

The Prosecution of Violent Psychiatric Inpatients: One Respectable Intervention

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Is arrest and prosecution an acceptable response to assault committed by a psychiatric inpatient? The first reported case of such a response was in 1978, and the second not until seven years later. Soon after, an inconclusive debate over the propriety of prosecuting patients, with additional illustrative examples, took place in the psychiatric literature. The present author adds three more case reports in this communication, as well as outlines what actually occurs in his state. Three very recent publications have clarified the conflicts and ethical issues in this still-delicate discussion. It is concluded that predatory patient behavior should, in selected circumstances, correctly lead to the imposition of criminal sanctions, whether initiated by victims or clinicians.

Assaults and other violent acts by psychiatric inpatients are unfortunately commonplace. Discussions at professional meetings often focus on the rise in such occurrences, particularly in the public sector, in an attempt to divine the reasons for this. Notwithstanding such acknowledgment of a serious problem, the response of arrest and prosecution of the offender has until quite recently been largely unaddressed in the literature.

The first known report of charges being brought against an inpatient was made by Schwartz and Greenfield in

1978¹ and published with the consent of the patient involved. The police were called to make an arrest after a nurse was struck on the head. After trial, the offender was placed on a one-year probation. The authors commented that prosecution seemed to have some therapeutic value, because the patient's behavior improved and she led a more productive life without further hysterical outbursts.

Four years later, Huber and associates² published an article on emergency room evaluations of persons perceived as dangerous to others. They concluded that it was all but impossible to "transfer" such people to the criminal justice system, even when it appeared to be the most sensible clinical method of dealing with the given facts and circumstances.

In a brief commentary³ regarding the

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rights of staff, bringing charges against a patient who assaults staff was presented as an option to be considered only in special circumstances and never as a first line of defense or in response to behavior that is clearly psychotic. Prevention was seen then, as it is now, as the best strategy.

In 1985 Stein and Diamond⁴ addressed the issue of holding outpatients in the community to the same standard of responsibility for their antisocial behavior as any other citizen who commits a crime. Emphasizing personal responsibility and opining that calling the police is not a substitute for treatment, they concluded that law enforcement can be appropriate and clinically useful for certain patients and behaviors. They were also describing misdemeanors committed while not in the actively psychotic phases of illness, and which likely would result in no more than a few days in the county jail.

The second known published report of arresting an inpatient came seven years after the first. Phelan and colleagues⁵ noted that the question of whether to prosecute created a split among staff. In this instance, the nurse assault victim opted to press charges. The patient offender pled guilty and received probation, a fine, outpatient treatment, and a warning to stay away from the complainant. These authors wrote that if patients were aware that they could be prosecuted for their actions, it may serve to deter future assaults. The authors questioned whether there may be a duty to report serious assaults.

Gutheil⁶ responded forthwith in opposition to these suggestions with a strongly worded letter to the editor. His central points were (1) that such action was a subversion of the treatment alliance, with the possibility that the use of criminal law processes may render the patient untreatable; and (2) that arrest may well be seen as resulting from a negative countertransference and invite a reciprocal response from the patient. He was especially critical of any duty to report.

The original authors countered that staff must feel secure and concerns for safety must, at times, take precedence, i.e., treatment alliances may have to be temporarily subordinated.⁷ Although clearly not the answer to all or most hospital violence, prosecution could nonetheless be therapeutically appropriate in setting limits, legally appropriate in bringing the matter to the attention of the public, and morally appropriate in that the injurious act would result in just consequences.

Without giving any statistics or reporting any cases, Engel and Marsh⁸ contributed a very critical element to this discussion. Calling the risk of being hurt by a patient an "occupational health hazard" for psychiatric staff, they advocated more programs such as their own, which respond to injured employees as victims, as would be the case with other crimes. The psychopathology resulting from staff assault could vary from short-term trauma to a full post-traumatic stress disorder, particularly where the staff members return to care for their attackers. Interestingly, only

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one victim in their report considered arrest. These authors also recommend that patient behavior not routinely be excused.

In 1987 13 cases of inpatient arrest were added to the literature. Hoge and Gutheil⁹ collected and described nine cases from five public hospitals wherein staff brought charges against patients who had assaulted them. The patients were categorized as either decompensating, intentionally assaultive, or unexpectedly assaultive. Two in the series were said to have benefited from this "final therapeutic maneuver," and both were classified as decompensating. All other outcomes were "adverse": the perpetrators were either lost to follow-up or their clinical course was unaffected. In most instances the legal system was reluctantly receptive. In five cases staff members were satisfied, feeling that they had appropriately asserted themselves with extremely difficult patients. The authors cautioned that clinical measures should always be the first line of defense, and concluded that prosecution is a rare event that can serve either constructive or destructive ends.

Miller and Maier¹⁰ reported four cases, one of which actually involved several patients, where "selective prosecution" was used as a last resort. They consider two arrests to have been beneficial to the treatment process. Potential gains may include assisting patients to accept responsibility for their own behavior, deterring future aggression, assisting staff to feel protected and thereby increasing willingness to work with difficult patients, and improving reality

testing, i.e., patient behavior as against societal expectations. The option of arrest was seen as a necessary tool, with the decision to be made on such factors as clinical condition, probable outcome, and impact on patients and staff. The authors urged caution so as not to excuse or protect character-disordered behavior, the consequences of which should be clear.

In response to these two articles, Perlman¹¹ added that the delays occasioned by right-to-refuse-treatment litigation placed the staff at unnecessary risk. He urged that data registries be kept and that the public be advised that prosecution could be an act on behalf of proper treatment.

Three more recent publications (and a panel at the 1992 AAPL meeting) have focused renewed attention on the prosecution of patients, sharply clarifying the conflicts that this creates. Norko *et al.*¹² added one more clinical case example of an assaultive insanity acquittee who ultimately received a two-year sentence for two of his acts and was found to be better behaved upon his return to the forensic psychiatric facility. They point out that the law does not stop at the hospital door, and that even if arrest and prosecution are not therapeutic, there may be societal justification. Further, there are risks to the avoidance of legal action.

In summarizing the literature, Norko and associates list the arguments in support of prosecution of patients. Prosecution encourages patient responsibility, serves as reality therapy by limit-setting, improves staff morale and ability to treat such patients, deters violent behavior,

allows public scrutiny of institutions, and may be a just consequence of behavior. Opposing views include that prosecution subverts therapeutic alliance, invites countersuit by patients, is an acting-out of countertransference, is impractical, scapegoats patients, may permanently alienate patients from treatment, and may violate confidentiality. They go on to offer a five-step guideline for determining the appropriateness of patient prosecution:

1. Every psychiatric hospital should clearly present patient rights and responsibilities to individuals upon admission.

2. The criteria for pursuing prosecution should be established as a matter of hospital policy.

3. Violent incidents by patients should be reviewed by clinicians not involved with their treatment.

4. The findings of the screening evaluation should be reviewed by the hospital administration and clinical director.

5. When the decision is made to go forward with the complaint, the treatment staff should not be responsible for filing the criminal complaint.

Appelbaum and Appelbaum¹³ present a model hospital policy for prosecuting patients, which was developed at Worcester State Hospital, Worcester, Mass. It is linked to a 16-step procedure for implementation. Individuals to whom this policy may best apply are nonpsychotic patients engaging in deliberate criminal activity and assaultive patients who have an unusually high risk for inflicting serious injury. The policy was subject to immediate criticism on

five counts: the incompatibility of the roles of treater and accuser; that retributive factors cannot justify patient prosecution; breach of confidentiality; potential lack of objectivity in making these decisions; and "practical" concerns such as alleged reluctance of courts to go forward.

It should come as no surprise that others criticized the proposed policy for its restrictiveness. They argued that prosecution should be allowed for therapeutic reasons, that the hospital should not be constrained from filing charges, and that the procedures are too cumbersome. However, in the first six months after this policy's promulgation, five cases were considered and not one resulted in the filing of charges.

The same authors also provide us with a treatise on the ethical issues involved in determining whether to prosecute patients for violent behaviors.¹⁴ They begin with the traditional justifications for imposing criminal sanctions, which are retribution, deterrence both general and specific, incapacitation, and rehabilitation. As practitioners, we are obligated to the individual patient, to other patients in the facility, to staff, and to society. Justifications and obligations are then interwoven with the well-known ethical principles of beneficence, nonmaleficence, and autonomy.

Appelbaum and Appelbaum find also that most writers would agree that patients can be held responsible for their behavior, but how this is to be determined is less clear. It is suggested that a clinical assessment of the degree to which the patient's behavior is moti-

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vated by mental disorder be made, and that, "The closer the link between psychosis and behavior, the less justifiable prosecution appears to be."¹⁴ Seriousness of the assaultive behavior needs to be factored into the decision-making equation as does the potential for harm to the patient. If all therapeutic interventions have failed, the patient will at least be incapacitated if he can be diverted to the penal system. However, if the disposition will ultimately be unsatisfactory, there appears to be no reason to proceed. Consideration must be given to the effects on other patients, the facility, and its staff, especially if prosecution fails.

Case Reports

Three heretofore unpublished cases of prosecution of inpatients lend support to proponents of such action. The first two are from the author's personal experience.

Case 1 Mr. A was under treatment at a psychiatric intensive care unit in a state hospital. He had been an inpatient on many occasions, often for long periods of time. The index admission was several years in duration, during which he was repeatedly assaultive toward both patients and staff. He remained overtly psychotic, with florid delusions. Trials of several medications in high doses, seclusion, restraint, and behavior modification, were unsuccessful. On one occasion he punched the ward psychologist in the mouth immediately after telling him how much he liked him. Permission was obtained from the Department of Mental Hygiene in Albany to process his

transfer to a correctional institution. This procedure was time-consuming and was then under (ultimately successful) attack in the courts on constitutional grounds. Before the transfer could be effected, another major incident occurred during a recreational excursion off premises. Without provocation, Mr. A. punched an aide in the face, resulting in the loss of his eye.

The patient remained continuously in seclusion while the staff considered what to do. It was concluded that there was no other choice; all other options except arrest had been exhausted. Arresting Mr. A. was designed to transfer him into the maximum security correctional facility immediately. This event took place on December 4, 1970. The staff continued to follow the patient through the legal system.

It was clear that his attorney viewed the matter as a manipulation of the medical and legal systems. Ultimately, it was determined that Mr. A. would maintain his status as a civil patient. He was remanded to the maximum security facility, where he remained for eight years. He was then transferred to a civil state hospital, where he stayed for several more years. No further follow-up is available.

Case 2 Mr. B's circumstances were considerably different. A large man with extreme violent tendencies, he repeatedly tore up welfare offices when his demands for additional benefits were not met. Despite their insistence that he was mentally ill, psychiatric evaluation consistently found that he was personality-disordered and not in need of hos-

pitalization. Following one such incident, the police brought Mr. B. to the hospital and left. He was reluctantly admitted, given the lack of obvious alternatives, with the diagnosis of antisocial personality disorder.

During this admission (1973), the patient, with no provocation, punched an aide, knocking her to the floor. He then stomped on her head while she was lying in the corridor, resulting in permanent neurological damage. Mr. B. remained unremorseful. The aide pressed charges, and he was arrested. Over several succeeding weeks, the legal system attempted to address the issues. First, the district attorney was reluctant to proceed. Then the grand jury hesitated to indict Mr. B. for acting as they presumed a patient would while in a psychiatric hospital. The defense decided to use an insanity plea, although this event was, and perhaps still is, unparalleled in the history of forensic psychiatry in that the defendant was evaluated by a psychiatrist (the author) both a few minutes before and moments after the offense, with the conclusion being that he had antisocial personality disorder and criminal responsibility.

The judge concluded that the patient properly belonged on the very psychiatric ward that had sent him to court. Ultimately no psychiatrist found him lacking in responsibility, and the defense plea-bargained for a four-year sentence. The judge then remanded Mr. B., without the further psychiatric assessment that is required by law, to a hospital for the "criminally insane" to be treated for his "mental illness" for the duration of

his sentence. He remained there for several years at least; no further follow-up information is available.

Case 3 Details of this case study of Peter Lancaster are taken from published appellate court decisions, and so are a matter of public record.¹⁵

On October 21, 1984, Mr. Lancaster was a patient at a state hospital pursuant to an insanity acquittal for a crime unrelated to the instant matter. According to grand jury minutes, he entered the room of a fellow patient after being denied entrance by an attendant who informed him that the man was asleep. He jumped on the bed of this sleeping patient and knocked him to the floor. He proceeded to punch him repeatedly about the head and face with closed fists. Despite attempts to restrain him, Mr. Lancaster managed to strangle his victim, repeating that he wanted to kill this man. After he was finally subdued, Mr. Lancaster asked to be let go to finish him off because he was a worthless person who deserved to die. The victim of this attack had become cyanotic; blood exuded from his eye and nose.

After arraignment, Mr. Lancaster was found incompetent to stand trial and remanded to a state forensic facility, where he remained for more than five months. During this time, the grand jury heard the case under a special procedure not requiring the presence of the accused if a determination of incompetency had been made. An indictment was returned for attempted murder in the second degree, assault in the second degree, and assault in the third degree. (In New York, murder in the first degree is re-

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served for killing of police or corrections officers acting in the line of duty, or for cases in which the offender is under a previous life sentence.) The grand jury had been aware that Mr. Lancaster was in a mental hospital. However, his attorney moved to dismiss the indictments, arguing that relevant psychiatric history was wrongfully withheld by the prosecutor, and that in particular, nothing was said about a possible insanity defense.

New York's highest court unanimously ruled for the prosecution, and in doing so affirmed a unanimous opinion of the intermediate appellate court. The decision is couched in language pertaining to jury function. A grand jury acts on reasonable cause, and thus there is not the same disclosure obligation in such proceedings as in actual trial. Consideration of a defense of insanity is exclusively within the province of the petit jury. The court noted that defendants found not criminally responsible are not set free, so a trial could not be considered unwarranted prosecution. In fact, the justices went on to conclude that, when evidence suggests mental disease or defect, prosecution is necessary to make such a determination. Then, with factual guilt presupposed, the court can commit a person found not responsible.

The importance to us of this case goes beyond the actual holding. All 12 appellate judges hearing the set of facts concluded quite directly that there was no legal reason not to prosecute a patient for committing a crime while hospitalized, even when he was under an insan-

ity acquittal. The question was not raised; it was apparently a given.

Law and Fact in New York

As in other jurisdictions, New York State Mental Hygiene Law¹⁶ includes a longstanding section mandating that directors of state facilities report to law enforcement officials when it appears that a crime may have been committed on the premises. Although included in a paragraph relating to patient abuse, annotations indicate that, in an informal 1975 opinion, the attorney general stated that this responsibility is not limited to a crime involving abuse or mistreatment. A subsequently enacted section of the law¹⁷ extends this mandate to all organized facilities providing patient care, but it specifies that the crime be committed against a patient.

New York also has an independent entity known as the Commission on Quality of Care for the Mentally Disabled. Created by statute, it reports directly to the governor's office and is charged with the responsibility to independently review, report, and recommend about any aspect of psychiatric care. Attending to the question of reporting crimes to law enforcement agencies, the commission documented widespread noncompliance.¹⁸ Indeed, relative to assaults, they found that for one month in three state hospitals, there were a total of 136 assaults, with 16 characterized as resulting in actual or potential major injury. Only two notifications to police were made. Suggestions for improvement included the establishment of closer working relationships

with local legal authorities, and that the threshold for reporting should be whenever there is "some credible evidence" that a crime may have been committed. Counsel to the Office of Mental Health responded with an internal quality assurance bulletin emphasizing that reporting is not optional, and providing legal definitions, sample agreements with police and the district attorney, and other guidance.

There is little reason to believe that much has changed in this regard in the seven years since the report was issued. According to the chairman of the Commission (C. Sundram, personal communication, June 1992), no statistics are being kept by his agency. Counsel's office in the Office of Mental Health (N. Halleck, personal communication, December 1992) is not gathering any data on this matter either. Both agencies indicated ongoing difficulties in obtaining police and/or prosecutorial assistance in pressing charges against patients. There are a variety of reasons for this, not the least of which is that resources need to be conserved to address the more heinous crimes being committed in the community.

Discussion

Numerous and relevant concerns have been articulated on this delicate subject of arresting patients. There will no doubt continue to be discussion and debate, particularly with regard to the relative importance of one or more of the factors involved in decision-making. The answers will not come easily, and opinions will be based in part on per-

sonal ethics. As we have seen in New York, even if reporting of crimes to appropriate authorities is both legislatively mandated and judicially condoned at the highest level, it is not a matter of routine practice.

Several of the authors cited in this article have made note of the paucity of literature on prosecuting patients. There are a total of 19 such reports, including the three cases added herein. In six of these instances, clinicians felt that there was some observable benefit to the patient. These numbers are much too small to attempt any inference except, perhaps, that treatment is not the only reason for such a highly unusual maneuver as having a patient arrested for in-hospital behavior. It is almost certain that a significant number of cases remain unreported.

Cases 1 and 2 involved assaults upon staff members. Of consequence is the seriousness of the injury, rather than whether the victim is patient or staff. In each of these cases, several operative principles were, and remain, valid. The decisions to proceed with prosecution were made by the clinical team, not by a single individual. It was a last resort, when all other avenues and options had been exhausted. It is essential that all efforts are expended by hospital staff to interface with the legal system to complete the process of transfer and prosecution. Of major importance is that one cannot give up on the patient. Until other clinicians assume responsibility, there remains a duty to the patient, especially if he or she requires medication.

Consideration must also be given to

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the stigma attendant to criminal behavior and mental illness. Both conditions are looked down upon by large segments of society. Unfortunately, they are also often linked in the minds of laypersons. It is commonly thought that psychiatric patients "get away with" antisocial behavior by virtue of their patienthood, and this does not inure to the benefit of the mentally ill. Possibly, if appropriate prosecution of patients for assaultive acts was pursued and publicized, there would be a wider separation of illness and violence. More aptly put, a better distinction could be made between "mad" and "bad."

Many patients have histories of both hospitalization and incarceration. In a correctional facility, violence is perhaps a fact of life, but it does not go unpunished. Why then should predatory behavior, with similar motivation but absent illness factors, be accepted in a hospital? Patients are people. They are at various times part of one or another system, and are always part of society. Treatment should be provided with this in mind. The option of responding to significant violence by a psychiatric inpatient with arrest and prosecution must be available as a measure of last resort utilizing the principles and criteria presented.

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