THE DECISION TO CRIMINALLY PROSECUTE THE PSYCHIATRIC PATIENT

J. Reid Meloy, Ph.D.

There is indirect evidence that mental health professionals are more inclined to actively participate in the criminal prosecution of violent psychiatric patients. The author discusses fourteen factors that may warrant the clinical decision to criminally prosecute a patient, including offense characteristics, patient history, and social and policy issues. He provides guidelines for clinical and legal decision-making concerning this complex, and controversial issue.

Although the science of human behavior is deterministic (1), mental health professionals are disinclined to ignore volitional behavior in their treatment of psychiatric patients (2). Various psychologies perceive individuals as being more or less responsible for their actions, and clinicians often make this distinction on the basis of presence or absence of psychosis.

Unheard of a decade ago, reports and discussions concerning the prosecution of psychiatric patients have begun to appear in the professional literature (3-7). This trend seems to reflect society's frustration with the increase of violence in the United States (8), and a professional willingness to hold certain individuals responsible for their injurious actions, despite the diagnosis of a psychiatric disorder and the occurrence of such behaviors in psychiatric treatment settings.

Phelan et al. (3) asserted that mental health professionals may have a duty to initiate charges where serious assault has taken place. Gutheil (4) responded that the issues of therapeutic alliance and a patient's reciprocal response to staff's use of physical restraint must be considered to balance the discussion of prosecution. Mills et al. (5) nevertheless argued that litigation may further the treatment alliance, deter future violence, and con-

tribute to staff morale. Hoge and Gutheil (6) reported mixed results following the prosecution of nine character disordered and mentally retarded patients and recommended judicious consideration before prosecution begins. Miller and Maier (7) discussed the benefits to psychiatric staff of having the option to prosecute, and the need to educate professionals regarding criminal proceedings. Bloom (9) cautioned that the advocacy of assault charges against patients may invite civil action for failing to protect patients from the effects of their psychiatric illness. My intent is to discuss a number of factors that the mental health professional can use to aid in the decision whether or not to criminally prosecute the psychiatric patient. I have divided these fourteen variables into offense characteristics, patient history, and social policy issues.

OFFENSE CHARACTERISTICS

Serious Injury to the Victim

Most assaults against mental health professionals result in minor physical injuries (9). Male nursing staff in inpatient hospitals are the most likely staff to be injured, especially when attempting to contain a patient (10). Assaults against staff are more likely to be head injuries and cause more absence from work (10). The most frequent victims of patient assaults, however, are other patients (9). Serious physical injury to the victim of the violent patient should strongly influence the clinical staff to pursue criminal prosecution for several reasons: the need for more secure containment of a patient capable of inflicting such injury; the imminent need to transfer the patient; the psychological sequelae for the victim, perhaps including symptoms of Post-traumatic Stress Disorder; the gratification of retributive fantasies of the victim or witnesses in a reasonable, prosocial manner; and the availability of evidence that a crime was committed.

Witnesses and Evidence

If a violent act, most commonly an assault or a battery, is to be criminally prosecuted, there must be evidence. Evidence is testimony, writings, material objects, or other things offered to prove the existence or nonexistence of a fact (11). In the psychiatric setting, evidence will usually be

limited to direct observation, and subsequent testimony, by the victim or witnesses of the violence. Facts concerning physical injury are also evidence, and may include medical examination reports, victim testimony, and actual photos of injuries taken soon after the crime. Without evidence, a peace officer does not have probable cause, the lowest standard of proof, to arrest an individual and begin the criminal process. He must reasonably believe that a crime has been committed. Once arrested, the patient's charge will be reviewed by the local prosecutor, usually a city, county, or district attorney, to determine whether there is enough evidence to convince a judge or a jury beyond a reasonable doubt that a crime was committed. If sufficient evidence is not available to meet this highest standard of proof, the prosecutor will not file a complaint, that is, charge the person with a crime, and the individual will be released from custody. This decision-making must usually occur within 48 hours of arrest (12). Criminal prosecution will not happen without evidence, and the prosecutor, an agent of the state, has broad discretionary powers to make this decision.

Predatory or Affective Violence

Aggression can be categorized as either predatory or affective, with distinctive neuroanatomical pathways and controlled by different sets of neurotransmitters (13). This model is helpful in understanding the biopsychological dynamics of patient violence. The affective, or emotional mode is characterized by heightened sympathetic arousal, the perception of an internal or external threat, an immediate reaction to the threat, the subjective experience of anger or fear, and the single goal of threat reduction (14). This is the most common form of violence between psychiatric patients and may, for example, be internally stimulated by paranoid delusion, or externally stimulated by staff behavior or other patient threats.

The predatory mode is characterized by minimal sympathetic arousal, the absence of a perceived threat, planned and purposeful approach to the victim, an emotionless state, and multiple goals (14). In a psychiatric treatment setting, goals may include retaliation, intimidation of staff or patients, sadistic gratification, sensation-seeking, or intentional disruption of the treatment milieu. This is a rarer form of patient violence, but oftentimes more dangerous due to the absence of behavioral clues that foreshadow the violence. The clinical observation of predatory violence

should weigh heavily in the decision to criminally prosecute the patient, since it infers a psychopathic, or antisocial personality disorder (14).

Weapons Use

The use of a weapon by a patient increases the risk of staff injury and suggests certain other factors: a history of weapons possession or use within the community, intentional planning prior to the violence, especially if the weapon was brought to the location of the violence, a conscious desire to inflict serious injury on the victim, skill in the use of weapons, and an increased use of weapons in subsequent violent episodes. The use of a weapon may also lead to an enhancement of the criminal charge, or a change in the felony complaint to a more serious offense, such as Assault with a Deadly Weapon (15). Anderson, Ghali and Bansil (16) found that 8.4 percent of 287 patients searched in a psychiatric emergency room during a seven-month period were carrying weapons, usually knives or razors. They advocated electronic screening for weapons to balance patients' civil rights and public safety.

Lowered Staff Morale

The aftermath of a violent offense may trigger a substantial decrease in staff morale. This should be carefully scrutinized through individual and group discussions to ferret out the reasons for the intense emotional impact of this particular violent event, especially if patient violence is a common occurrence in the treatment setting. Staff morale issues may suggest countertransference problems with a particularly difficult, usually personality disordered patient; or may indicate an atavistic fear of real danger that the patient continues to present to the treatment setting, and the widely held, but unspoken belief among staff that the patient is untreatable (14). The latter finding suggests a need for more secure containment of the patient, and criminal prosecution may provide such an environment in a maximum security forensic hospital.

PATIENT HISTORY

Violence and Criminality

Although arrest history may not measure dangerousness (16), there now are more individuals with criminal histories in psychiatric settings

(17-20). The clinical staff's decision-making may be aided by knowing the criminal history of the particular patient, information accessible through law enforcement or prosecuting agencies. Such historical information, although usually not admissible during trial, is a useful predictor of future criminal and violence risk (21). It will also provide data concerning the nature and seriousness of prior criminal history, and the disposition of each charge (dismissed, acquitted, or convicted). A history of violent felony convictions, for instance, would weigh heavily toward prosecution since future violence would be likely; but a history of misdemeanor charges that were subsequently dismissed, such as defrauding an innkeeper, would be irrelevant to the clinical decision. Such information should be requested from the law enforcement or prosecuting agency.

Personality Disorder

Personality disorders appear to correlate with violent behavior, particularly the presence of one of the DSM-III-R (22) Cluster B personality disorders: antisocial, narcissistic, histrionic, and borderline (21, 23). Paranoid Personality Disorder and Delusional (Paranoid) Disorder implicate massive use of denial and projection of responsibility for violence in a psychiatric setting and are particularly resistant to treatment (24). Such diagnoses should be carefully weighed when considering the amenability of such patients to further treatment in a psychiatric milieu following a violent offense. Criminal prosecution of such patients may result in placement in more secure settings where aversive conditioning is more likely to have an impact on habitual, destructive behaviors; and future violence risk to the community is reduced.

Failed Civil Commitments

The violent psychiatric patient with frequent acute hospitalizations and repeated failures to voluntarily cooperate with outpatient referrals is a poor risk for continued civil commitment. A history of law enforcement initiated referrals is especially problematic, since the repeatedly used dangerousness commitment criteria (25) implies a greater risk of future violence. The brevity of civil commitment in the United States (26) may exacerbate the nonresponsiveness of certain patients to less restrictive outpatient care. An arrest and prosecution may transfer such patients to a penal commit-

ment setting where there is opportunity for long term hospital stabilization. In California, the first penal commitment usually follows a judicial determination of incompetency to stand trial, and varies from a minimum of 90 days to a maximum of three years (27).

Malingering and Rationalization

The intentional use of psychiatric symptoms, whether completely feigned or exaggerated, for external incentives implicates antisocial traits in the patient (22). Malingering does not rule out, however, the presence of an Axis I disorder, and a genuine history of psychiatric symptoms may be used by the violent psychiatric patient to rationalize his willful behavior (14). Although the detection of malingering and deception is an uncertain task (28), the clinician should be suspicious of the violent patient who always imputes his behavior to a certain symptom, such as command hallucinations. Malingering and rationalization introduce dishonesty into the treatment, and should encourage criminal sanctions in the aftermath of a violent offense.

Detachment

The absence of an attachment history in the violent psychiatric patient has certain treatment and management implications: difficulty forming a treatment alliance (29), the presence of a personality disorder, an absence of empathy toward others, asocial or antisocial behavior, and conscience or superego deficits (14). Attachment, or bonding, is the avenue for psychotherapeutic change, and its absence attenuates the effectiveness of future treatment interventions unless only pharmacotherapy in a controlled setting is sought.

SOCIAL AND POLICY ISSUES

Staff Education and Training

Criminal prosecution of the violent psychiatric patient is only conscionable if the professional staff has not provoked, or contributed to, the patient's violence. The potential for such abuse is diminished through comprehensive training and education programs concerning the management of assaultive behavior, especially for nursing staff. This should be an expected and repeated component of continuing education for all mental

health staff in both outpatient and inpatient settings, ranging from verbal intervention to containment and self-defense techniques. Such training also defends against the accusation of deliberate indifference (30) toward the patient's inability to control his impulses that might arise in a civil action against professionals involved in criminal prosecution of a patient (9). Other training of particular relevance concerns countertransference reactions, fantasy issues, and psychological defenses in understanding patient violence (14, 31). These latter issues may be woefully neglected in biologically-oriented inpatient treatment settings.

Administrative Policy

Mental health administrators are generally hesitant to advocate for the criminal prosecution of a patient due to civil liability risks and bad public relations. They will be more inclined to discount the impact of patient violence on staff morale and arrange for the inconspicuous transfer of a particularly fearsome patient. The clinical decision to participate in the criminal prosecution of a patient should be measured against the support, or absence of support, of the administration. There may be policies forbidding such involvement, despite their questionable legal merit. On the other hand, extensive procedures may exist for reasonable decision-making concerning prosecution. The absence of policy for such activity can substantially increase the stress experienced by clinicians involved as witnesses, since it may foster dissension among staff and, in extreme cases, jeopardize the clinician's employment.

Police and Prosecution Cooperation

Mental health clinicians should assume that both law enforcement and prosecuting agencies will be resistant to initiating criminal litigation against a mental patient. This is probably due to their beliefs that mental illness and violence correlate, and perceptions that the mental health professional is naturally assuming physical risk, as the peace officer does, by doing such work. If there is a complete absence of law enforcement cooperation, criminal prosecution cannot proceed. Unlike Britain where citizens can initiate criminal prosecution of each other, in the United States only government agencies can criminally prosecute a citizen. Law en-

(37). If the peace officer refuses to write a police report and staff have not been dissuaded, the officer's supervisor should be contacted and brought to the site of the alleged offense to conduct his own investigation.

The victim and witnesses should each write separate, detailed reports of what they saw and heard at the time of the offense. No conclusions, inferences, or hearsay should be included in these statements of personal observation. Copies should be forwarded to mental health administration and the prosecuting agency.

The supervisor or administrator should contact within 24 hours the person or division within the local prosecuting agency that issues complaints or criminal charges. The supervisor should strongly press for the issuance of a complaint, noting the detailed accounts of the offense and the willingness of the victim or witnesses to fully cooperate in the prosecution of the patient. Staff should be made aware that participation in such a case can be tedious and lengthy, with many delays, and may raise the ire of other mental health staff who believe that no patient should ever be criminally prosecuted. The supervisor's task is to solidify the prosecuting agency's conviction that a crime has been committed and the trier of fact (judge or jury) can be convinced that it has occurred beyond a reasonable doubt, the criminal standard of proof in the United States.

If criminal charges are filed, the patient will be arraigned before a judge or magistrate. This is the stage of the criminal process at which a defendant is required to enter a plea in court (38). Subsequent proceedings will be held, all done within strict time frames to protect the patient-defendant's due process, that is, the constitutional guarantee found in the Fifth and Fourteenth Amendments that the government will act fairly when it attempts to deprive a person of life, liberty, or property (38). Throughout the criminal process, up to and including sentencing, clinical staff may be subpoenaed, or required to appear and give testimony, by the prosecution or defense. Subpoenas may force involvement by staff who were opposed to criminal prosecution in the first place, and stir feelings of both anger and guilt.

Due to the interminable length of some criminal proceedings, mental health supervisors should be sensitive to the need for ongoing processing of the emotions of the involved clinicians. This will diminish the impact of

the criminal process on the treatment milieu long after the patient has been arrested and transferred to custody.

CONCLUSIONS

Once anathema to the mental health profession, criminal prosecution of the psychiatric patient in some circumstances is being discussed (3-7) and is certainly warranted. Fourteen factors have been offered, involving characteristics of the offense, patient history, and social and policy issues that may be considered in deciding whether or not to advocate for such a serious social consequence of behavior.

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ABOUT THE AUTHOR

J. Reid Meloy, Ph.D. is Chief of the Forensic Mental Health Division, San Diego County, California; Adjunct Professor, University of San Diego School of Law; and Assistant Clinical Professor of Psychiatry, University of California, San Diego, School of Medicine. Dr. Meloy is also a Diplomate in Forensic Psychology, American Board of Professional Psychology.