is that it is different from dangerous *behavior.* Dangerousness is the expectation, the probability, the perceived potential for dangerous behavior. Estimations of dangerousness are predictions. Such predictions are becoming the most important factor in involuntary commitments of mental patients under both civil and criminal orders. As this criterion gains in importance, the radical differences between states in demands placed on the psychiatrist are perplexing. One example of these bewildering differences is the current situation in Pennsylvania and New York.

In September, 1971, a revised section of the New York Criminal Procedure Law became effective requiring that two psychiatrists report to the court whether incompetent, indicted felony defendants were dangerous. While giving this mandate, the statute gave no adequate definition of dangerousness nor implied any criteria by which it might be determined. A dangerous incapacitated person was defined as . . . "an incapacitated person who is so mentally ill or mentally defective that his presence in an institution operated by the department of mental hygiene is dangerous to the safety of other patients therein, the staff of the institution or the community" (Sec. 730.10). Thus, a patient is dangerous if he is dangerous to someone's safety. Quite a tautological definition!

At the same time that New York was implementing this new statute, Pennsylvania's task force studying possible revisions of its mental health and retardation laws "ascertained to its complete satisfaction that the assumption of this kind of expertise (power to recommend preventive detention by predictions of dangerousness) is quite unwarranted and rejected it after extensive deliberations" (5). This same committee's report further concluded that "since the capacity to predict dangerous conduct is no greater in the case of mentally ill persons than others, preventive detention is no more justified in the case of mental illness than elsewhere." (5-6)

Thus, two states in close geographic and temporal proximity have reached radically different positions on the validity of psychiatric predictions and judicial determinations of dangerousness. These issues of predictive expertise lead me to the second implication from the Baxstrom experience.

2. More Investment Must Be Made in Accumulating Systematic Data On Psychiatric Predictions

The current state of psychiatric predictions of dangerousness is aptly summarized in the following two statements by two esteemed forensic psychiatrists. The first is by Seymour Halleck:

> Research in the area of dangerous behavior (other than generalizations from case material) is practically non-existent. Predictive studies which have examined the probability of recidivism have not focused on the issue of dangerousness. If the psychiatrist or any other behavioral scientist were asked to show proof of his predictive skills, objective data could not be offered. (1967)

A similar conclusion if offered by the recent article of Rubin mentioned above:

> Treatment interventions depend on predictions of the likely consequences of such interventions. Such predictions are unavoidable for the psychiatrist . . . There is, however, another type of prediction, that of the likely dangerousness of a patient's future behavior. This prediction is expected of the psychiatrists – and psychiatrists acquiesce daily. This belief in the psychiatrist's capacity to make such predictions is firmly held and constantly relied upon, in spite of a lack of empirical support. (1972:397)

Our Baxstrom research although retrospective was cognizant of and concerned with these questions of psychiatric predictions. One reason for our interest in this group was the implicit psychiatric predictions of dangerousness involved in the evaluation of their unsuitability for civil hospitalization. The mass transfer of these patients provided one test of how accurate these psychiatric predictions would be. As we have seen above, there is much to indicate that these predictions were overly conservative.

Concerning prediction, what may be as important as any indication of undue conservatism is the inability of our data to differentiate those groups who did act out in severe ways after their transfers. For example, of the 967 Baxstrom patients, only 26 were returned to New York's two hospitals for the criminally insane at some time during our follow-up. Of the many social and criminal background characteristics we tested, only two, age and summary scale of severity of criminal history, showed any differences between the returnees and the rest of the Baxstrom patients. The average age of the returnees was 33 at transfer compared to the 47 for the entire population. Our Legal Dangerousness Scale score reflected presence of any juvenile record, number of previous incarcerations, presence of violent crime convictions, and seriousness of most recent arrest/conviction. The higher this score between 0 and 15, the more severe the criminal background. All Baxstrom males averaged 6.0 on this scale, while the returnees averaged 9.2. While this difference is statistically significant, it helps very little in making individual predictions, since over 90% of those patients with scores of 9 and over did *not* return.

Similarly, in our sample of Baxstrom patients those with assaults were younger than those without and those released were younger than those who were never released from civil institutions. Unfortunately, our data have little else that assists prediction and what we have here is so basic and unastounding, that the younger patient/inmate is the most apt to act out in both civil hospitals and the community, that it is little help in the business of psychiatric/judicial prediction.

The major conclusion concerning prediction to be inferred from the Baxstrom data is a strong conservatism on the part of psychiatrists dealing with criminally insane patients. The patients being approved for transfer to civil facilities while the Baxstrom patients were being passed over, the Pre-Baxstrom patients, were much older, more frequently white, and with less severe criminal histories. However, both groups did quite well.

This is not to say such conservatism is not desired and even demanded by the public and legislators. It simply highlights the tendency to institutionalize many people who are not dangerous, rather than to inadvertently release the very few that are. Because such conservatism is desired by the public-at-large does not necessarily mean that psychiatric acquiescence is the answer.

The feeling I am left with on the topic of prediction from the Baxstrom data is disappoint-

ment. Disappointment that we were not able to better distinguish subgroups within the Baxstrom patients. Disappointment that statutes mandating additional psychiatric prediction of dangerousness are being expanded before data exist in even most rudimentary forms to assist such decisions. In a positive vein, I do see in the work of many people here today a strong commitment to gather these necessary data. To contribute to these endeavors was one aim of the Baxstrom research.

Now let us turn to what I see as the third major implication of the Baxstrom experience.

3. Lawyers Have Serious, Unmet Obligations in the Mental Health Field

The direct effect of legal counsel in the Baxstrom case is evident in the transfer of the 967 patients from hospitals for the criminally insane to civil hospitals. While this group may be one of the largest ever to see such effects directly from a court ruling on a mental health law, there remains a vast group barely touched by qualified legal concern. Rubin estimates that 50,000 mentally ill persons a year in the U.S. are involuntarily detained under civil orders on the basis of dangerousness. In addition there are an estimated 10,000 mentally ill offenders each year who receive involuntary psychiatric care. Thus, there is a large number of people each year whose involuntary mental hospitalization involves some type of prediction of dangerous behavior. These people need informed, concerned legal counsel.

While mental health and criminal laws in most states have provisions requiring legal counsel at involuntary civil and criminal commitment hearings, the importance of lawyers in these proceedings *and* during any subsequent institutionalizations are sometimes overlooked. The importance of lawyers may often be overlooked because they are not one of the three major decision-makers in pathways to involuntary mental commitment. For civil involuntary commitment and, of course, for criminal commitments the agent most frequently deciding who will receive initial psychiatric evaluation is the police officer. Upon arrest or during pretrial detention the police/correction officer is a major determiner of who is brought to psychiatric attention.

After psychiatric evaluation is requested, decisions of involuntary commitment involve the psychiatrist and the judge. As an expert witness, the psychiatrist provides information and recommendations to the court. From this and other testimony, the court rules. However, we have found in our current research on criminal competency that there is about a 90% concurrence between psychiatric recommendations and judicial determinations. Other research (Gove, 1971) has indicated a similarly high concurrence in civil cases. Thus, in effect, the decisions of dangerousness and involuntary commitment are psychiatric ones.

In the processes of involuntary commitment the lawyer makes none of the actual decisions that directly result in commitment. However, their competent participation in these hearings are critical to the outcomes. Research (Wegner and Fletcher, 1969) has shown that when legal counsel is present at civil hearings, there are significantly fewer cases committed. The preliminary results of our current work indicate major differences in the quality of counsel participating in competency hearings. Our preliminary findings suggest that it may be to the defendant's *disadvantage* to have private counsel as opposed to Legal Aides. Most private counsel is involved in so few of these cases that they are unaware of the specifics of the statutes, hearing procedures, and institutional networks into which their clients may be going. These observations are supported by additional data reported by Rosenberg and McGarry (1971).

As a diversion from the criminal justice system, the commitment of criminal defendants or offenders to mental hospitals involves many more patients than the number of interested lawyers would indicate. The removal of persons from the community through involuntary civil commitments because of dangerousness may present an even greater disparity between need and legal concern.

Certainly one of the factors in low interest and participation of competent private counsel is economic. People being involuntarily committed via either criminal or civil procedures are usually poor and inept; inept socially and/or as criminals (i.e. they were caught). Monetary rewards for their defense in most cases are not competitive. It would seem appropriate for some adjustment on both sides, higher allotments for public defense in these commitment cases and more social concern allowing more frequent acceptance by qualified private counsel of lower fees in such cases.

As preventive detention enters the considerations on these cases one is talking about social control as well as rehabilitation. As a method of societal protection or control, involuntary commitment and dangerousness as a criterion for it, demand lawyers' attention. The presence of informed legal counsel develops a healthy tension for all participants. It is necessary that lawyers see the broader issues of these hearings for the mentally ill. The principles of preventive detention, self-protection, competence, dangerousness, etc. relate to broader legal questions that also pertain to the aged, juveniles, the poor, the weak, and in general to the disadvantaged. The Baxstrom patients represent one group that reflects some obvious direct, benefits from the legal efforts in one case. More of these efforts are in order.

The final implication that I offer today is implicit in many of the things I have already said.

4. There Is Need for Interdisciplinary Research

It is very traditional to end sociological presentations with a cry for more research. I am concluding this paper with such a cry not to be traditional, but because this is one of the strong implications to be drawn from the Baxstrom experience. The call I am making here is for interdisciplinary research. I use the term, interdisciplinary, rather than multidisciplinary to indicate that what is important is not the sheer number and range of disciplines working on these problems, but the level of cooperative endeavor of those that are involved.

As I make this recommendation I recall the disappointing encounters I have observed in recent years between sociologists and psychiatrists especially at the APA annual meeting. It seems that these encounters inevitably end with little cooperation or mutual stimulation, but with attack and counter-attack about the medical model and its appropriateness or inappropriateness. Your invitation to me I hope proves to be a step towards more cooperative ventures. What I have tried to do here is to present some empirical data and develop some of their implications. As such I hope this will further develop working relationships between social scientists, psychiatrists, and legal professionals to develop the data that are needed.

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