The McQuillan Decision: Civil Rights for the Mentally Ill Offender

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In 1974, the Michigan Supreme Court handed down a decision in the case of *People v. McQuillan.*[1] That decision, in combination with the new Michigan Mental Health Code,[2] drastically changed the fate of patients who previously had been committed to the Department of Mental Health after they had been found not guilty by reason of insanity. This precedent-setting decision had great effects on patients, mental health personnel, courts and attorneys. The purpose of this paper is to review the *McQuillan* decision and discuss its effects.

In Michigan, prior to the *McQuillan* decision, defendants found not guilty by reason of insanity had been automatically committed to the Center for Forensic Psychiatry. At the Center, mental health personnel held a dual role, serving as agents of the court and also providing treatment. Criminally insane patients were held for an indefinite period of time and discharged only after they had been thoroughly evaluated by a committee of clinicians and had successfully completed a program of graduated responsibility in the community. Some patients had been housed at the Center for seven years – the entire period of the Center's existence. Although their situations had been periodically reviewed, clinicians responsible for the welfare of these patients felt that they were either mentally ill or dangerous, or both.

The *McQuillan* decision arose logically from previous decisions of other courts. In *Baxstrom v. Herold,*[3] Baxstrom, who was serving a sentence in a New York prison, was certified insane by a prison psychiatrist and transferred to Dannemora State Hospital, a mental institution under the jurisdiction of the New York Department of Correction. At the expiration of his prison sentence, he was civilly committed and his custody was transferred from the Department of Correction to the Department of Mental Hygiene. However, he remained at the Dannemora State Hospital. He challenged this procedure by petitioning for a writ of habeas corpus. In a unanimous opinion, the United States Supreme Court held that Baxstrom had been denied equal protection since he had not been given the opportunity to have the jury review of initial commitment which was available to other persons who were civilly committed. He was also denied equal protection by his commitment to an institution under the control of the Department of Correction without the judicial determination of dangerousness required

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before other civilly committed persons could be placed in such an institution. The Supreme Court's decision in *Specht v. Patterson*[4] carries the procedural safeguards allowed the mentally ill criminal offender one step further. It spells out the due process rights of criminal patients. Namely, a criminal defendant at a commitment hearing must be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and have the right to offer evidence of his own. There must also be findings made which are sufficient to make meaningful any review available. However. the court in *Ragsdale v. Overholser*[5] held that a verdict of not guilty by reason of insanity allows the state to commit the defendant for the period of time reasonably necessary to determine whether he is still mentally ill and whether he will be dangerous to society if he is released.

In *Bolton v. Harris,*[6] Bolton appealed a denial of a habeas corpus petition requesting his release from St. Elizabeth's Hospital, attacking the mandatory commitment provisions of the District of Columbia Code requiring that after a successful voluntary plea of not guilty by reason of insanity, the defendant must be committed. Bolton was tried in August, 1966, on charges of stealing a car in June, 1965. He admitted the act but was acquitted by reason of insanity and committed. Three months later, he brought a habeas corpus action alleging that although mentally ill at the time of the theft, he was no longer mentally ill, having been successfully treated in the interim for five months at Rockland State Hospital in New York.

In his opinion, Judge Bazelon noted that criminal conduct could not be deemed sufficient justification for substantial differences between the procedures and requirements for civil and criminal commitment, and that a writ of habeas corpus could no longer be thought to afford adequate protection against unwarranted detention. He determined that after acquittal by reason of insanity, there was a need for a new finding of fact about whether the patient now met the requirement for civil commitment. The initial trial had determined only that there was reasonable doubt about the defendant's sanity in the past. According to Judge Bazelon, present commitment is predicated on the finding of present insanity. The practical effect of this case was that although the court found that automatic commitment for the purpose of determining whether the defendant is presently mentally ill and dangerous is permissible, defendants found not guilty by reason of insanity must be given a judicial hearing with procedures similar to those followed in civil commitment hearings before they may be indefinitely committed.

The defendant in *Jackson v. Indiana*[7] was found to be incompetent to stand trial and was committed to a mental institution until such time that he be certified as sane. However, the Indiana commitment statute made no provision for periodic review of his mental condition by the court or mental health authorities. Furthermore, there was no evidence that Jackson would ever be sane enough to stand trial, so his commitment was permanent in effect. The United States Supreme Court, in reviewing this case, stated:

> [W]e cannot conclude that pending criminal charges provide a greater

justification for different treatment than conviction and sentence. Consequently, we hold that by subjecting Jackson to a more lenient commitment standard and to a more stringent standard of release than those generally applicable to all others not charged with offenses, and by thus condemning him in effect to permanent institutionalization without the showing required for commitment or the opportunity for release afforded by § 22-1209 or § 22-1907, Indiana deprived petitioner of equal protection of the laws under the Fourteenth Amendment.[8]

The *McQuillan* decision is of national interest as it provides an additional link in the chain of cases which interpret the state's rights and limitations in the involuntary confinement of the mentally ill offender. In deciding the *McQuillan* case, the Michigan Supreme Court delineated the central legal question involved:

> The major issue in this case is whether the automatic commitment statute . . . is unconstitutional in that automatic commitment deprives one found not guilty by reason of insanity of (1) due process by lack of a hearing on present sanity before commitment or within a reasonable time thereafter and/or (2) equal protection of the laws by not providing similar commitment and release procedures found in other (*e.g.* civil) commitment proceedings.[9]

The defendant in that case, James McQuillan, was charged with assault with intent to rape and indecent liberties in connection with a sexual attack on a minor female. The trial judge initially ordered the defendant committed to the Center for Forensic Psychiatry for a competency evaluation. After such an evaluation, the defendant was found to be competent to stand trial. In a subsequent trial, he was adjudicated not guilty by reason of insanity. He was then automatically committed for an indeterminate period of time to the Department of Mental Health and was confined in a state hospital for the criminally insane. He remained there for two years without evaluation or recommendation for release by the Center for Forensic Psychiatry. In March, 1972, the defendant filed what was called a "Delayed Motion to Vacate Commitment Order" with the Circuit Court trial judge.

After oral argument, that judge vacated the commitment order. In his opinion, he explained that the automatic commitment statute was constitutionally deficient in failing to provide substantially equal treatment in terms of commitment and release procedures to those committed criminally as was accorded to those committed civilly. The trial judge then sought to fashion a proceeding according such protection to the defendant. A new sanity hearing was held, McQuillan was adjudicated sane and discharged from the custody of the Department of Mental Health. The prosecution appealed the granting of the defendant's motion to vacate the original commitment order and the judge's subsequent finding of sanity. The Court of Appeals was bypassed and the appeal was heard directly in the Michigan Supreme Court.

In the majority opinion, the Supreme Court addressed four major issues. The first concerned whether a circuit court, upon motion, has jurisdiction to

review the constitutionality of the commitment of a defendant found not guilty by reason of insanity made by it almost two years beforehand. The prosecution contended that the original trial court, which was in Wayne County, did not have jurisdiction to consider the motion because it was, in substance, a habeas corpus action, proper venue for which would be in the county of detention, Ionia. The Supreme Court held that it did. The second issue considered was whether the automatic commitment statute denied equal protection and due process under the Fourteenth Amendment by providing for automatic temporary detention. The Court weighed the public's right to be protected from possibly dangerous mentally ill persons against the individual defendant's right to be protected against unjustified detention. The Court decided that the statute was constitutional by construing it to call only for temporary detention for the period of time necessary to evaluate a defendant's *present* mental condition. The Court then set forth sixty days as a reasonable period of time for such an examination. The third matter discussed by the Court concerned whether a defendant must have notice and a hearing on present mental condition after the conclusion of such an examination. The Court held that a defendant found not guilty by reason of insanity was entitled to a sanity hearing after the completion of a sixty-day period of observation and examination. The Court also mandated that the hearing be identical with the usual civil commitment proceedings. Lastly, the Court turned its attention to release procedures and concluded that a defendant who was rightfully committed should be accorded the same release procedures as persons who had been committed through civil commitment procedures.

In summary, the Michigan Supreme Court, in its discussion of the *McQuillan* issues, concluded:

> Neither due process nor equal protection prohibit a period of temporary statutory detention for examination and observation of one found not guilty by reason of insanity. However, upon completion of the examination and observation, due process and equal protection require that a defendant found not guilty by reason of insanity must have the benefit of commitment and release provisions equal to those available to those civilly committed.[10]

While this decision had no effect on McQuillan himself, because he had already been released from the Department of Mental Health and had left the state, it was to have extensive effects on the lives of other defendants found not guilty by reason of insanity. The *McQuillan* decision, without specifying procedural guidelines, directed that within sixty days all patients who previously had been found not guilty by reason of insanity must be reexamined to determine their present mental status. If they were still mentally ill, a civil commitment procedure comparable to that used for other patients must be instituted. This decision thereby provided that the defendant who had been found not guilty by reason of insanity must receive notice sufficiently in advance of the commitment hearing, has a right to legal counsel during these proceedings, has the right to be present at these proceedings and has the right to demand a jury. These were the traditional

protections afforded, though infrequently invoked by, the civilly committed.

This decision would prove to be far-reaching. There were approximately two hundred and seventy patients who had been found not guilty by reason of insanity and were still committed to the Department of Mental Health. However, the effects of the *McQuillan* decision were complicated by the fact that Michigan had recently passed a new Mental Health Code. This Code, forward-looking in its intent and obscure in its language, spelled out a whole new series of procedures and safeguards for the involuntary civil commitment of mentally ill patients who were not accused of crimes. The courts, struggling to interpret this Code, were forced to use it prematurely as they reexamined the cases of two hundred and seventy patients who had been previously automatically committed to the Department of Mental Health after having been found not guilty by reason of insanity and were now entitled to a hearing on their civil commitability as a result of the *McQuillan* decision.

The new Mental Health Code was described in its preamble as "[a] n act to modernize, add to, revise, consolidate, and codify the statutes relating to mental health . . ."[11] It addressed itself to the powers and duties of the Department of Mental Health. These included the delineation of state and county fiscal responsibility for public mental health services, the establishment of procedures for civil admission and discharge of both mentally ill and mentally retarded patients, and action on a wide range of other mental health issues. However, the rights of forensically committed patients were not specified.

Of special concern, with reference to the *McQuillan* decision, was that section of the Code which dealt with civil commitment. The *McQuillan* decision ensured that it was to be these civil commitment criteria which would be considered in the reevaluation of the two hundred and seventy criminally committed patients. This section of the Code stated that an individual may be medically certified if he is:

> (a) A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation. (b) A person who is mentally ill, and who as a result of that mental illness is unable to attend to those of his basic physical needs such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.[12]

One of the first difficulties to arise in the implementation of the *McQuillan* decision was clarification of the language of the Mental Health Code; for example, what was to be the definition of mental illness? Three months after the Supreme Court decision, the Department of Mental Health of the State of Michigan defined mental illness as follows: "[a] condition of mental illness exists when there is a substantial disorder of thought, mood, perception, orientation or memory which significantly impairs judgment,

behavior, capacity to recognize reality or ability to cope with the ordinary demands of life."[13] This definition seemed to encompass those mental illnesses which may be categorized as psychotic, severely neurotic or organic and to exclude character disorders. The Department went on to explain that "a condition of mental illness must be identified as the causative factor of potentially harmful behavior."[14] In essence, this indicated that in order to be involuntarily committable, a person must be dangerous *because* of mental illness rather than dangerous *and* mentally ill. Other unresolved linguistic difficulties centered around interpretation of what constitutes "serious injury," "threats," and the temporal interval meant by in "the near future."

After the release of the *McQuillan* decision, administrative and procedural problems became apparent. The first question centered on which court would decide whether a "*McQuillan* patient" was civilly committable after the sixty-day period of evaluation. The next set of questions centered on who would file a petition to initiate that civil commitment proceeding. Problems of confidentiality led to questions about who would examine the patient to see if he were civilly committable. The treating psychiatrist, the administrative ward physician or a specially appointed outside psychiatric consultant were all possible examiners. Then there were additional questions about the scheduling of court appearances, as there was an extreme shortage of personnel. At the time of the decision, seven psychiatrists were responsible for the preliminary and final court hearings on two hundred and seventy patients. These patients were distributed over forty counties. Furthermore, it had been mandated that these hearings be held within sixty days. To complicate matters, there had not been provided a standardized form on which the certifying physicians could record their evaluations, opinions and recommendations and thereby make this material available to the courts.

In those first weeks following the *McQuillan* decision, no clear solutions to the many procedural problems emerged. However, many of these eventually were clarified by direct order of the Supreme Court, by statements of the Department of Mental Health or by local administrative personnel. It was decided that the superintendent of the hospital involved would file the initial commitment petition. Because of the confidential relationship existing between therapist and patient, a nontreating physician from that agency would be appointed to evaluate each *McQuillan* patient. An administrative order from the Supreme Court made it clear that the sixty-day diagnostic period laid out in the original decision could be extended because of the practical impossibility of examining and testifying on all patients involved within that period. A specialist was designated to act as a liaison between the Center for Forensic Psychiatry and the probate courts. One of his duties was the prompt scheduling of court appearances. The Department of Mental Health, in conjunction with the Center for Forensic Psychiatry, prepared specialized forms for civil commitment procedures. There was considerable debate concerning each of these procedural matters, but solutions gradually emerged.

The *McQuillan* decision had an extensive effect upon the psychiatric staff who would be involved in these proceedings. The first of many issues that arose for psychiatric personnel was how to perform this specialized

evaluation. The psychiatrist was required by the Supreme Court to read a statement to the patient at the outset of the evaluation indicating the purpose of the examination and informing him or her that the psychiatrist's observations and opinions would be relayed to the court. It also gave the patient an opportunity to refuse to speak with the physician if he or she chose to do so. While it was immediately clear that a standard psychiatric interview would be part of this evaluation, it soon became clear that the patient needed to be questioned in detail about the crime for which he or she had been found guilty by reason of insanity. The patient also had to be extensively questioned about any acts which might be construed as dangerous which he had performed in the past in the community or while institutionalized. It also became necessary to discuss carefully with the patient his or her future plans subsequent to discharge with particular reference to the issue of medication. Additionally, a mental status evaluation was performed with special care to make some determination about the strength of the patient's impulse control, level of anger, insight into his illness and the presence or absence of an active psychotic process. However, apart from the direct interview material, there arose a question about the admissibility of a documented history of previous dangerous behavior. While it was standard clinical practice to review all pertinent records in formulating any sound psychiatric opinion, the legislators and legally trained administrative aides who had drafted the mental health code suggested that the patient should be evaluated on the basis of the interview only without regard to history. A history of past dangerous behavior was held to be of no consequence in evaluating a patient's present psychiatric state and might not be admissible as evidence in the prediction of future dangerousness.

Experienced clinical personnel found this point of view rather clinically naïve and felt that the historical material was truly necessary for the performance of an adequate evaluation. However, at the time of this writing there had been no clear statement from the courts concerning the use of historical data both in the formulation of an opinion and the support of such an opinion by testimony. Another question which concerned psychiatric personnel was the reliability of diagnostic formulation, since, by institutional convention, the patient was to be interviewed by two independent clinicians.

While psychiatric personnel were dealing with these effects of the *McQuillan* decision, they also were having to deal with a change in how they must see themselves and how they were defined by their patients. For the first time, psychiatric personnel felt that they might not be therapists for the patient, but instead might be his adversaries. The vast majority of the patients who would be reexamined pursuant to the *McQuillan* decision saw this process as an avenue to freedom. They felt that any psychiatrist who might suggest that they were mentally ill and/or dangerous was an adversary. Even though care was taken to provide that the psychiatrist doing the evaluation was not the treating physician, psychiatrists in general came to be viewed by the patient population as jailors and custodians contributing to their confinement. Additionally, psychiatrists and other clinical staff members had to answer to themselves profound questions concerning the essence of mental illness, their role in the treatment process, the accuracy of diagnosis and the accuracy of their prediction of dangerousness. Staff

anxiety levels rose, and, although all clinicians handled or denied new issues of transference and countertransference in different individual styles, there was a noticeable turnover in clinical personnel.

The *McQuillan* decision likewise had considerable effects, apart from the legal ones, upon the patient population. The patient population affected by the decision was a nonhomogeneous group which fell into essentially four categories. First, there were those patients who were mentally ill and clearly dangerous to others. An example was a confessed "hit man" who suffered from a chronic thinking disorder which was exacerbated each time he left an institutional setting. The second group of patients were those who were mentally ill but were not clearly dangerous. In this category were many who had been found not guilty by reason of insanity for a variety of misdemeanors such as loitering, crimes against property, etc. The third group of patients were those who were not seen as clearly mentally ill but who were very clearly dangerous. An example here was a patient who suffered from an enduring character disturbance and raped repeatedly when not institutionalized. Lastly, there were those patients who were not mentally ill and were not dangerous but who had been found not guilty by reason of insanity because it seemed expedient and/or kindly to hospitalize these persons rather than send them to jail. The patients in each of these groups responded somewhat differently to the *McQuillan* decision. However, all the patients manifested a significant increase in their level of anxiety. There were increased degrees of acting out. All of these patients had at least been in a stable living situation and had not been in a position of uncertainty about their future. Many of them had been hospitalized for considerable periods of time and lacked stable homes, sustained family relationships or possibilities of employment. For them, the potential of discharge was quite disorganizing. For others who saw themselves as unjustly hospitalized, the possibility that there would be further commitment with a determination of mental illness was viewed as a threat and provoked considerable anger. In this situation, it became necessary for ward personnel to assist patients, not only by answering informational questions such as who would be evaluating them, who would be their counsel, etc., but also by providing some opportunity for the patient to work through his anxiety or anger in the face of uncertainty about an altered life situation.

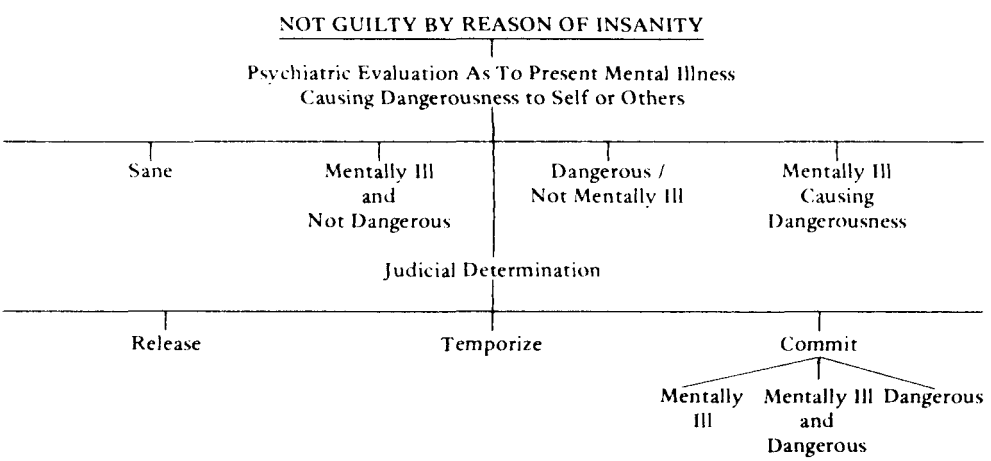
While confusion, concern and anxiety subsequent to the *McQuillan* decision were highly apparent among psychiatric personnel and the patients affected by the decision, the judicial system and court personnel were themselves grappling with difficult problems. No civil commitments under the new Mental Health Code had been held prior to the *McQuillan* decision. Prosecutors, defense attorneys and judges were now confronted with the problem of interpreting and defining a new law in conjunction with dealing with an extremely difficult group of patients.

An illustration of the judicial anxiety rampant during this time was one judge who spent the entire first day of his initial *McQuillan* hearing complaining about mental health professionals, defense attorneys, prosecution attorneys and members of the media. At the end of the day, he confessed from the bench in open court his own anxieties concerning dealing with this volatile combination. He subsequently disqualified himself

from conducting the hearing. Attorneys again faced the question of whether or not a civil commitment of a mentally ill offender should be conducted as a civil proceeding or as a criminal trial. The possibility of involuntary detention of a client has always led some attorneys to view commitment as a hybrid procedure. This situation raises questions about whether the patient-defendant can be compelled to testify against himself, the rules of evidence to be followed and the other procedural issues. Additionally, attorneys, along with psychiatrists, were confronting the issues of how one proves mental illness, how one substantiates the prediction of dangerousness and what is the accuracy of such a prediction. It is not surprising that with the welter of legal and psychiatric questions, jurors themselves found decision-making difficult. It was not uncommon to have a jury in a civil commitment procedure return a verdict of "guilty" rather than "mentally ill" or "committable."

Despite the profound effects of the *McQuillan* decision and the numerous legal and psychiatric questions that it raised, virtually all of the two hundred and seventy initial patients found not guilty by reason of insanity have since been reevaluated. The decisions regarding the future of these patients may be categorized into three major areas: a judicial decision to temporize, a clear commitment of that patient or a clear release of that patient. (See Figure 1.)

FIGURE 1



Concerning a judicial decision to temporize, it was noted that this strategy was used primarily in the early months subsequent to the *McQuillan* decision. In these months, all parties to the hearings were confused as to how the hearings should be handled. A variety of strategies existed if the court, prosecution or defense was unclear how to proceed in a commitment hearing, or was unwilling to do so. For example, some patients were required by the court to be examined by three psychiatrists, even though the law asks for only one psychiatric opinion. In another situation, a judge, prosecuting attorney and a psychiatrist all, for a variety of personal or technical reasons, disqualified themselves from the proceedings, stretching that hearing on for six months. However, as the courts became more familiar with the new Mental Health Code and there was a clarification of not only the procedures,

but of the language of the Code, the hearings proceeded in more expeditious fashion.

Some of the patients involved were clearly committed to the hospital for continuing treatment. In some cases these commitments were valid as the patients were indeed seriously mentally ill and dangerous. However, in others, although psychiatric testimony was received by the court and that testimony indicated that the patient was no longer mentally ill or dangerous, patients were recommitted because of a variety of community pressures, including adverse press and political pressure. In some other situations, judges and/or juries disregarded the Department of Mental Health's definition of mental illness and concluded that mental illness could be construed to include what are commonly called personality or character disorders as well as psychotic conditions. Lastly, there were a series of patients no longer mentally ill but seen as dangerous, and for that reason alone they were recommitted to the hospital

While there was considerable variability among those patients clearly committed, there was similar variability among those patients clearly discharged. Some of those validly discharged were patients who were no longer mentally ill or dangerous but who had been held in the hospital so that they might be gradually, rather than precipitously, released into the community. Their discharge had been in process prior to the *McQuillan* decision, they had usually been on extended leaves of absence from the hospital, and they were in the process of readjusting to the community and establishing connections with community agencies for follow-up care. Some of the clear discharges were ill-advised. The most bizarre and frightening example was a patient who had admitted, prior to his hospitalization, numerous murders in the community. Psychiatric testimony at the commitment hearing indicated that this patient was severely mentally ill and dangerous. The jury disregarded this testimony and discharged the patient. The press polled the jury and found that they believed the psychiatrist but thought the prosecution presented inadequate evidence, feeling that one psychiatrist was not enough. Unfortunately, this patient was charged with another brutal murder within a brief period of time after his discharge. This incident generated considerable adverse community reaction and extensive discussion in the media of many of the issues raised by the *McQuillan* decision.

As a direct result of this decision and the public discussions of the psychiatric and legal issues involved, we have seen two new statutes emerge. Both of these laws reflect a conservative and perhaps regressive change in mental health legislation. The first statute defines mental illness *in law* as "a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or cope with the ordinary demands of life."[15] This *statutory* definition will, we hope, provide more consistency in legal determinations of mental illness. However, this law, in a much more conservative fashion, amends the Mental Health Code's criteria for involuntary commitment. In an attempt to facilitate such commitment, it allows court-ordered hospitalization of mentally ill persons whose judgment is so impaired as to render them unable to recognize the need for treatment. The second statute lays out the tests and procedures for the

insanity defense.[16] This law requires that any defendant filing an intent to plead not guilty by reason of insanity *must* be examined by the Center for Forensic Psychiatry in reference to exculpability. In an effort to reduce "inappropriate" not guilty by reason of insanity verdicts, the law stipulates that should a defendant not cooperate with this examination, all testimony relating to insanity shall be barred from the trial. The law also indicates that three determinations are to be made by the examining clinician in determining criminal responsibility: (1) Was the defendant, at the time of his alleged act, mentally ill? (2) If the defendant was mentally ill, was he *as a direct result* of that mental illness lacking substantial capacity to appreciate the criminality of his conduct? (3) As a direct result of that mental illness, did he lack substantial capacity to conform his conduct to the requirements of the law? This is the test laid out in the American Law Institute's Model Penal Code. A companion statute sets up procedures for trial in which the jurors are instructed, prior to hearing expert testimony, about what they will have to consider.[17] The jurors are informed that they will have to look separately at the issues of mental illness and responsibility. At the end of the trial, when the jury is charged, they are to be told that they must consider (a) whether the defendant committed the crime, (b) whether he was mentally ill, and (c) whether he was irresponsible. If a jury finds all three, the patient will be found not guilty by reason of insanity. However, a new verdict is now available to jurors, that of "guilty but mentally ill."[18] The jury may return this verdict if they find that the defendant committed the crime and is mentally ill, but that the crime is not the result of the illness. After such a verdict, the court imposes a sentence. The defendant will then be treated for his illness within the mental health system. However, upon discharge, he will be returned to Corrections for the balance of the sentence.

The *McQuillan* decision has had a profound effect upon legal thinking in the area of mental health. It has raised complex questions concerning the definition of mental illness, the reliability of diagnostic formulation and the ability of psychiatrists to reliably predict dangerousness. The *McQuillan* decision has also had an extensive effect on mental health personnel. They have been discouraged by long and arduous hearings, problems with the transference reactions of the patients involved, and the need to become expert, not only in psychiatric matters, but in legal matters as well. We have seen only the initial returns with respect to the effects of the *McQuillan* decision. It is clear that this finding will have far-reaching implications that are yet to emerge and will have long-lasting consequences.

The *McQuillan* decision and the new Mental Health Code are now over two years old. The decision stands and the Mental Health Code is being extensively revised. The body of this paper has discussed the problems which these two important changes have presented to patients, mental health workers and courts. The acuteness of the situation has been alleviated; now the chronic problems and questions remain. These remaining questions are, indeed, the more thorny issues which explore the interaction of psychiatry and law.

References

1. 392 Mich. 511, 221 N.W. 2d 569 (1974)
2. Mich. Comp. Laws § 330.1001-.2106 (Mich Stat. Ann. § 14.800 (1)-(1106) (Callaghan 1976))

3. 383 U.S. 107, 86 S. Ct. 760, 15 L. Ed. 2d 620 (1966)
4. 386 U.S. 605, 87 S. Ct. 1209, 18 L. Ed. 2d 326 (1967)
5. 281 F.2d 943, 948 (D.C. Cir., 1960)
6. 395 F.2d 642, 652 (D.C. Cir., 1968)
7. 406 U.S. 715, 92 S. Ct. 1845, 32 L. Ed. 2d 435 (1972)
8. *Id.* at 729-30, 92 S. Ct. at 1854, 32 L. Ed. 2d at 446
9. 392 Mich. at 518, 221 N.W. 2d at 572
10. 392 Mich. at 546-47, 221 N.W. 2d at 586
11. Preamble, Mich. Comp. Laws § 330.1001-.2106 (Mich. Stat. Ann. § 14.800 (1)-(1106) (Callaghan 1976))
12. Mich. Comp. Laws § 330.1401 (Mich. Stat. Ann. § 14.800 (401) (Callaghan 1976)). In 1975, a new section was added to the statute:

    (c) A person who is mentally ill, whose judgment is so impaired that he is unable to understand his need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to himself or others. This person shall be hospitalized only under the provisions of sections 434 through 438 of this act.
13. Memorandum, Michigan Department of Mental Health, Dec., 1974
14. *Id.*
15. Mich. Comp. Laws § 330.1400a (Mich. Stat. Ann. § 14.800 (400a) (Callaghan 1976))
16. Mich. Comp. Laws § 768.20a (Mich. Stat. Ann. § 28.1043 (1) (Callaghan Supp. 1976))
17. Mich. Comp. Laws § 768.29a (Mich. Stat. Ann. § 28.1052 (1) (Callaghan Supp. 1976))
18. Mich. Comp. Laws § 768.36 (Mich. Stat. Ann. § 28.1059 (Callaghan Supp. 1976)). Judge Susan Borman of the Recorder's Court for the City of Detroit in *People v. McLeod,* Recorder's Ct. No. 76-01672 (1976), has held that this verdict is a nullity. She found that the provision of the statute which requires that persons found guilty but mentally ill be treated for their illness was legally inert "because the state did not have adequate treatment facilities."