Book Reviews

Alan R. Rosenberg, Editor

MISUSE OF PSYCHIATRY IN THE CRIMINAL COURTS: COMPETENCY TO STAND TRIAL. Group for the Advancement of Psychiatry. Vol VIII, Report No. 89. New York. Pp. 60. Feb. 1974.

The Group for the Advancement of Psychiatry is an independent organization of 300 psychiatrists whose committees have prepared many studies and reports dealing with psychiatry and society. This report on Competency to Stand Trial is the product of the Committee on Psychiatry and Law; its attitude towards this legal problem is expressed in its selection of title: Misuse of Psychiatry in the Criminal Courts.

Overall, this GAP report is a somewhat brief and sketchy analysis of the problem of competency to stand trial. Nonetheless, it serves in many ways to crystallize the history, the trends in law, and the failures and abuses of the system and spells out specific recommendations; it therefore is a valid reference statement for those interested in the topic and reflects of high-level and knowledgeable psychiatric input.

The report's initial statement conveys our society's increasing distrust of our governmental processes, the law, and decision-making. This particular subject of competency to stand trial is important because, until recently, relatively little attention was directed towards it in the legal and psychiatric literature. Hand in hand with this "low visibility" was a confusion, felt even by lawyers and judges, of the concepts and standards of "competency" and "responsibility." The massive literature on the latter concept has indeed been a curious phenomenon in view of the much greater frequency of application of the former. For example, Steadman's and Cocozza's study[1] indicated that in New York, ten times as many men were institutionalized for lack of competency to stand trial as were found NGI (not guilty by reason of insanity).

The GAP report, in portraying the "demeaning and degrading" conditions foistered on the incompetents, demonstrates the hypocrisy in our system and puts some of the burden on American psychiatry, if only for its "passive complicity." I would take some exception to that characterization. If there is a problem, let us deal with it, speak out, communicate, anything! But the trend in this country constantly to blame others or oneself becomes tiresome. Even our unlamented ex-vice president struck a responsive chord (at least in my breast) when he bewailed the "masochism" in American life. Blame attribution contributes little towards solutions (look at our tort system!) and may even be counterproductive to meaningful efforts to restructure social systems in accord with changing times. If a system no longer works, identify the inadequacy and then change it to ensure reasonableness applied to policy determination. But enough of the futility of blame-putting.

Whatever the statistics, certain facts are clear. The incompetent group is large; their handling poor. Many charged with crime have faced permanent or very long-term incarceration on logically specious grounds without treatment and in an abusive environment.

The GAP report discusses the Dusky case,[2] presenting some of the background and of

the court transcript. In that federal case, the U.S. Supreme Court clarified the test for competency to stand trial – namely, whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as a factual understanding of the proceedings against him."

Many problems have arisen as a result of the incompetency review. *Pate v. Robinson*[3] allowed parties other than the defense to raise the issue. In some areas of the country, the issue has not been raised because of cost. In some cases, the prosecutor has used incompetency to dispose of cases either appropriately or for strategic reasons. In others the concept has been used punitively, to deny bail, or as an alternative to civil commitment, as occurred in California when new hospitalization laws made civil commitment very difficult. For example, in 1969 the Metropolitan State Hospital received 20 such defendants; in 1970 the number committed as mentally incompetent rose to 600. Many attorneys have had little experience with this concept and so have tended to ignore its possible application.

Apparently, the incompetency issue arises historically from the necessity for a defendant to make a plea: at times the courts were confronted with the problem of the mute defendant. A competent defendant was necessary to safeguard the accuracy of the proceedings, to guarantee a fair trial, to preserve the dignity of the legal process, and to ensure that a guilty defendant knew why he was being punished (in order to make the concept of retribution meaningful).

The standards of competency remain vague and controversial, even though couched in terms of the capacity of the defendant to consult with his attorney and to understand the charges and proceedings against him. The GAP report attempts to specify the psychiatric issues involved in competency valuation. Various psychiatrists have attempted to create formulas for this purpose. These have been expanded by some to consideration of the defendant's abilities to collaborate in trial strategy, to tolerate stress at the trial or while awaiting trial, and to refrain from irrational and unmanageable behavior during the trial.

As has been the case elsewhere, the effort to appraise future behavior is one of questionable psychiatric validity, although GAP feels that in cases of competency such appraisals should be ventured. Such opinions actually bear upon potential incompetency rather than current incapacity, which I feel is a more relevant and appropriate psychiatric consideration. GAP also directs attention to the psychiatrist's "meaningful" collaboration with the individual attorney, rather than with attorneys generally. The GAP members disagreed as to whether the psychiatrist should offer a specific opinion as to legal competency instead of a detailed mental status appraisal as a guideline to the judge. History would seem to indicate that the battle may be more semantic than real.

GAP comments briefly on two fascinating issues: (1) competency appraisal and application of the concept of amnesia, and (2) the use of psychoactive drugs at time of trial. In some cases, defendants have been taken off medication so that they could go to trial in a "pure" state, only to relapse because necessary treatment was denied. It would seem appropriate to provide the dictated medication. One curious case[4] resulted in a reversal of conviction because it was felt that the defendant's demeanor at trial could have been affected to his detriment by drugs; the defendant evidently appeared cool, calm, and detached as he related the details of a gory crime, and aroused a negative reaction in the jury. GAP feels that the judge and both legal counsel should be informed about the use of drugs, the amount, and the possible effect on behavior, and that this information should be admissible at the discretion of the defense attorney. The use of videotaped psychiatric interviews was suggested to portray pre-drug functioning; the GAP report strongly denounced withdrawal of necessary medication.

GAP, in discussing past abuses, makes reference to *Jackson v. Indiana*,[5] which placed a limit on incarceration for incompetency to stand trial. They feel that there should be prompt evaluation before transportation to an institution for the criminally insane and

that referrals for extensive diagnosis and treatment should be resisted unless for a genuine psychiatric need. The use of out-patient facilities, bail, and regular hospitals (for the non-dangerous defendant) is urged. A maximum of six months of confinement for treatment should be allowed, as this period will suffice for most cases for return to court and trial. If there is such gross mental retardation, brain damage, or chronic deteriorated state as to make it likely that the defendant will never regain competency, then charges should be dropped and appropriate civil commitment instituted. If, after six months, the defendant does not fit into either category, the judge should hold a rehearing and, if indicated, grant a six-month extension, after which there should be a disposition in accord with the first two possibilities.

Another possibility (with a serious felony) is the retention of criminal charges and jurisdiction for a prolonged period, guided by the potential penalty as a time limit.

The need for prompt evaluation and treatment should be the prime concern of the psychiatrist, who should take an active role in eliminating the temporal and institutional abuses of the past (though there are matters traditionally subject to limited psychiatric input and power).

An interesting companion piece is the detailed, thorough, and knowledgeable review by Halpern,[6] who also analyzes this very GAP report. It would not be appropriate to review his extended discussion, but I recommend his article to the reader, particularly in view of his plea for elimination of the incompetency issue. He feels that psychiatrists should not participate in the process unless the system is altered. He offers interim guidelines which incorporate many of the GAP recommendations, and he makes the crucial point that competency to proceed, not cure of mental illness, should be the goal of the psychiatrist, so that the defendant may not be denied the right to a speedy trial as well as his other constitutional rights.

Irwin N. Perr, M.D., J.D.

References

1. Steadman H J and Cocozza J J: Careers of the Criminally Insane. Lexington Books, Lexington, Mass. 1974
2. *Dusky v. United States*, 271 F. 2d 385 (8 Circ., 1959); *Dusky v. United States*, 362 U.S. 402 (1960); and *Dusky v. United States*, 295 F. 2d 743 (8 Circ., 1961)
3. *Pate v. Robinson*, 383 U.S. 375 (1966)
4. *State v. Murphy*, 56 Wash. 2d 761, 355 P. 2d 323 (1960)
5. *Jackson v. Indiana*, 406 U.S. 715 (1972)
6. Halpern A L: Use and Misuse of Psychiatry in Competency Examination of Criminal Defendants. Psychiatric Annals, 15 (April, 1975), 8 *et seq.*

MOODSWING – THE THIRD REVOLUTION IN PSYCHIATRY. By Ronald R. Fieve, M.D. New York: William Morrow & Co., Inc. Pp. 263 plus 13 reference. 1975. Bantam paperback $1.95.

It would appear to be the fate of all newly discovered methods of treating human ills to go through a predictable cycle of usage. After a brief pause following the initial publication of a new technique or the results of a new drug, a rapid and accelerating acceptance and popularity occur, spurred on by the avarice of those who make a business out of the treatment of misery and supported by the gullible, the lazy, and the overenthusiastic members of the medical profession. Uncritical therapists needful of results cooperate with their poorly informed and needful patients. "Wonder drugs" become nostrums in a climate of patient expectancy as to what should be prescribed; inappropriate and ineffective therapy therefore continues long after it has been dis-

credited by time and further research. The present mishandling of drugs and other forms of treatment by the medical profession is yet another reason why trust in physicians is being eroded.

Much of the mythology created around treatment modalities is initiated by the so-called "science writer" who frequently disregards the tentative claims of the original clinical researcher and presents the general public with yet another "miracle cure." As in the case of this book, a considerable time usually elapses before a well written and definitive attempt is made by a competent authority to present the facts and fancies in such a manner that the reading public can comprehend the true scope of a form of treatment. Ronald R. Fieve presents us with a book written in language which will be understood both by the general public and by its doctors. He covers a broad field in order to focus on the value of drugs presently in use in manic depressive illness, especially Lithium Carbonate. My personal criticism of his method is that he spends much time in the description of his patient studies, and in descriptions of political and historical madness. In this latter effort he emulates those psychoanalysts whom he criticizes for their attempts to formulate an "understanding" of the behavior of the famous according to traditional psychodynamic terms; he may have entered the same trap.

There will be considerable agreement with Fieve's statement that "mental illness, when it is painful, self-destructive, and harmful to others, should be recognized as such and treated. Other forms of so-called illness often constitute simply what is normal for the culture and should be left alone." Sadness is not depression, nor joy, mania. We do not seem to be able to tolerate sadness, however appropriate, and mourning is treated as weakness or even sickness by many physicians. Hence the popularity of certain well-known anti-depressants and singularly overprescribed medications.

We need the touch of madness to put our sanity in perspective and provide both the drive of the genius and the absurdity of the clown, and this book makes that point loudly and clearly. It is an easily read and wise book which I will be recommending to our medical students, to some of my patients, and to those colleagues whose therapeutic idiosyncrasies might well be modified by their reading of it.

WILLIAM A. WOODRUFF, M.D.
Associate Professor of Psychiatry
College of Medicine
University of Vermont

CAREERS OF THE CRIMINALLY INSANE. By Henry J. Steadman and Joseph J. Cocozza. Lexington, Mass.: Lexington Books, D. C. Heath & Co. Pp. 206 + xix. 1974. Price $14.00

> Statistics which are not really statistics are worse than useless; and the reason is that they beguile the student with a show of knowledge and thus take away the main inducement to further inquiry. Why should he look further for truth when it already lies before him? Some of the prevalent errors respecting insanity and the insane are fairly attributable to these vicious statistics, for figures make a deeper impression on the mind than the most cogent arguments.
>
> — Isaac Ray, 1873

In an address at the AAPL meeting in Atlanta on March 16, 1973, the senior author of *Careers of the Criminally Insane* called for "inter-disciplinary" research and the further development of working relationships among social scientists, psychiatrists, and legal

professionals. What a pity that this approach was ignored in the preparation of *Careers!* With the help of even the fledgling novitiate in correctional psychiatry, Steadman and Cocozza could easily have avoided the horrendous blunders evident in practically every chapter of their book.

They draw two conclusions from several years of analysis of records, questionnaires and direct interviews. The first, "The Baxstrom patients were not very dangerous," is simply a restatement and confirmation of what had been so ably described by Hunt and Wiley seven years earlier at the APA meeting in Detroit.[1] The second, that these not very dangerous patients were inappropriately confined for long periods in hospitals for the criminally insane because psychiatrists, through ignorance, chicanery, callousness or self-interest, erroneously "decided" that the patients *were* very dangerous, is in no way supported by the data presented. Instead of facts, we find throughout the book, with trance-inducing repetition characteristic of the political demagogue, a series of derogatory, disparaging and pejorative references to psychiatry and psychiatrists. We are reminded no less than 110 times of the blatant deficiencies of "psychiatrists," "psychiatry," the "medical model," and the "mental health system" in phrases such as "conservative tendencies of mental health agents" (p. 51), "psychiatry developed a position of power" (p. 8), "transfers to civil hospitals were never approved by psychiatrists" (p. 9), "psychiatrists were reluctant to transfer or release them" (p. xiv), "psychiatric decision-making" (pp. 6, 77, 113, 115, 187), "psychiatric conservatism" (pp. 8, 33, 53, 110, 111), "psychiatrically approved for transfer" (p. 64), "including evidently the psychiatrists responsible for this group of criminally insane patients" (p. 94).

Just who were the Baxstrom patients whose "careers" led the authors to their startling conclusions? The persons who fell under the unanimous 1966 Supreme Court *Baxstrom* decision were those inmates of New York State Department of Correction hospitals for the criminally insane (Dannemora and Matteawan State Hospitals) whose sentences had expired. The true "Baxstrom patient" would logically be the individual who was transferred from such a hospital to a civil state hospital, since without a finding of mental illness and dangerousness after a trial (before a jury if desired by the patient), his continued incarceration would be unconstitutional. The authors chose to include under the term "Baxstrom patient" the following additional groups of patients who were transferred from Matteawan following the 1966 *Baxstrom* decision: defendants who were considered incompetent to stand trial and who had been in Matteawan longer than the maximum sentence for the crime of which they had been accused, and patients with a history of imprisonment who had been transferred from a civil state hospital to Matteawan under a clearly unconstitutional section of the Correction Law which, in fact, had been repealed a year before the *Baxstrom* decision. In all, there were 967 patients in the New York Baxstrom population: 750 time-expired convicts, 175 incompetent defendants and 42 former civil state hospital patients with a record of imprisonment.* Patients from two other categories of "criminally insane" persons, namely, hospitalized patients who had been found "Not Guilty By Reason of Insanity" after a public trial and civil patients transferred to Matteawan after being adjudged dangerously mentally ill, were not included in the Baxstrom patient group.

The sample selected by the authors for special study consisted of 199 Baxstrom patients. These were compared to 312 "pre-Baxstrom patients." The latter "were defined as all those patients transferred from Matteawan and Dannemora to civil mental hospitals in the two years immediately preceding the Baxstrom patient transfers."

The first major flaw in the study is that the Baxstrom sample was not properly selected, since of the 199 patients, 67.3 percent were time-expired mentally ill inmates,

*These figures are approximations only, since the authors strangely failed to report the exact numbers (p. 52), notwithstanding the fact that they had at their disposal accurate information concerning the status of each patient.

while of the 967 original Baxstrom patients, 77.6 percent were time-expired mentally ill convicts, and there is no breakdown given of the percentage of patients in each group who were transferred from Dannemora and Matteawan respectively. The second major flaw is that the pre-Baxstrom population is not a comparable group, since only 40.4 percent of the 312 pre-Baxstrom patients had been time-expired mentally ill convicts, and no less than 53.2 percent of the pre-Baxstrom patients were in the "incompetent to stand trial" category, compared to only 19.6 percent of the Baxstrom patient sample.

The resultant failure to compare the Dannemora Baxstroms with the Dannemora pre-Baxstroms, and the Matteawan time-expired Baxstroms with the Matteawan time-expired pre-Baxstroms, throws into grave question the validity of the authors' findings, since there were very many important differences between the Dannemora and Matteawan patients, not the least of which was the fact that all the Dannemora patients were convicted felons and practically all the Matteawan time-expired patients were convicted misdemeanants.

The third obvious flaw is that, aside from combining the time-expired patients from Dannemora and Matteawan, the authors did not analyze the data for each of the two major groups (i.e., the time-expired mentally ill convict group and the incompetent defendant group) separately, and thus their conclusions, based on a hodgepodge of input, must surely be suspect. For example, including under one figure all the categories of criminally insane persons, they show that 48.2 percent of the Baxstrom patients were black compared to 29.8 percent of the pre-Baxstrom patients, but they are able to defuse the apparent conclusion that racial discrimination was a factor by offering data to indicate that a large number of blacks were in the all-inclusive Baxstrom group not because of discriminatory release or transfer policies but because the admission rate of young blacks had drastically increased. Well, I don't buy it. I believe that no psychiatrist with even minimal Dannemora experience would have failed to detect the factor of rampant racial discrimination influencing the release decisions at that institution. In my visits to Dannemora in the early sixties I saw large numbers of black prisoner-patients but never once a black correctional officer (guard) or black mental health worker, nor did I ever see any but black inmates in restraints or in seclusion rooms. I challenge the authors to re-examine the records of the time-expired patients of Dannemora State Hospital and compare the Baxstrom group with the pre-Baxstrom population. I predict that they would not be able to come up with any explanation other than racial discrimination to account for the differences in the percentages of whites and blacks in each group. While they are at it, they might look over other easily obtained data which could throw light on the question of racial discrimination, such as the death rates of black and white inmates at Dannemora during the pre-Baxstrom period.

The authors go to great lengths to stress that the patients in Dannemora and Matteawan were considered dangerous. They were apparently unaware that mentally ill prison inmates remained at Dannemora as long as they were considered *mentally ill:* dangerousness had nothing to do with it. Had the authors consulted anyone (not necessarily a psychiatrist) who had visited Dannemora even briefly prior to the February 1966 Supreme Court *Baxstrom* decision, they would have obtained convincing information that the large number of over-tranquilized patients, lying on the floor of the massive dayroom, shuffling about or rocking endlessly on heavy wooden chairs, were no more dangerous than the patients in an overcrowded third-rate state hospital anywhere in the country. Unfortunately, Steadman and Cocozza did not avail themselves of the statistical data contained in *Mental Illness, Due Process and the Criminal Defendant*[2], a book from which they drew practically all of their abbreviated history of Dannemora and Matteawan State Hospitals. They would have found that the Dannemora staff, who according to them were so conservative and prone to overprediction of dangerousness, had recommended 222 patients for transfer as of May, 1965, almost a year prior to the *Baxstrom* decision. Of these, only two had in fact been transferred by August, 1965.[3]

The refusal by the Department of Mental Hygiene to authorize transfer was on the grounds that the patients were "objectionable," not dangerous, and the decision was an administrative, not a psychiatric, one.

The reader of *Careers*, even a highly sophisticated forensic psychiatrist, could be taken in by the elaborate statistical data and neatly drawn tables, unless he possessed special knowledge of the laws of New York State. For example, Chapter 7, which discusses factors related to community release, provides incontrovertible statistical support for the following conclusion: "More important for their release than how well they were mentally, how well they were adjusting within the civil hospital or any other consideration, including those related to their dangerousness, was whether there was an interested family." The not too subtle implication, of course, is that bad psychiatrists kept the patients imprisoned when family interest was lacking. The unsuspecting reader may well be ensnared by the authors' air of scientific impartiality as studied hypotheses are advanced: "There are several possible explanations for the importance of this factor. Many of them revolve around the idea that psychiatrists respond to family desires as a means of coping with their jobs and avoiding potential difficulties and family pressures. Another major explanation is that psychiatrists tend to perceive the patient's chances of succeeding in the community as much better if there is a family available to support and help reintegrate the patient into community life" (p. 135). Nowhere do the authors mention that until it was amended in 1966, the New York Correction Law (Section 409) required that in addition to being "reasonably safe to be at large," the Matteawan prisoner being considered for discharge to the community was required to have friends or relatives willing and able to support him. Needless to say, the Dannemora officials followed the same practice, although the law did not so specify. *Mental Illness, Due Process and the Criminal Defendant* traces the practice "back to 1858 when in the era of county poorhouses the legislation organizing Matteawan's predecessor, the Auburn Asylum, authorized discharge of a prisoner upon expiration of sentence even if he were still mentally ill, so long as some friend or family would execute a written indemnification against his becoming a public charge."[4] My point is obvious: statisticians and statistics can be very dangerous.

It is regrettable that the authors chose to avoid a study of the prepatient period of the true Baxstrom patients, satisfying themselves with "weighing" only "some pertinent prepatient information" (p. 5). A remarkable wealth of prepatient data was available to them, including presentence reports to the Court, state prison records and commitment papers, as well as complete data concerning the committing physicians and the medical personnel at the receiving hospital for the criminally insane. Had they looked, they might well have found substantial data which would have led them to very different conclusions concerning the assumed dangerousness of the Baxstrom patients and the decision-making and conservatism of the "psychiatrists." For example, rarely were prisoners who were transferred from Attica or Auburn Prisons examined by psychiatrists prior to transfer. The committing physician almost invariably was on the prison payroll, and statements on the commitment certificate were based mainly on what he was told by the correctional personnel. Non-conformity, "trouble-making," and protesting of prison conditions were more likely to be reasons for transfer to the hospital for the criminally insane than mental illness *per se*. The statement by Steadman and Cocozza implying that these inmates were transferred while serving time because they were "diagnosed by psychiatrists or other prison mental health professionals as mentally ill" (p. 17) is simply not true. In any event, mental illness, if present, could have been easily treated at the prison if there had been the slightest desire on the part of prison officials to serve the interests of the inmate. How many prisoners were transferred, as was Johnnie K. Baxstrom himself, as the time for the termination of their prison sentences approached? Why might the prison authorities have wanted these inmates to be incarcerated beyond the expiration of their sentences? The authors do not say a word about such issues. I wonder why not.

Steadman and Cocozza assert that they concentrated "on the formal structures and career contingencies of the inpatient and postpatient phases" (p. 6). Had they included in their study of the inpatient phase an analysis of the careers of the psychiatric staff, they might again have found information which could have led them to different conclusions. For example, they would have found a physician group consisting mainly of overworked, undertrained, unlicensed doctors, most of whom did not even possess the ECFMG, and not a single Board-certified psychiatrist doing clinical work at either Dannemora or Matteawan. Frightened, not so much of the patients as of the possibility that the ECFMG qualification requirement would be extended to include physicians employed by the Department of Correction and they would therefore be dismissed, they were utterly demoralized and intimidated by the correctional officers, and they readily provided the necessary formal medical (hardly psychiatric!) sanction for non-medical staff administrative decisions. The latter, of course, determined who was to be recommended for transfer to civil state hospitals, not the "psychiatric evaluations," "psychiatric decision-making," or "the tendency of psychiatrists toward conservatism and overprediction," as persistently emphasized by the authors.

How would Steadman and Cocozza explain the fact that 118 patients were released from Dannemora in 1962, compared to a paltry 21 in 1960 and 14 in 1965?[5] Sudden occurrence of non-dangerousness? Or confusion and fear on the part of the Department of Correction that it would be faced with a publicized large increase in court hearings as a result of the "1961 decision of the New York Court of Appeals upholding the adminstratively transferred time-serving inmate's right to seek relief by habeas corpus"?[6]

How would the authors explain the fact that for years vastly more admissions to Dannemora came from Clinton Prison than from Attica, Auburn and Sing Sing Prisons (in 1962, the figures were 137, 27, 11 and 23 respectively[7])? Dangerousness? Or, in view of the fact that Clinton Prison is adjacent to Dannemora State Hospital, proximity to Dannemora (a factor never mentioned by the authors)?

The forensic psychiatrist who would like to obtain confirmation that persons labelled criminally insane have been erroneously regarded as dangerous by the uninformed and have been unnecessarily confined in institutions for lengthy periods of time, will find the book worth reading.

However, the importance of the book as a contribution to the history of forensic psychiatry in America lies not in what it says, but in what it so eloquently does not say: namely, that there is a most urgent need for the establishment of a specialty board in forensic psychiatry, as well as standards for the operation of psychiatric services for mentally ill inmates of prisons and a code of ethics for forensic psychiatrists. Only when these things come to pass will research sociologists, even those who are unaware of their anti-psychiatry bias, find it difficult to yield to the temptation to hold psychiatry and psychiatrists responsible for the abominations that befall mentally ill criminals.

ABRAHAM L. HALPERN, M.D.

References

1. Hunt RC, Wiley ED: Operation Baxstrom After One Year. Amer J. Psychiatry 124:134-8, 1968
2. Association of the Bar of the City of New York: Mental Illness, Due Process and the Criminal Defendant. New York: Fordham University Press, 1968
3. *Ibid.*, p. 41
4. *Ibid.*, p. 29
5. *Ibid.*, p. 219
6. *Ibid.*, p. 205
7. *Ibid.*, p. 218