

Mentally Ill Persons Who Commit Crimes: Punishment or Treatment?

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In many countries, there continue to be conflicting opinions and mechanisms regarding the appropriateness of treatment and/or punishment for mentally ill individuals who commit crimes. The general population is concerned with public safety and often finds it difficult to accept the possibility that a mentally ill individual who commits a crime can be hospitalized and eventually discharged, sometimes after a relatively short time. In most countries the options of incarceration and hospitalization are available in concert. In some, incarceration occurs before hospitalization. In others, hospitalization is first, followed by a prison term. An additional option could be "treatment years." The court would determine the number of years of treatment required, according to the crime. This dilemma has no unequivocal solution. The goal is to reach a balance between the right of the patient to treatment and the responsibility of the courts to ensure public safety.

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Should mentally ill individuals who commit crimes be referred to psychiatric treatment or should they be punished? In recent years, there has been increased awareness of patients' rights, integration of mentally ill individuals into the community, reduction of duration of hospitalization and of psychiatric hospital beds, and more ambulatory services.¹ However, rights entail corresponding civil obligations and responsibility for one's actions.² The public is concerned with safety and often finds it difficult to accept the possibility that a mentally ill individual who commits a crime (sometimes a serious crime) can be hospitalized and eventually discharged, sometimes after a relatively short time.

Although this outcome may be legally possible if the mental state of the patient has improved, potential danger and threats to public safety remain primary concerns. There is no easy solution to this dilemma. The question of future risk can tip the scales in the direction of not releasing the patient from responsibility because of mental illness, even in situations when it might be appropriate. There are certainly cases in which a mentally ill individual who commits a crime is sent to prison. For example, in

1999, a patient with a history of schizophrenia pushed a woman he had never met onto the New York City subway tracks in front of an oncoming train, causing her death. Previously, he had been discharged from the hospital against his will. The jurors determined that he was mentally ill but guilty, because he understood the nature and meaning of his actions and because he told the police that he knew his actions were wrong.³

In many countries, there is an increase in the rate of court-ordered hospitalizations of mentally ill individuals who commit crimes. There is a trend toward criminalization of compulsory hospitalization: more court-ordered admissions and fewer hospitalizations for medical reasons. This situation is apparently the outcome of overcautiousness in the civilian process of involuntary commitment in response to increased awareness of patients' rights.

In Israel, the regional psychiatrists (who are responsible for civil commitment decisions in a designated district)⁴ seem to have become more lenient and do not issue commitment orders for patients whose actions may have warranted involuntary hospitalization in the past. Psychiatric committees are now also more apt to release involuntarily committed patients who appeal their confinement. Thus, some mentally ill individuals who do not receive appropriate treatment may eventually commit crimes that lead to involuntary hospitalization by court ruling.⁵ For example, cases of domestic aggression that previ-

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ously resulted in involuntary hospitalization, as per commitment order by the regional psychiatrist, may now be referred to the police and result in compulsory court-ordered hospitalization.

The Forensic System in Europe

The responsibility for forensic services differs among countries. It may be handled by the Justice Department (e.g., Greece, Italy, and Portugal), or by the Health Department (e.g., England and Germany), or there may be joint responsibility for forensic services (e.g., Belgium). In all countries, there is a consensus that the law relates to mentally ill individuals who have schizophrenia and other psychotic disorders.

There are countries that have a dichotomous, all or none, view of criminal responsibility, such as Austria and Israel. However, most countries have a graduated view that leads to partial responsibility and/or reduced punishment or treatment.

In all countries, the suspect has the right to an attorney, even if legal representation is contrary to the will of the accused. The courts are extremely cautious with regard to the prospect of the mentally ill representing themselves. In most countries, the cost of the attorney is covered by the department of justice, and the accused is not required to participate physically in the trial, though he or she must appear in court for the verdict.

In the case of incompetence to stand trial, most countries would suspend the trial. If the accused was ill when the crime was committed and is currently ill, in all countries, the patient would be sent to the hospital for treatment. The danger to public safety and illness-related threats become considerations when the patient was ill when the crime was committed, but is not currently ill.

Treatment or Punishment

That there are many mentally ill individuals in the prisons (including those incarcerated under circumstances like the New York case described earlier) raises the question of whether indeed it is a desirable situation.⁶ Today, there is more emphasis placed on the examination of the relationship between the crime and psychotic content. There is no longer an automatic exemption from responsibility for a criminal who has a chronic psychiatric illness such as schizophrenia.

This more focused approach does not necessarily mean that more patients will find themselves behind bars.⁷ In addition, the option of partial responsibility in some countries leads to some prison time. In most countries, the options of incarceration and hospitalization are available in concert. In some, incarceration occurs before hospitalization. In others, hospitalization is first, followed by a prison term. In effect, this attitude can be described as a treatment/punishment ruling that integrates both concerns and contributes to public safety.

In the United States, the concept of guilty but mentally ill began in Michigan in 1975 and gained momentum following the *United States v. Hinckley* trial (1982).⁸ Many states added this option to the insanity defense and did not abolish it. This verdict leads to a double stigma, and more prison time, because it implies that the accused committed the crime, was aware of the wrongfulness of the crime, but had a mental disorder that interfered with compliance with the law. This course was intended to be intermediary, but it did not reduce the number of rulings of not guilty by reason of insanity. A more severe course of punishment was created—one with no limitation on punishment, including the death penalty. The emphasis is on punishment and consideration of public safety and not psychiatric treatment in prison.⁹

Guilty but mentally ill is not a defense, but rather a court ruling that the individual is guilty and a candidate for punishment. The emphasis is on punishment and consideration of public safety and not psychiatric treatment. The discussion focuses on duration of hospitalization.

The common denominator between the treatment model and the punitive model is the concern for public safety and prevention of repeated endangerment. Repeat evaluations during hospitalization are necessary. In most countries standard risk assessment is performed with the PCL-R (Psychopathy Checklist-Revised) and HCR-20 (Historical Clinical Risk-20).¹⁰ Re-evaluation is generally performed every six months; however, there are countries that re-evaluate only once a year or even less frequently.

In Israel, the issue is deliberated in the Supreme Court, though from a different vantage point.¹¹ In a case in which the patient was hospitalized by court order for many years because his mental state did not improve, but the period of hospitalization by court order was based on a nonserious crime (theft of a

bicycle), The Honorable Judge Barak ruled that the duration of hospitalization should not be longer than a prison sentence would have been for the identical crime. In the event that the patient's condition would require additional treatment, he would be transferred to the civilian course of treatment.¹²

In this case, it seems that the intentions of the Court concerned allocation of responsibility, since the ruling mandates the maximum, not the minimum, duration of treatment. Throughout the years, the pendulum has swung between punishment and treatment, between complete exemption from responsibility and limiting the insanity defense. For example, the insanity defense has been partially abolished in five of the United States (Montana, Utah, Idaho, Kansas, and Nevada); however, testimony regarding mental state is still permitted and *mens rea* must still be proved.¹³

Combination of the Treatment and Punitive Positions

How, then, can the matter of treatment versus punishment be settled—the right of the patient to be treated versus the right of the public to be protected? Medically, there is room for the narrow approach when there is clear evidence that the crime is directly related to the illness. Discharge should be determined by a legal committee or by the courts, as is done in many countries. In England, for example, according to the Mental Health Act of 1983, the patient under court order is discharged as per medical decision by the physician, unless there is a restriction order, which can be declared by the Crown Court for a patient who has committed a serious crime. Discharge is then handled by the Psychiatric Committee, not the treating physician.

However, this could create a situation in which a person who is no longer psychotic would have to remain in the hospital because the legal committee did not release him. The question then arises concerning whether the hospital is the appropriate place for that individual and whether public safety is the only question at hand. The dilemma is raised of how to treat a patient (who committed a crime and was found not responsible for his actions) after his recovery from the psychotic state, to prevent mental relapse with danger to the public. In many countries, there is no legal recourse for prevention, a subject that may necessitate legislation. If the individual is no longer ill, but is still dangerous, should he or she

remain in the hospital or be transferred to a nonmedical incarceration facility? The opinions are divided, although many believe hospitalization is most appropriate, since the core of the problem is the illness.

Administratively, there is an option for mandatory conditional discharge and/or compulsory ambulatory care following every court-ordered hospitalization. This option would allow for closer follow-up and would enable rehospitalization in the event of deterioration of the mental state that could create a risk based on prior proven dangerousness. Discharge and transfer to the community should be gradual. After prolonged hospitalization in a closed ward, the patient needs assistance and close supervision for a designated period. The aim is to assist the patient when necessary and to protect the public. In a few countries, such as Germany and The Netherlands, discharge is always conditional, and thus appropriate community outpatient facilities are needed that are not available in all countries.

An additional option could be “treatment years.” The court would determine the number of years of treatment required, according to the severity of the crime and the risk to public safety. The treatment setting would be determined by medical professionals in accord with the decision of a psychiatric committee, under court supervision when necessary, with the option to appeal. When in a psychotic state, the patient would be hospitalized but would later be a candidate for a rehabilitation program, once his condition improved. He would then be eligible to be transferred to ambulatory care, with the approval of the psychiatric committee. Ambulatory care would be mandatory after discharge, and the frequency of visits and treatment would be determined by the attending physician. Follow-up visits would be required at least monthly for severe crimes. In addition to the regular medical follow-up, legislation would be necessary to enable supervision by a parole officer who would be responsible for enforcing compulsory ambulatory treatment. If the patient's condition were to deteriorate, he would be readmitted based on the original treatment years order, until stabilized. This solution is low in cost, considering that it makes use of existing treatment facilities, with the addition of a parole officer who would have the authority to enlist the help of the police to enforce compulsory treatment when necessary. Guaranteed ongoing treatment is economical and could help avoid exac-

erbatation of the patient's condition and thus reduce the risk of recidivism.

Conclusions

The dilemma of whether to treat or punish has no unequivocal solution. Every option has benefits and disadvantages. These alternatives contribute to the public's peace of mind and to the patient's welfare. In the end, the patient must return to the community. The goal is to reach a balance between the rights of the patient to treatment and the responsibility to ensure public safety. The balance between patients' rights, the right to treatment, and public safety is taken into account with the "treatment years" approach.

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