

The Impossible Dialogue between Psychiatry and the Judicial System: A Language Problem

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Abstract: The interface between psychiatry and law is complex and has the potential for gross misunderstanding. Each discipline has its own concerns with regard to the psychiatric patient, and there is a significant language gap between the two disciplines. The language of the medical discipline describes the patient's state on a continuum that ranges from extremely ill to completely healthy. The judicial language, on the other hand, is a binary language: the patient is either competent or incompetent, either dangerous or not dangerous. This article describes three potential areas for discourse in the Israeli context: involuntary hospitalization, criminal responsibility and legal representation of involuntarily hospitalized patients. The two systems can be complementary only if both sides make a serious effort to communicate and respect each other's principles and language.

Forensic psychiatry is the bridge between two disciplines that have substantial difficulties conducting a mutual dialogue. According to the World Psychiatric Association's Madrid Declaration (1), "Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient." Psychiatrists, as physicians, perceive hospitalization as a means to provide medical care and to promote mental health. The courts of law are concerned with the freedom and the rights of the individual much more than with the mental health of the patient (2, 3). Legal representatives tend to compare psychiatric hospitalization with incarceration in prison, which may be the basis for their premise that hospitalization must be avoided whenever possible. In a famous case argued before the Supreme Court, the judge stated: "Hospitalization of a person in a mental institution is harsh and bitter for the person concerned and for their family and when the hospitalization is involuntary, this is one of the most severe and de-

pressing forms of revoking a person's freedom" (4). The question whether hospitalization in an overcrowded internal medicine ward is not similarly distressing for the patient and his/her family should also be raised. The physician is concerned with the need for medical treatment to improve the health of the patients, while the court rules by the letter of the law to assure protection of the rights of the individual and the public (3).

Aside from the difference in the focus of concern, there is also a language gap between the two disciplines. The language of the medical discipline is a continuum; most patients are not either sick or healthy. They are somewhere on the spectrum between "extremely sick" or "completely healthy." The judicial language, on the other hand, is a binary language; the patient is competent or incompetent, dangerous or not dangerous.

In daily life the interface between the two disciplines occurs mainly at times when decisions have to be made regarding involuntary hospitalization and criminal responsibility. There is a new platform for discourse (and friction) in the current Israeli law: the patient's right to be represented by a lawyer at the District Psychiatric Committee (DPC) during the process of appeal or extension of the commitment time period.

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Involuntary Hospitalization

Involuntary or compulsory hospitalization of mentally ill patients is one of the most distressing needs of society. In making the decision to involuntarily hospitalize an individual, the balance among three ethical issues must be considered: the patient's right to receive medical care, the patient's personal rights for liberty and dignity and the protection of the public.

According to the Israeli 1991 Law for the Treatment of the Mentally Ill three conditions must be met for compulsory hospitalization:

1. Presence of mental illness that gravely impairs the person's ability to judge reality.
2. Immediate physical danger to oneself and/or to others.
3. A causal link between the illness and dangerous situations.

It should be noted that the law enables compulsory hospitalization which is not urgent in situations when the danger is not immediate and when the patient's basic needs are gravely neglected or when the patient inflicts damage to property. However, these circumstances are not common and are not the focus of this paper.

Similarly, the U.S. Supreme Court has stated that: "A finding of mental illness alone cannot justify a state's confining persons in a hospital against their will. Instead, involuntarily confined patients must be considered dangerous to themselves or others, or possibly so unable to care for themselves that they cannot survive outside" (5).

Diagnosis of a severe mental illness (mainly psychosis) is a basic task for the psychiatric profession. Though the medical decision is usually not under dispute, the discourse with the legal system generally concerns the definition and prediction of dangerousness.

What have the courts taught us about the definition of "immediate physical danger to oneself or to others"? A woman who suffered from paranoid schizophrenia, with delusions of voices coming from a transmitter in her teeth, expressed her wish to have all her teeth extracted and was, consequently, hospitalized involuntarily. She appealed her hospitalization to the courts, whose decision was that the

compulsory hospitalization was unjustified since living without teeth does not constitute immediate threat to one's life (3). Looking at the issue from the medical point of view, can we then extrapolate that severing an ear, or blinding oneself because of psychotic delusions is equally not life-threatening and, therefore, does not justify involuntary hospitalization? In another appeal to the district court a psychotic woman was hospitalized after uttering threats to assault others. While in hospital she attacked an elderly female patient who mistakenly got into her bed. This psychotic woman's state was not considered dangerous enough to satisfy the criteria of being dangerous to others (6). Again the question arises: What is the threshold of dangerousness to others for a psychotic, highly irritable, angry and threatening patient? Causing severe injuries to others? According to the medical model both patients may be considered dangerous since due to their delusions they have the potential to cause irreversible damage to themselves or to others, damage that can be prevented through treatment. According to the judicial model in the above cases, it could be understood that this potential damage is not severe enough to confine a person and therefore does not justify limiting the patient's freedom. However, in many other cases, the court rules in accordance with the medical opinion (7).

The question of who will be held responsible if such a patient commits truly severe damage to himself or to others, while not under treatment, remains unanswered. The representatives of the judicial system including the District Psychiatrist have procedural immunity by virtue of their role, but the treating physician does not. This is an essential difference between the two systems. Compulsory hospitalization which prevented assault and battery or suicide cannot be proven. At the same time, in the event of aggravated assault or completed suicide the burden of guilt will be focused on the medical community that "didn't do enough to prevent it." Thus, society is under the impression that either the psychiatric system compulsorily hospitalizes without adequate need or, conversely, is lax in performing its duties. The number of assaults or suicides prevented by involuntary hospitalization cannot be calculated.

The issue of predicting dangerousness or assessing risk is another serious point of contention be-

tween the two systems. The psychiatric assessment of dangerousness is based on a clinical evaluation that considers the current knowledge regarding violent behavior. It has been shown that the best predictor of future violence is past violence (8) and that “nothing predicts behavior like behavior” (9). Clinical data suggest that the combination of previous violent behavior, alcoholism and antisocial personality disorder markedly increase the risk of future violent behavior (10). An often-used medical assessment tool is the Relative Risk (RR) and Odds Ratio (OR) of violence in different diagnostic groups compared with the general population. For example, the Odds Ratio of violence and criminal convictions among male schizophrenic patients is seven-fold that of the general population (10, 11). When schizophrenia is combined with alcoholism the risk increases to 17–25 (10). These statements, however, refer to categories of people while we are concerned with individuals. The judicial system is often not satisfied with the clinical risk assessment that it perceives as being too general and intuitive. Thus, there is constant pressure on the medical system to produce more accurate and specific predictions.

Over the past several years an alternative to clinical prediction has been developed, using statistical or “actuarial” risk assessments. A number of risk assessment tools have become available, and courts in the United States are increasingly approving the use of these instruments. The empirically valid risk factors include personal data, psychopathology and past history (12). A recent actuarial model was generated in the MacArthur Violent Risk Assessment Study to predict violence in the community by patients who have recently been discharged from psychiatric facilities (13). This model showed considerable accuracy, placing each patient in one of five categories for which the likelihood of violence in the next several months varied from 1% to 76%. Classification of Violence Risk (“COVR”) software is now available. Some promising findings have validated the model, although its validity in other settings such as outpatient facilities or for people outside the U.S. remains to be determined empirically (14). The actuarial approach may be helpful to clinicians and may serve as a complementary tool for prediction and assessment of the risk for violence.

Criminal Responsibility

The judicial system identifies two components of criminal offence: criminal act (*actus reus*) and evil intent (*mens rea*). The existence of these two components should be proved by the prosecution in order to show criminal responsibility of the offender in a criminal case. A person who, as a result of severe mental disease or defect, is not able to appreciate the nature and quality of his or her acts is not held responsible for committing them. This judicial approach, known as “the M'Naughten rules,” was put forward after the famous M'Naughten case from the British courts of 1843. It is the standard for the present defense of insanity in most Anglo-American jurisdictions (15). Accordingly, the judicial language regarding criminal responsibility and ability to stand trial is absolute and binary. It divides people into criminally responsible and criminally not responsible. The concepts of the psychiatric discipline are more relative, multifactorial and often far from absolute. A patient suffering from schizophrenia with persecutory delusions and some cognitive impairment still preserves most cognitive skills. Associated factors such as alcohol or drug abuse and personality traits play a crucial role in the patient's behavior. In many such cases the secondary or associated factors are primarily responsible for criminal acts committed during psychotic states.

This difficulty in differentiating between full responsibility and lack thereof is often criticized by the judicial system regarding the discharge of patients hospitalized under court order. A hospital, however, is an establishment for people who need medical treatment and not a penal institution. Psychiatrists are ready to discharge patients when they achieve remission, which sometimes occurs within a month or two following admission, and that may seem too short for “punishment” for a severe crime. Similar criticism is leveled when a patient needs to stay in a psychiatric hospital for a long time following a minor offense. Should clinical or judicial considerations determine the length of hospitalization? Matters of protection, public safety and crime prevention are social issues, and do not involve medical considerations. These issues are currently dealt with by the DPC that includes an attorney and two physicians who weigh medical, legal and social considerations

when deliberating the discharge of a patient hospitalized by court order. This committee is intended to serve as a psychiatric/legal mediator, yet its decisions still provoke public criticism.

Compulsory outpatient treatment is a less restrictive means for non-responsible criminal offenders. However, this ambivalent approach to psychiatric treatment by court order exists also with regard to compulsory outpatient treatment. This is an order “with no bite” and its implementation is determined, in effect, by the patient’s goodwill and cooperation. Although a non-compliant patient under community order can be brought by force for regular injections, an examination order must be requested each time. The chief justice of the Supreme Court, Judge Aharon Barak, expressed his view that it is not the duty of the district psychiatrist to enforce legal orders (16). Thus, the judicial system does not consider violation of an order for compulsory outpatient treatment as a transgression that requires immediate legal recourse. The rulings maintain the separation between the medical role of the physicians and the “punitive” or “protector of society” roles of the courts. In effect, there are no sanctions against patients who do not follow the court orders, and, subsequently, patients drop out from psychiatric care. As a consequence, the patient and family continue to suffer, and the risk of criminal victimization increases (17). Attempts to resolve this issue may include a periodical examination by a special committee and sanctions for patients who are non-compliant with treatment.

The amendment of reduced punishment for murder introduced in 1995 (18, 19) can be seen as an attempt to bridge between the two languages. The legislator accepted the argument that given certain conditions the ability of a person with severe mental illness to fully comprehend the nature of his or her acts and to avoid them, may be somewhat limited but not totally lacking. Such people are not considered to be not responsible for their actions, but due to their limitations they warrant a reduced punishment. This attitude approaches the medical model and is a good example of how dialogue between the two models can be mutually beneficial.

Legal Representation of Involuntarily Hospitalized Patients

In 2004 an amendment was implemented in the Law for the Treatment of the Mentally Ill (1991), regarding legal representation. The amendment (Article 29a) states that during a session of the DPC, as well as during an appeal on its decisions, the patient is entitled to be represented by a lawyer. In a session on involuntary psychiatric hospitalization the lawyer represents the patient at the hearing before the DPC and defends the patient’s right not to be hospitalized. The treating psychiatrist finds himself in a situation where he has to take a side and to convince the DPC, as if he assumes the role of a prosecutor. The amendment may express a shift from the medical model towards the legal model. Israel seems to be the only country in the world where a legal representative litigates with a psychiatrist rather than with an attorney.

The objective of the legal representative is often perceived as being to release the patient from the hospital. This perception fits the legal model that views hospitalization strictly as a denial of the patient’s rights and freedom, much like prison. The clinical evaluation in those hearings, which is based on longitudinal information and on past experience with the patient, seems irrelevant to the legal representative, who prefers to adhere to the judicial model with which he is acquainted.

The psychiatrist is required to supply details as evidence in order to determine whether he in fact witnessed the patient’s dangerous behavior. Details in the patient’s chart describing dangerous behavior may be unacceptable since they are considered hearsay testimony. Thus the psychiatrist is sometimes required to conduct an investigation for legal evidence. However, as noted before, the psychiatric model is based on behavior and probability and the psychiatrist is not familiar with and does not have the means to manage an investigation or to collect evidence, as expected by the legal model. Furthermore, the psychiatrist is not really interested in “winning the trial” but rather in securing the benefit of the patient. As a result psychotic patients may be released from hospital prematurely, causing high levels of distress to themselves and to their families, a situation that may potentially lead to homelessness and criminality.

The idea of legal representation as a safeguard for

the patient's basic rights seems to be a timely decision when viewed in the context of the previous paternalistic approach of the medical system. There are indeed many benefits in strict adherence to the personal rights of psychiatric patients (20), for example legal aid in personal issues involving property and inheritance, and advocacy for social equality. However, we must be aware that, oftentimes, reduction of hospitalization harms the patient's basic right, the right for adequate medical care and promotion of good health. The zealotry of the battle for patients' rights may cause the pendulum to swing too far, at the expense of the patient's welfare. At the same time we must cautiously ensure that the paternalistic attitude does not spill over to the legal system. The interface between the two systems can be much more productive if both sides learn to understand and respect the principle of the other system. The physicians need a deeper understanding of the legal standpoint and the attorneys need to extend their medical knowledge.

Conclusion

The interaction between the psychiatric (or medical) discipline and the judicial discipline has inherent difficulties. The two disciplines use different languages which often can hardly merge into a common one. Each discipline has its own responsibility and part to play with regard to the psychiatric patient. The psychiatrist's concern is to provide the best therapeutic intervention, while the court is concerned with the patient's rights, social justice, and protection of society. The two systems can be complementary only if both sides learn to understand and respect the principles and language of the other. Such mutual understanding may lead to more appropriate mental health legislation and regulation that would benefit the psychiatric patients, their families and society at large.

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