Mental Illness and Criminal Commitment in Michigan

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MENTAL ILLNESS AND CRIMINAL COMMITMENT IN MICHIGAN

By Grant H. Morris*

“A man said ‘Thou tree!’ The tree answered with the same scorn: ‘Thou man! Thou art greater than I only in thy possibilities.’”

—Stephen Crane

1. INTRODUCTION

In 1969 the Michigan Legislature, in a one-line budget item, appropriated funds to revise mental health statutes.1 In order to achieve that goal, in the spring of 1970 the Legislative Council2 created the Michigan Legislative Committee to Revise the Mental Health Statutes. Additionally, the Governor appointed a Commission on Mental Health Program and Statute Review. The Governor's Commission has been working with and through the staff of the Legislative Committee in a joint effort to secure broad-based bipartisan support for the legislative enactment of their ultimate recommendations.

As Legal Counsel to the Legislative Committee, this writer has examined the statutes dealing with criminal commitment and maximum security confinement. Preliminary work on this subject has been completed and has been submitted for discussion to the Legislative Committee and the Governor's Commission in the form of a working paper. This article is a modified and shortened version of that paper.3 The recommendations for statutory revision are, at this stage, personal recommendations only and have not been accepted by the reviewing bodies.

This article concentrates on one vital issue: to what extent are

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2 The Legislative Council is a bipartisan fourteen-member group of Michigan legislative leaders. The Council has responsibility for the legislative service bureau which assists in the research and preparation of bills. MICH. COMP. LAWS ANN. §§ 4.313–4.321 (1967).

3 Portions of the working paper eliminated from this article consider such issues as the appropriate standard for criminal responsibility, procedural safeguards necessary to assure that criminal responsibility is properly determined, and the criteria and safeguards necessary to determine competency to stand trial.
differences in treatment justified because of a mentally ill person’s “criminal” involvement. While the article is primarily concerned with Michigan institutions and Michigan statutes, the discussion and the solutions proposed are in many respects applicable to all states of the Union. Not only must all states reevaluate their policies toward criminal commitment of the mentally ill in light of ever-changing medical and penal theory, but they must also consider the developing constitutional concepts in this area. These constitutional issues are raised here only to the extent necessary to alert the reader to possible objections to present custodial policies in Michigan and other states; authoritative conclusions have not been attempted.

It seems desirable at the outset to list certain principles which represent progressive and rational guidelines for statutory change in the area of criminal commitment of the mentally ill. They are: (1) when a mentally ill person is placed in a mental hospital or mental ward, the underlying purpose of such placement is treatment of that person’s illness, notwithstanding any “criminal order” status of the person; (2) security measures should not be imposed on any mentally ill person unless there is a necessity for such measures, as determined by the diagnosis and pathology of the individual’s mental condition, not by his “criminal order” status; (3) even when security measures must be imposed on a mental patient, the emphasis of the mental hospital should be on treatment of the patient’s mental condition, not on maintaining security; and (4) security measures imposed on a mental patient should be eliminated as soon as his improved mental condition warrants.

II. MENTALLY ILL EX-CONVICTS

Michigan law currently provides for the transfer of insane convicts from the various state prisons to Ionia State Hospital,4 a maximum security institution. If the criminal patient’s insanity continues after the expiration of his or her criminal sentence, an application can be made to the Ionia County Probate Court “for an order to retain such person in the hospital until he or she is

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4 Mich. Comp. Laws Ann. § 330.66 (1967). Ionia State Hospital is located in Ionia County in northern Michigan. Ionia in the past has had several main categories of patients: (1) mentally ill ex-convicts [See Section II infra]; (2) dangerous civil patients who are transferred to Ionia [See Section III infra]; (3) defendants who have been found incompetent to stand trial [See Section IV infra]; (4) defendants who have been acquitted by reason of insanity [See Section V infra]; (5) criminal sexual psychopaths [See Section VI infra]; and (6) mentally ill convicts [See Section VII infra].
restored to reason." After a hearing and determination of "insanity" the judge may order the person committed "to the department of mental health for treatment in an appropriate state hospital . . . ." The statute also provides that the insane convict whose sentence has expired can be paroled by the medical superintendent and entrusted to his friends or relatives.

The United States Supreme Court discussed the constitutional problems of a similar New York statute dealing with mentally ill ex-convicts in Baxstrom v. Herold. In New York if a convict became mentally ill while serving his sentence in prison, he was transferred to Dannemora State Hospital, a maximum security institution administered by the New York Department of Correction. The New York statute provided that upon expiration of his sentence, the now mentally ill ex-convict was to be committed to the custody of the Commissioner of Mental Hygiene and placed in an appropriate institution in the Department of Mental Hygiene or the Department of Correction. Placement in a Department of Correction maximum security institution was "appropriate" only if the ex-convict was dangerous and in need of maximum security confinement. Johnnie K. Baxstrom was a mentally ill convict who had been transferred from prison to Dannemora during his sentence. Upon expiration of that sentence and in accordance with the statute, the Commissioner of Mental Hygiene designated Dannemora as the appropriate institution for Baxstrom's continued confinement. Subsequently, Baxstrom sought a writ of habeas corpus. In holding that Baxstrom had been denied equal protection of the laws in contravention of the fourteenth amendment, the Supreme Court reasoned that although New York law deemed commitment pursuant to the statute a civil commitment, the statutory procedure authorizing the Commissioner of Mental Hygiene to commit Baxstrom denied him the possibility of a jury review of the propriety of his commitment, a right which was available to all other persons civilly committed in New York. Additionally, the Court held that by authorizing the Commissioner of Mental Hygiene to order Baxstrom confined in an institution maintained by the Department of Correction, the statute deprived Baxstrom of a judicial hearing to determine whether he was dangerously men-

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6 According to the April 7, 1970 census of Ionia State Hospital, seventy-two patients are confined in that institution pursuant to Mich. Comp. Laws Ann. § 330.68 (1967). Unless otherwise indicated all subsequent references to patient population will be based on the April 7, 1970 census.
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tally ill. Under New York law, a civil patient could not be transferred from a civil hospital to a Department of Correction maximum security mental institution unless he was first judicially determined to be dangerously mentally ill. The statute in issue unconstitutionally circumvented this procedural safeguard.

There are differences between the New York and Michigan situations such that the specific holding of Baxstrom does not necessarily apply to Michigan. First, in Michigan both the regional mental hospitals and the maximum security hospital (Ionia) are within the jurisdiction of the Michigan Department of Mental Health. There is no bifurcation of administrative responsibility as in New York. Second, mental patients at the various regional hospitals are not now statutorily entitled to a judicial hearing prior to their transfer into Ionia.

However, the issue is not whether the Michigan statute would be constitutionally defensible if it were subjected to judicial scrutiny, but whether the statute should be altered to avoid such potential confrontation by conforming to the thrust of the Supreme Court opinion. In Baxstrom, the Court was concerned not only with the specifics of a New York statute, but also with the question of whether a mentally ill individual whose prison sentence has expired and whose debt to society has been paid is entitled to be treated equally with all other nonconvict mentally ill persons. By holding that Baxstrom had been denied equal protection of the laws, the Court answered this question with an emphatic "yes."

Although recent statutory amendments indicate that Ionia may someday become a regional mental hospital, that goal has not yet been reached. No state district has been assigned to the Ionia State Hospital, and the Department of Mental Health continues to use it solely as a maximum security hospital.

In light of Baxstrom the Michigan statute should be amended to the extent that it treats mentally ill ex-convicts as a unique category of mentally ill persons and to the extent that it does not

9 N.Y. MENTAL HYGIENE LAW § 85 (McKinney 1971).
10 The Baxstrom decision resulted in the transfer and/or discharge of 992 patients from the maximum security hospitals in New York.
11 MICH. COMP. LAWS ANN. § 330.67 (1967). The recent case of Dixon v. Attorney General, 325 F.Supp. 966 (N.D. Pa. 1971) supports the contention that Baxstrom v. Herold is relevant to the Michigan situation. Farview State Hospital, Pennsylvania's maximum security hospital, is within the jurisdiction of the Department of Public Welfare, as are the state's other mental hospitals. Nevertheless, the federal district court in Dixon, relying on Baxstrom, held that the Pennsylvania statute permitting continued confinement of ex-convicts in Farview upon expiration of their criminal sentences was unconstitutional.
12 MICH. COMP. LAWS ANN. § 330.68 (1967).
differentiate Ionia State Hospital from the regional hospitals. Specifically: (1) if an ex-convict is to be confined as a mentally ill person at the expiration of his term of imprisonment, the probate court ordering the confinement should be the court of the county of the person’s residence as provided for other mentally ill persons, rather than the Ionia County Probate Court; (2) the involuntarily committed ex-convict should be confined initially in the regional hospital that services his place of residence (as is the rule for other mentally ill persons) rather than Ionia; (3) ex-convict mental patients should be transferred to Ionia only if they meet the statutory criteria for transfer established for other civil mental patients; (4) ex-convict mental patients should be released from hospitalization in accordance with release procedures established for nonconvict mental patients. For example, a Michigan statute provides for discharge of civil mental patients who have been on convalescent status for the period of time specified by the medical superintendent. The statute dealing with ex-convict mental patients contains no similar discharge provision.

III. DANGEROUS CIVIL PATIENTS

A. Administrative Placement of Dangerous Patients

A Michigan statute provides that the superintendent of any regional hospital may transfer to Ionia State Hospital any mental patient who has been guilty of an act of homicide prior to admission to the hospital or while under treatment in the hospital. Similarly, the superintendent may transfer to Ionia any patient who “develops unmistakable dangerous or homicidal tendencies.” The statute permits the Department of Mental Health to administratively determine whether a patient has developed “unmistakable dangerous or homicidal tendencies” sufficient to permit transfer from the regional hospital to Ionia. In essence, the statute treats Ionia as just another mental hospital; clearly it is not. While the statute may provide the Michigan Department of Mental Health with desired flexibility, the legislation cannot be justified solely on that ground.

14 MICH. COMP. LAWS ANN. § 330.68 (1967).
15 MICH. COMP. LAWS ANN. § 330.67 (1967).
16 Sixty patients in this category are confined in Ionia.
17 A Department of Mental Health task force on statutes recommended that [Probate Court] commitments be made to the Department of Mental Health rather than to a specific state hospital. The Department would then deter-
The New York experience after the *Baxstrom* decision illustrates the dangers inherent in the administrative placement of mental patients into maximum security confinement. The Supreme Court's decision in *Baxstrom* did not result in the immediate discharge of a single patient from New York's maximum security hospitals (Dannemora and Matteawan) directly into society. Rather, the New York Department of Mental Hygiene "transferred" to civil (regional) hospitals all ex-prisoners whose sentences had expired and who were being held in maximum security confinement pursuant to the unconstitutional statute. This process was called "Operation Baxstrom." After one year, the New York Department of Mental Hygiene reported:

The most striking news is that there is no news. None of the hospitals has any particular problems to report. The hospital directors all use similar terms in conveying that the *Baxstrom* patients are no more a problem than anyone else, that nobody any longer thinks of them in any special way, no lists are kept and that one never hears any reference to this group by staff or patients.18

After one year, 147 Baxstrom patients had been discharged to the community compared with seven patients who were recommitted to Matteawan as dangerously mentally ill. For each patient retransferred from the civil hospitals, twenty-one were absolutely discharged.

Three conclusions can be drawn from the success of Operation Baxstrom. First, the psychiatrists in the Department of Mental Hygiene apparently lacked the ability to diagnose properly dangerous mental illness and to determine the necessity for maximum security confinement. Only seven of the 992 patients diagnosed as dangerously mentally ill by the Department prior to the Supreme Court decision in *Baxstrom* were subsequently found to be dan-

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gerous by the courts. Second, before the Supreme Court required the removal of ex-convict mental patients from maximum security confinement, the Department of Mental Hygiene was apparently unwilling to accept and treat in the civil hospitals those mental patients whose lives had been stained by the label of criminality.19 Third, the Department of Mental Hygiene did have the capacity—personnel-wise and facility-wise—to treat within the civil hospitals over 99 percent of the patients whom it considered dangerously mentally ill. When the Operation Baxstrom patients were integrated with other civil patients and given treatment indistinguishable from that afforded other civil patients, they responded readily.20

While no court decision has as yet mandated a judicial determination of dangerousness prior to transfer of a patient into a maximum security hospital or maximum security ward, the courts

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19 White, Krumholz, & Fink, *The Adjustment of Criminally Insane Patients to a Civil Mental Hospital*, 53 MENTAL HYGIENE 34 (1969). In discussing the transfer of ex-convict patients to Central Islip State Hospital (a civil hospital), the authors concluded at 38:

> Superficially it appears that, somehow, a sum was taken of two negative labels, "criminal" plus "psychotic," that yielded a supernegative value of "the psychotic criminal." These two labels derive from two different philosophies of human behavior and are perhaps complementary approaches to the same phenomenon. In any case, they do not have additive properties.

20 A New York Department of Mental Hygiene report states:

> Although all Operation Baxstrom patients were transferred into the civil hospitals as involuntary patients, 36% of the patients remaining in the civil hospitals on August 31, 1966 were retained on a voluntary or informal status. This compares favorably with the 39% of civil patients generally that were admitted from the community in June 1966 on these noncompulsory statutes.


In recommending that responsibility for the care and treatment of all civil mental patients, including dangerous patients, be vested in the New York Department of Mental Hygiene, the Bar Association of the City of New York also proposed

that special safeguards be provided to protect against arbitrary admission of patients who are not so dangerously mentally ill as to require maximum-security custody. The decision to admit a patient to such an institution should not be left to administrative judgment. Whereas very few such patients are admitted to Matteawan under [the existing statute which requires a judicial determination prior to transfer of "dangerous" civil patients], the mass exodus and negligible returns of former prisoners following the Baxstrom decision appears to indicate that administrative placements occur in many cases in which the evidence to obtain a judicial order is lacking.

The Baxstrom case does not of itself require that these admissions be based solely on a judicial determination of dangerous mental illnesses. In our opinion, however, the importance of so significant an event in the life of an individual patient is sufficient warrant to recommend that no person be admitted to a central high-security facility except upon a judicial determination that it is necessary for the protection of others. New York’s 35-year old policy of requiring judicial action should be continued even though such a new institution would be entirely within the same hospital system.
have recently shown an increased concern over the possible abuses of administrative placement. The *Baxstrom* case is but one example.

In the District of Columbia, there is only one mental hospital, St. Elizabeth's. In *Covington v. Harris*, the United States Court of Appeals for the District of Columbia Circuit held that a civil patient, confined in the maximum security ward of St. Elizabeth's as dangerously mentally ill, could properly petition the court by a writ of habeas corpus to obtain a transfer to a less restrictive ward within the same hospital. Chief Judge Bazelon, writing the opinion of the court, noted that although a mere request for a change of dormitories or for a transfer between substantially similar wards would not sustain a petition for habeas corpus, facilities for the criminally insane

have, in the past, notoriously rivalled maximum security prisons in the pervasiveness of their restraint upon liberty and the totality of their impositions upon dignity. Thus, there is reason to believe that confinement in John Howard [the maximum security ward] is not normally contemplated for civilly committed patients and entails extraordinary deprivations of liberty and dignity which make it, in effect, more penitentiary than mental hospital, even if it also provides some treatment. It makes little sense to guard zealously against the possibility of unwarranted deprivations [of liberty] prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without. The commitment statute no more authorizes unnecessary restrictions within the former range than it does within the latter.

Two United States Supreme Court cases also tend to indicate that prior to transfer of an allegedly dangerous mental patient to Ionia, a judicial hearing with appropriate procedural safeguards may be necessary to satisfy the due process requirements of the United States Constitution. In *In re Gault*, a fifteen year old boy was adjudicated a "juvenile delinquent" and committed to a state reformatory. Although the hearing was statutorily declared to be a "civil proceeding," the Supreme Court held that the state's

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21 419 F.2d 617 (D.C. Cir. 1966).
22 Id. at 622-24.
failure to provide Gault with notice of charges, right to counsel, confrontation and cross-examination of witnesses, and the privilege against self-incrimination had denied him due process. Although these safeguards are traditionally provided only in criminal proceedings, the Court focused its attention on the character of the sanctions that could be imposed in a juvenile delinquency proceeding and was not swayed by the "civil-not-criminal" label attached to the proceedings or by the "rehabilitation-not-punishment" motive for the confinement. In requiring these procedural safeguards, the Court stated that "commitment is a deprivation of liberty. It is incarceration against one's will, whether it is called 'criminal' or 'civil.'"  

Commentators have suggested that the influence of Gault will extend beyond the juvenile court system to other "civil" commitments for alcoholism, sexual deviation, narcotics addiction, and mental illness. If the procedures for civil commitment of the mentally ill are open to constitutional doubt for not providing certain due process safeguards, surely the Michigan statute, Mich. Comp. Laws Ann. § 330.67 (1967), by authorizing administrative transfer of nonconvict mental patients into Ionia without any hearing or procedural safeguards, is even more suspect. 

In Specht v. Patterson, the United States Supreme Court held that a person convicted under Colorado law of a sex crime (maximum sentence ten years) could not be sentenced under the Colorado Sex Offenders Act (sentence of one day to life) without a full hearing. The Court held that the imposition of the indeterminate sentence required a new finding of fact which was not an ingredient of the offense charged at trial, i.e., that the defendant constitutes a threat of bodily harm to members of the public, or is an habitual offender and mentally ill.

Similarly, the finding in a probate court civil commitment hear-
ing that a mentally ill person meets the criteria necessary for involuntary commitment in a regional mental hospital does not include a finding that the person meets the statutory criteria for transfer into Ionia. For placement in Ionia, a new finding of fact is required which was not an ingredient of the initial civil commitment, i.e., that the patient has developed unmistakable dangerous or homicidal tendencies rendering his presence at the regional hospital a source of danger to others.

The Specht case affords convicted criminals a safeguard. A similar safeguard should not be denied to mental patients who have not even been accused of a crime.

B. Ionia and the Regional Hospitals Compared

The progress of modern psychiatric therapy, enhanced by the introduction of tranquilizing and other psychoactive drugs in the mid-1950's, has signaled the end of the custody-oriented mental hospital. While the drugs do not, in and of themselves, cure patients, they make patients more amenable to other forms of psychiatric treatment by relieving the symptoms of mental illness. The incidence of restraint or seclusion of patients has diminished drastically and locked doors on hospital wards have been opened.28 Indeed, the “open-door” concept has become such an integral part of modern psychiatric treatment that the Michigan Department of Mental Health has stated that “an effective psychiatric treatment program is not compatible with a maximum security environment.”29

Ionia State Hospital is a maximum security institution and provides a maximum security environment. The Final Report of the Ionia State Hospital Medical Audit Committee, published on October 4, 1965, provides an important insight on the character of life in the institution.

Patient Activities

The members of the Medical Audit Committee were impressed by the fact that even the oldest buildings were as clean and polished as men could make them. The floors, old and in a worn condition, shone like polished ivory. On the other hand, the wards contain nothing which a man could use

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28 As stated by the Michigan Department of Mental Health:
Perhaps it is sufficient to say that today's state mental hospital is no longer oriented toward isolation, custody, and long-term confinement. On the contrary, the mental hospital today is open, permissive in theme, community-oriented, and patient stays are increasingly shorter in duration.

DEPARTMENT OF MENTAL HEALTH, PRELIMINARY PROSPECTUS FOR SPECIAL SECURITY HOSPITAL AND FORENSIC CENTER 4 (Dec. 16, 1968) [hereinafter cited as DMH-PROSPECTUS].

29 Id. at 9.
to occupy his mind, other than to observe television or read some very ancient periodicals of which there seemed to be few. The library, which seems to have a very large collection of books, was locked and empty. One member of the Committee was informed that the library was not available to patients because it would be impossible to supervise them in that setting.

... ... 

The absolutely apathetic, empty existence that these men lead on the wards and the groping efforts which they follow to busy themselves with nothing, is terrible to behold. There was obviously little about which to be hopeful.

The over concern for security is evident everywhere, and this reflects the poor understanding of the mission of the hospital, the culture which surrounds the hospital, and the lack of training for the security attendant staff. As one passes from building to building, one begins to feel somewhat like a mole. Obviously, it is not necessary to pass through the miles of tunnels in order to go from one building to another. It is impossible to believe that this is the best way to provide security. The psychological oppressiveness of this system, in itself, makes it worthy of modification. It seems that a high wire fence topped by barbed wire around all of the buildings, would provide the degree of security necessary to enable groups of men to move back and forth between buildings.

Clothing is limited and non-working patients are showered only once a week. Working patients shower two times each week. The bathing is limited because clothing supplies and linens are limited. Male patients shave two times each week, and attendants give haircuts as needed. No barber is employed.

Seclusion patients usually wear only a night shirt. Seriously disturbed patients may be placed in seclusion without clothes and with nothing but an indestructible blanket. Anyone who threatens or attempts suicide is immediately placed in seclusion, a type of restraint usually reserved for acutely disturbed patients. Since the fear of violence is so marked, and the number of employees is so limited, there is little tolerance of any untoward behavior. Seclusion is used quite widely but always with a physician’s order. However, since the physicians are over-extended, there are times when the need for seclusion is determined by the attendant staff. Physicians’ orders are then obtained as soon as possible, but there can certainly be a lapse of time, since the few physicians are not readily available to ward staff.

Night time toilet needs are met by the use of metal pots for each patient. These pots are not covered, although ten to
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twelve men may sleep in one locked dormitory room. Since ventilation is a problem in some areas, this must be quite an odorous situation by morning.\(^{30}\)

The impact on a mental patient of his transfer from a regional hospital to Ionia is indeed significant. It should be noted that Ionia has undergone changes in structure and operation in the last ten years. For example, the patient census has been reduced from 1,472 (1961 census) to 701 (1970 census). The oldest buildings have been closed to patient occupancy and overcrowding has been eliminated in the remaining structures.\(^{31}\)

However, these improvements have solidified Ionia's position as Michigan's maximum security mental hospital and highlight the disparity in treatment afforded patients confined therein and those confined in regional hospitals. Dr. A. A. Birzgalis, the Medical Superintendent of Ionia, has admitted:

A negative result of the discharge of the enormous number of recovered or improved patients is the continuing great concentration of dangerous patients at the Ionia State Hospital.

The issues of patients being a menace to others and the need for protection of society from them profoundly influence the whole operation of the Ionia State Hospital, its programs, length of hospitalization of patients, relationship of patients with the personnel of the institution, the relationship of this hospital with the news media and the public image of this hospital. Dangerous patients pose special security problems and require proper management.\(^{32}\)

Ionia State Hospital has also had difficulty in recruiting professional staff. According to the June 30, 1969 Hospital Personnel Table,\(^{33}\) Ionia employed only four psychiatrists and nine professional nurses for the 967 patients confined in the institution.\(^{34}\) By comparison, Northville State Hospital, a regional mental hospital with 1,163 resident patients, employed twenty-eight psychiatrists and forty-two professional nurses. Ionia employed no occupa-

\[^{30}\text{Final Report of the Ionia State Hospital Audit Committee 16-18 (1965) [hereinafter cited as Medical Audit].}\]


\[^{32}\text{Id. at 8-9.}\]

\[^{33}\text{Raw data supplied by Mr. James Foster, Associate Director of Operations Analysis and Research Division, Michigan Department of Mental Health, April 29, 1970.}\]

\[^{34}\text{These statistics on the number of patients at the hospitals is as of February 28, 1970. Raw data supplied by Mr. James Foster, Associate Director of Operations Analysis and Research Division, Michigan Department of Mental Health, April 29, 1970.}\]
tional therapists and four social workers. Northville employed four occupational therapists and thirty-six social workers.

C. Recommendations

At a minimum, several statutory changes should be made. First, the Michigan Legislature should enact the following proposal:

ADMINISTRATIVE PLACEMENT OF MENTAL PATIENTS IN IONIA SHALL BE ELIMINATED. PRIOR TO THE TRANSFER OF ANY PATIENT FROM A REGIONAL HOSPITAL TO IONIA, A JUDICIAL HEARING SHALL BE REQUIRED AND JUDICIAL APPROVAL OBTAINED. THE PATIENT SHALL RECEIVE PROCEDURAL SAFEGUARDS INCLUDING, BUT NOT NECESSARILY LIMITED TO: NOTICE OF THE ALLEGATION, RIGHT TO COUNSEL, RIGHT TO INDEPENDENT PSYCHIATRIC EXAMINATION (AT STATE'S EXPENSE IF THE INDIVIDUAL IS IN-DIGENT), RIGHT TO CONFRONT AND CROSS-EXAMINE WITNESSES, AND THE PRIVI-

LEGE AGAINST SELF-INCRIMINATION. THE BURDEN OF PROOF THAT THE INDIVIDUAL MEETS THE STATUTORY CRITERIA FOR TRANSFER SHALL BE PLACED ON THE STATE. ADDITION-

ALLY, THE STATE SHALL BEAR THE BURDEN OF EXPLORING POSSIBLE ALTERNATIVES TO TRANSFER (THAT IS, THE STATE SHALL BE FORCED TO PROVE THAT NO LESS DRASTIC AL-

TERNATIVE, SUCH AS AN INCREASED DOSAGE OF TRANQUILIZERS OR TRANSFER TO A MORE SECURE WARD WITHIN THE SAME HOSPITAL, IS APPROPRIATE TO THE INDIVIDUAL'S CASE).\(^{36}\)

Second, the criteria for transfer of a patient to Ionia should be clarified. The statute\(^{37}\) now provides for transfer to Ionia of any patient who "develops unmistakable dangerous or homicidal tendencies, rendering his presence [at the regional hospital] a source of danger to others." (Emphasis added). Similarly, persons who have committed acts of homicide before or during hospitalization

\(^{35}\) See Section VIII, The Future of Ionia, infra, for recommendations which are considered even more desirable.

\(^{36}\) See Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966), in which the court, per Judge Bazelon, held that prior to ordering the involuntary confinement of an individual in a mental hospital, the court should satisfy itself that no less onerous disposition, such as outpatient treatment with a guardian appointed, would serve the purpose of the commitment.

and whose presence at the regional hospital is a danger to others, may be transferred. While the standard seems sufficient on its face, the word "danger" and its derivatives need further definition. As Judge Bazelon recently stated:

"[D]angerousness" is a many splendored thing. Unless muzzled by discriminating analysis, it is likely to weigh against nominally competing considerations the way a wolf weighs against a sheep in the same scales: even if the sheep is heavier when weighed separately, somehow the wolf always prevails when the two are weighed together. Keeping dangerousness on a taut leash is especially difficult where there is danger of murder, since the danger is admittedly grave and since its improbability which theoretically discounts its gravity, is exceedingly difficult to quantify.

Moreover, once a man has shown himself to be dangerous, it is all but impossible for him to prove the negative that he is no longer a menace. 38

Instead of utilizing the vague standard of "develops unmistakable dangerous tendencies," the following terminology should be substituted:

NO PATIENT SHALL BE TRANSFERRED TO IONIA UNLESS THE REGIONAL HOSPITAL PROVES BEYOND A REASONABLE DOUBT THAT THE PATIENT, WHILE CONFINED IN THE REGIONAL HOSPITAL, COMMITTED AN ACT OR ACTS WHICH HAVE RESULTED IN, OR IF CONTINUED WILL NECESSARILY RESULT IN, SERIOUS BODILY INJURY OR DEATH TO OTHER PATIENTS OR HOSPITAL PERSONNEL AND THAT THERE WAS NO JUSTIFICATION FOR SUCH BEHAVIOR. FURTHER, THE HOSPITAL MUST PROVE THAT IT HAS UNDERTAKEN ALL REASONABLE EFFORTS TO PREVENT REOCCURRENCE OF THE CONDUCT AND THAT SUCH EFFORTS HAVE FAILED TO DETER THE PATIENT AND THAT THERE IS REASON TO BELIEVE THAT THE PATIENT'S INJURIOUS CONDUCT WILL CONTINUE AND BE REPEATED IN THE FUTURE.

PENDING THE COURT HEARING AND DETERMINATION, THE HOSPITAL SHALL BE PERMITTED TO UNDERTAKE REASONABLE PRECAUTIONS, SUCH AS ISOLATING AND RESTRAINING THE PATIENT, TO INSURE THE SAFETY OF

38 Covington v. Harris, 419 F.2d 617, 627 (D.C. Cir. 1969).
OTHER PATIENTS AND HOSPITAL PERSONNEL. HOWEVER, THESE PRECAUTIONS SHALL NOT INCLUDE EMERGENCY TRANSFER TO IONIA.\(^{39}\)

Third, steps should be taken to insure that dangerous patients transferred to Ionia are transferred back to the regional hospitals when their conditions sufficiently improve. In discussing the discharge of patients from Ionia, Dr. Birzgalis has stated that the patients "can be divided into two main groups, namely, 1) patients who are returned either to the criminal courts or to the correctional institutions and 2) patients who are placed on convalescent status into the open community."\(^{40}\) Dr. Birzgalis' statement seems to indicate that dangerous patients who have been transferred into Ionia from the regional hospitals are not transferred back to the regional hospitals when their condition has improved to the point that they are no longer dangerous. In essence, the regional hospitals are permitted to "give up" on problem patients and to relieve themselves of this burden permanently by transferring patients to Ionia. This may even be a factor that unnecessarily encourages transfer to Ionia. Considering the detrimental effects of maximum security confinement on the treatment potential of patients, retransfer to the regional hospitals when the danger abates is highly desirable.

It is not sufficient merely to provide by statute that the Superintendent of Ionia or the Director of the Department of Mental Health shall administratively order the retransfer of ex-dangerous patients from Ionia to the regional hospitals. The New York experience is illuminating on this point. Prior to 1966, the statute merely provided that a person transferred into Matteawan as dangerously mentally ill was to be retained there until he was "no longer dangerous to safety whereupon he may be... transferred to any hospital in the department [of Mental Hygiene] upon the order of the commissioner [of Mental Hygiene]."\(^{41}\) In response to criticism of the Department of Mental Hygiene's failure to retransfer to regional hospitals those patients who were no longer dangerous, the New York legislature amended the statute in 1966 to provide a six month limitation on the original period of detention of any person transferred to Matteawan as dangerously men-

\(^{39}\) The author has considered other possible criteria for transfer to Ionia such as "patient manifests suicidal tendencies" or "patient poses a high risk of escape." The existing statute does not permit transfer on these grounds. Considering the differences in treatment between the regional hospitals and Ionia, an expansion of existing transfer criteria is not warranted.

\(^{40}\) Birzgalis, supra note 31, at 10.

\(^{41}\) Ch. 704, § 4, [1963] N.Y. LAWS.
Thereafter the director of Matteawan could apply to the court for a further period of detention if the patient continued to be dangerous. Of the 210 patients transferred into Matteawan pursuant to the transfer statute who still remained there in 1966, the Superintendent of Matteawan chose to request orders of retention for only seventy-four. The other 136 patients were re-transferred to the regional hospitals of the Department of Mental Hygiene. Unless 136 dangerous mental patients were miraculously cured for their dangerousness in a very short time, it may be assumed that 62 per cent of the patients confined in Matteawan in 1966 pursuant to the "dangerous patient transfer statute" were not, in fact, dangerous.

In order to lessen the possibility that a patient transferred to Ionia as dangerous will be retained indefinitely regardless of improvement in his mental condition, and to prevent claims that the Ionia hospital staff has not recognized a patient's improvement or has arbitrarily delayed in acting upon it, the concept of periodic judicial review should be introduced into Michigan law. A new statute should provide:

NO PATIENT ADMITTED INTO IONIA STATE HOSPITAL SHALL BE RETAINED IN IONIA FOR LONGER THAN SIX MONTHS EXCEPT AS AUTHORIZED BY COURT ORDER GRANTED AT INTERVALS OF SIX MONTHS AFTER NOTICE TO THE PATIENT AND OPPORTUNITY TO DEMAND A HEARING AS HEREINAFTER PROVIDED.

IF THE SUPERINTENDENT OF IONIA DETERMINES THAT ANY PATIENT ADMITTED TO IONIA REQUIRE RETENTION IN IONIA BECAUSE OF DANGEROUS MENTAL ILLNESS, HE SHALL APPLY WITHIN SIX MONTHS OF THE PATIENT'S ADMISSION FOR AN ORDER AUTHORIZING RETENTION. THE PATIENT SHALL BE NOTIFIED OF THE APPLICATION AND GIVEN AN OPPORTUNITY TO DEMAND A HEARING. THE PATIENT SHALL BE ACCORDED ALL PROCEDURAL SAFEGUARDS ACCORDED AT THE PREVIOUS HEARING [See first recommendation supra]. THE STANDARD FOR RETENTION SHALL BE THE SAME AS FOR INITIAL ADMISSION TO IONIA [See second recommendation supra]. THE COURT MAY ORDER THE RETENTION OF

42N.Y. MENTAL HYGIENE LAW § 85 (McKinney 1971).
THE PATIENT (WHEN THE STANDARD IS MET) FOR A PERIOD NOT TO EXCEED SIX MONTHS FROM THE DATE OF THE ORDER, THE TRANSFER OF THE PATIENT TO A REGIONAL HOSPITAL, OR THE RELEASE OF THE PATIENT FROM INVOLUNTARY CONFINEMENT.

FURTHER ORDERS FOR CONTINUED RETENTION MAY BE APPLIED FOR AND ORDERED AS ABOVE.

IV. INCOMPETENCY TO STAND TRIAL

A. Inadequacies of the Pre-1967 Procedure

In 1966 the Michigan Legislature enacted statutes which substantially changed the procedure used to determine competency to stand trial.\(^4\) Prior to 1966 the statute mandated confinement of persons found incompetent to stand trial in Ionia State Hospital. The 1966 legislation was enacted in response to revelations that defendants were being found incompetent to stand trial and committed to Ionia—many for the rest of their lives—as an expedient disposition of the charges against them.\(^5\) In addition, there was some evidence that the incompetency procedure was abused at Ionia State Hospital. A Michigan Department of Mental Health publication stated:

Individuals remained at Ionia for long periods of time in semi-criminal milieu, without any treatment specifically directed toward readying them for trial. . . . There was no statutory review procedure which would serve to encourage frequent reevaluation. The "staff conference" and review by the Medical Superintendent, accomplished in the normal course of hospital administration, was the only review. The clinical notes of many patients reveal that often the treating physicians were not aware that the individual had not been convicted of a crime and was in any different status than a transferee from Jackson Prison. Nor did the clinical notes reveal that the patient was supposed to be treated in order that he might return to trial. Records of staff conferences did not reveal that the staff members conducting the conference were necessarily aware of what was expected of the defendant upon his return to court and consequently it is obvious

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that the staff would be unable to make an informed judgment.\footnote{MICHIGAN DEPARTMENT OF MENTAL HEALTH, PSYCHIATRIC EVALUATION IN CRIMINAL CASES 10 (1967) [hereinafter cited as DMH-PSYCHIATRIC EVALUATION].}

Although the 1966 statutes helped eliminate abuses in incompetency procedures, a careful analysis of the 1966 legislation and the administrative decisions of the Department of Mental Health and the Attorney General indicates actual and potential new abuse that should be eliminated.

B. Confinement in Ionia of Persons Found Incompetent to Stand Trial

When a court determines that a person who has been accused of a crime is mentally incompetent to stand trial, the statute provides that "he shall be committed to the department of mental health for treatment in a public institution approved for the purpose by the department of mental health."\footnote{MICH. COMP. LAWS ANN. § 767.27a (5) (1968).} While some incompetent defendants have been placed in the regional hospitals since the 1966 enactments, 101 patients who were adjudicated incompetent to stand trial after the new laws went into effect remain confined in Ionia State Hospital. Only fifteen of the 101 were initially admitted to regional hospitals before they were transferred to Ionia. The remaining eighty-six were admitted directly to Ionia upon a finding of incompetency to stand trial.

The statute should be changed because it provides for mandatory commitment to a mental hospital upon a determination of incompetency to stand trial. That determination is based on considerations of whether the accused understands the criminal proceedings against him and whether he is capable of assisting his attorney in defense of the charge. The test of competency to stand trial is neither synonymous with the test for involuntary commitment of civil patients to a mental hospital nor determinative of the accused's need for hospitalization. Thus, automatic commitment to a mental hospital upon a finding of incompetency to stand trial implicitly violates the principle enunciated by the United States Supreme Court in \textit{Specht v. Patterson} that without a full hearing a defendant cannot be sentenced under a statute which requires a new finding of fact. Commitment to a mental hospital requires a "new finding of fact" which is not a part of the incompetency determination.

A statute should be drafted to provide:
WHEN A COURT DETERMINES THAT A DEFENDANT IS INCOMPETENT TO STAND TRIAL, IT MAY ORDER THE ACCUSED TRANSFERRED TO THE JURISDICTION OF THE PROBATE COURT IN THE COUNTY OF HIS RESIDENCE FOR AN EXAMINATION AND JUDICIAL DETERMINATION OF WHETHER THE ACCUSED MEETS THE STATUTORY TEST FOR CIVIL COMMITMENT. IF SO, THE INDIVIDUAL SHALL BE HOSPITALIZED IN A REGIONAL HOSPITAL.

Transfer of the individual from criminal court jurisdiction to probate court jurisdiction for a determination of civil commitability seems warranted, first, because the accused’s mental condition which rendered him incompetent to stand trial may also meet the criteria for civil commitment, and, second, because the state has a legitimate interest in bringing criminal defendants to justice as quickly as possible. The treatment accorded the patient in a regional hospital can be expected to improve his mental condition to the extent that he will become competent to stand trial sooner than if he received no treatment.

Since the state has this interest in bringing accused criminals to justice, the state may require the mentally incompetent defendant to undergo therapy designed to restore his competency; but unless the defendant’s mental condition meets the criteria for civil commitment, involuntary institutionalization for treatment should not be required. If it can be shown that the mentally incompetent person can obtain adequate treatment for his mental condition without the necessity of involuntary confinement, the court should make the less onerous disposition.48

The existing statute should also be changed because it provides for an administrative determination of the proper place for treatment of mentally incompetent defendants—a determination that may result in placement in Ionia. It is an elementary but fundamental principle of our legal system that a person accused of a crime is presumed innocent until he is proven guilty. Although he may be required to post bail and is obligated to appear at his trial, a defendant in a criminal case does not forfeit his right to vote, to engage in a profession, etc., because of his status as an accused. For purposes of mental hospitalization, mentally incompetent defendants are similarly situated with noncriminal mentally ill persons. The legal and social policy arguments which support the conclusion that admission to Ionia of allegedly “dangerous” civil

48 See discussion of Lake v. Cameron, supra note 36.
patients should not be left to administrative judgment also apply to the admission of persons accused of crimes.\textsuperscript{49} The recommendations made previously should be extended to mentally incompetent defendants:

PRIOR TO THE ADMISSION TO IONIA OF A MENTALLY INCOMPETENT DEFENDANT, A JUDICIAL HEARING SHALL BE REQUIRED AND JUDICIAL APPROVAL SHALL BE OBTAINED. PROCEEDURAL SAFEGUARDS SHALL BE ACCORDED THE PATIENT. THE STANDARD FOR PLACEMENT IN IONIA SHALL BE PHRASED IN TERMS OF REQUIRING PROOF THAT THE DEFENDANT ENGAGED IN CONDUCT WHILE A PATIENT IN A REGIONAL HOSPITAL THAT HAS RESULTED IN, OR IF CONTINUED WILL NECESSARILY RESULT IN, SERIOUS BODILY INJURY OR DEATH TO OTHERS. PERIODIC JUDICIAL REVIEW OF COMMITMENTS TO IONIA SHALL BE REQUIRED.\textsuperscript{50}

\textsuperscript{49} See Subsection III.A., Administrative Placement of Dangerous Patients, supra.

\textsuperscript{50} If further proof of the dangers of a policy of mandatory commitment and administrative placement of mentally incompetent defendants is needed, New York's experience with incompetents is illustrative. Prior to 1965, New York required mandatory commitment of mentally incompetent defendants at Matteawan. In 1965, the applicable statute was amended to allow the place of hospitalization to be determined by the individual’s medical needs, not by a conclusive presumption of dangerousness from the mere fact of indictment for any crime. The decision of where to send the mentally incompetent defendant was taken out of the court's hands and entrusted to the New York Department of Mental Hygiene. Presumably fewer defendants would be sent to Matteawan under the new procedure. However, the Bar Association of the City of New York reported that in the first seven months of operation under the new law, there were eighty-five patients in one incompetent subcategory assigned to Matteawan by the Department of Mental Hygiene compared with only forty-seven patients so assigned by the courts during the entire prior fiscal year. N.Y. BAR REPORT, supra note 20, at 99. The Bar Association concluded:

We agree with the basic but unarticulated premise of the new procedures—that a defendant who is to be hospitalized should be cared for in an ordinary civil state hospital unless the nature of his illness requires care and custody under high-security conditions. We also believe, however, that so long as a central high-security facility is used for these patients, the decision as to the need for such custody should be made by a court. The available statistics appear to indicate that when the decision is left to clinical judgment, placement at Matteawan occurs in a far greater number of cases than when a court decides, and that very few defendants sent by courts to civil hospitals under the former procedures had to be transferred to Matteawan at a later date.

In our view the state should not continue to view the mere pendency of a criminal charge or indictment as a rational basis for denying these patients the same protection against unnecessary confinement in a central maximum-security correctional institution which is given to every other patient not actually serving a penal sentence—a judicial determination of dangerous mental illness.

C. "Old-Law" Patients

Instead of protecting mentally incompetent defendants until they were ready for trial, incompetency adjudications prior to 1967 were used as an alternative to the regular penal system without the formalities of trial and conviction. As a result of this abuse, 588 mentally incompetent patients were confined in Ionia when the new legislation became effective on March 10, 1967. The act specifically provided that persons presently confined in Ionia as incompetent to stand trial under the old law "shall be subject to the provisions of this 1966 amendatory act . . . ." In order to accelerate the processing of "old-law" incompetent defendants, the Legislature enacted a special section in 1967 which certified incompetent defendants to the Probate Court of Ionia County. Nevertheless, 173 "old-law" incompetents remain confined in Ionia.

There are several complicated constitutional issues involved in the continued confinement of these "old-law" incompetents in Ionia. First, it is arguable that those unconvicted defendants who have been confined in Ionia for periods exceeding the maximum sentences to which they could be subjected after trial and conviction are similarly situated with mentally ill ex-convicts. Following the rationale of Baxstrom v. Herold, if a person convicted of a crime cannot be detained in Ionia by the administrative decision of the Director of Mental Health after his sentence has expired, surely an unconvicted defendant cannot be detained by the Director beyond the maximum possible sentence that could be imposed against him if he had been convicted. Further, the Court in Baxstrom held that ex-convicts whose sentences have expired cannot be administratively classified as dangerously mentally ill in spite of their proven past criminal activity; a fortiori this holding applies to "sentence-expired" accused defendants whose past criminal activity is only alleged.

The second issue concerns the fact that the statute authorizes

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51 During the period July 1954 to December 1960 a total of 470 defendants were committed to Ionia as incompetent to stand trial, a rate of about 84 admissions per year. During this same period approximately 105 were discharged back to the committing court, a rate of little more than 16 per year. Comment. Criminal Law—Insane Persons—Competency to Stand Trial, 59 MICH. L. REV. 1078, 1088 (1961).

52 Birzgalis, supra note 31, at 5.


54 MICH. COMP. LAWS ANN. § 767.27c (1968).

55 On the other hand, it can be argued that until Act 266 became effective, time spent by defendants incompetent to stand trial in Ionia was not credited against any sentence subsequently imposed at trial. However, at least since March 10, 1967, the effective date of Act 266, "old-law" patients should be entitled to this credit.

56 MICH. COMP. LAWS ANN. § 767.27(c) (1968).
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civil commitment of these "old-law" patients by the Probate Court of Ionia County. In fact, the statute also authorized the assignment of "a visiting or retired judge to the Ionia county probate court for a period not to extend beyond June 30, 1969, for the exclusive purpose of hearing cases under this section which judge is authorized to hold court within the Ionia State Hospital."

For involuntary civil commitment of any other mentally ill person, the statutes require a petition and hearing before the probate court of the county in which the mentally ill person resides. A court might hold that the Michigan statute denied equal protection of the laws by authorizing civil commitment of incompetent defendants through a specially convened Ionia County Probate Court whose exclusive purpose was to hear these cases and which might have been less sympathetic to the patient's position than the court in the patient's home county. It would be difficult for the State to contend that involuntary commitment of an individual at Ionia as incompetent to stand trial changes his county of residence to Ionia County.

Finally, those "old-law" incompetents who were retained as civil patients in Ionia might have been denied equal protection of the laws for yet another reason. The law currently authorizes transfer into Ionia of patients in the regional hospitals who develop unmistakable dangerous or homicidal tendencies and whose presence there is a source of danger to others. Civil patients other than "old-law" incompetents are admitted directly to regional hospitals, not Ionia. However, the statute dealing with incompetents, as it was administered, was utilized as an Ionia admissions statute for "old-law" incompetents. Admission to Ionia was authorized for this class of civil patients even though they exhibited no dangerous or homicidal tendencies in a regional hospital.

To do justice to these "old-law" incompetents who have been denied justice for so long, this writer recommends that a statute be enacted to provide:

ALL CIVILLY COMMITTED "OLD-LAW" INCOMPETENTS SHALL BE CERTIFIED TO THE PROBATE COURT OF THE COUNTY OF THEIR RESI-

See also Baxstrom v. Herold, 383 U.S. 107, 111 (1966): "Equal protection does not require that all persons be dealt with identically but it does require that a distinction made have some relevance to the purpose for which the classification is made."
DENCE. THE PROBATE COURT SHALL DETERMINE THE ISSUE OF CIVIL COMMITTABILITY AS IT DOES FOR ALL OTHER ALLEGEDLY MENTALLY ILL PERSONS. IF COMMITMENT IS ORDERED, THE PATIENT SHALL BE CONFINED IN THE REGIONAL HOSPITAL THAT SERVICES HIS PLACE OF RESIDENCE, ONLY IF THE PATIENT DEVELOPS DANGEROUS TENDENCIES AT THAT HOSPITAL SHALL HE BE TRANSFERRED INTO IONIA IN ACCORDANCE WITH THE PROVISIONS OF MICH. COMP. LAWS ANN. § 330.67 (1967)\textsuperscript{61}

D. Treatment of Incompetent Defendants in the Regional Hospitals

In the ten year period from July 1, 1956, to June 30, 1966, approximately eighty persons per year were adjudicated incompetent to stand trial in Michigan.\textsuperscript{62} As mentioned previously, prior to the 1966 amendatory legislation, all such adjudications resulted in commitment to Ionia. One of the most significant changes made in 1966 was the enactment of a section which provides that once a person has been adjudicated as incompetent to stand trial "he shall be committed to the department of mental health for treatment in a public institution."\textsuperscript{63} While commitment is still mandatory under the new legislation, confinement in Ionia is not.\textsuperscript{64}

The quality of treatment accorded persons found incompetent to stand trial who are confined within the regional hospitals requires close examination. There is no doubt as to the right to treatment of persons confined as incompetent to stand trial. First, the statute specifically mandates treatment for these patients.\textsuperscript{65} As Professor B. J. George, Jr. has stated:

In the past the Department sometimes felt that it had to hold persons committed as incompetent to stand trial in a purely custodial, non-treatment status, a result that com-

\textsuperscript{61} Obviously, if the recommendations made previously for changes in MICH. COMP. LAWS ANN. § 330.67 (1967) are adopted, they should apply to these "old-law" incompetents also.

\textsuperscript{62} DMH-PSYCHIATRIC EVALUATION, supra note 46, at 16.

\textsuperscript{63} MICH. COMP. LAWS ANN. § 767.27a (5)(1968).

\textsuperscript{64} Part B of this section recommends the elimination of both mandatory commitment and administrative placement upon an adjudication of incompetency. The recommendation, if accepted, should result in an even greater reduction in the number of commitments to Ionia and a significant increase in the number of incompetents confined in the various regional hospitals. This does not mean that there will be an increase in the total number of incompetency adjudications. They can be expected to continue at approximately 80 per year.

\textsuperscript{65} MICH. COMP. LAWS ANN. § 767.27a (5)(1968).
pounded the original injustice in committing the man in the first place without adequate trial of the issue of incompetence. By authorizing treatment, the legislation avoids any suggestion in future litigation that detention without therapy constitutes cruel and unusual punishment.  

Professor George's statement that litigation will be avoided is only correct if therapy is in fact given these patients in the regional hospitals. The statutory requirement of treatment could well result in patients who have been inadequately treated obtaining release on writs of habeas corpus.  

This is not to suggest that if the statutory requirement of treatment were eliminated, the state could confine persons adjudicated as incompetent without according them adequate treatment. As Professor George indicated above, such confinement might constitute cruel and unusual punishment. Furthermore, confinement without adequate treatment to improve his mental condition might arguably violate the accused's constitutional guarantee of a speedy trial.  

It appears, however, that the Department of Mental Health does not consider treatment of incompetent defendants to be its paramount function. In a memorandum dated September 26, 1968, and addressed to the Superintendents of the regional mental hospitals, William H. Anderson, M.D., the Department's director, stated:  

When patients in this legal category [incompetent to stand trial] are hospitalized at the regional hospital, it must be remembered that these patients do represent a special group

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67 Habeas corpus can be used to determine whether a patient's commitment to an institution conforms to the statutory requirements. Ex parte Brooks, 331 Mich. 631, 50 N.W.2d 306 (1951), Ex parte Fidrych, 331 Mich. 485, 50 N.W.2d 303 (1951); Mich. Comp. Laws Ann. § 600.4322 (eff. Jan 1, 1963). The recent case of Bilingsley v. Birzgalis, 20 Mich. App. 279, 174 N.W.2d 17 (1969), held that that statute, providing the incompetent defendants confined in an institution cannot be released without the approval of the Center for Forensic Psychiatry, does not preclude resort by the incompetent to the remedy of habeas corpus.  

Mention should also be made of a case recently decided by the New York Court of Claims. The court awarded the claimant, a person found incompetent to stand trial, a $300,000 judgment against the State as compensation for moral and mental degradation, physical injuries, pain and suffering, and loss of earnings caused by a twelve year denial of the right to treatment. Whitree v. State, 56 Misc. 2d 693, 290 N.Y.S. 2d 486 (Ct. Cl. 1968).  

68 While no court has held that the state has a duty to improve the mental condition of an incompetent defendant, that conclusion might be reached by a court considering the four factors of length of delay, cause or motivation of the delay, prejudicial results, and waiver. The general rule is that these factors must be weighed in determining whether there has been a denial of the right to a speedy trial. Needel v. Scafati, 412 F.2d 761 (1st Cir.), cert. denied, 396 U.S. 861 (1969).
in a legal sense and the Department of Mental Health is charged with their custody and confinement in addition to their hospital treatment.

Clarification is being sought from the Attorney General as to the degree of security required [in the regional hospitals]. As an interim measure, you are requested to treat these patients on locked wards or their equivalent, until they are either returned to court as competent to stand trial or certified to the probate court for civil commitment as required by statute. Although this may constrain, to some degree, therapeutic programming for these individuals, our legal responsibilities for confinement and custody must take precedence.

Although the directive “to treat these patients only on locked wards or their equivalent” was ostensibly rescinded by a memorandum dated March 19, 1969, this latter memorandum stated that “the avoidance of an unauthorized absence or escape is to be given priority consideration.” These memoranda indicate that the Department of Mental Health is employing a highly questionable policy regarding patients who are incompetent to stand trial. Although all incompetents evaluated as dangerous or escape risks are supposedly sent directly to Ionia, the Department’s policy seems to be that those incompetents sent to regional hospitals still present a special security problem, and that treatment of incompetents at the regional hospitals should be sacrificed to security.

This Department policy has resulted in the decision by some Medical Superintendents to concentrate all criminal order patients received by the hospital into a special high security ward without regard to the level of security required in the individual case. Thus, there is no assurance that incompetents placed in regional hospitals instead of Ionia will receive treatment commensurate with their mental conditions as contemplated by the legislation.

Therefore, a new set of principles should be enunciated to guide the regional hospitals in providing adequate treatment to mentally incompetent defendants. This writer suggests the following:

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Even Dr. Anderson has recognized the injustice inherent in this practice. In a memorandum dated March 5, 1970, to the Superintendents of the regional hospitals, Dr. Anderson wrote:

My own opinion is that where we are operating separate nursing units for mentally ill offenders we may well find ourselves duplicating the problems that originally led to dissatisfaction with the treatment programs at Ionia. There is also the possibility that separate units may be looked upon by courts as not having the same level of access to therapeutic resources as mixed nursing units.
1. The Department of Mental Health is not a jailor and should neither be expected nor required to treat any patient in its custody as a prisoner. The Department of Mental Health has "custody" of civil mental patients committed through the probate courts. The same treatment given to the civil mental patients should be afforded those patients who are adjudged incompetent to stand trial and committed to the Department by the criminal courts. These patients should no longer be treated as criminals and confined in high security or locked wards; security should only be maintained when a patient's mental condition warrants it. Patients within the Department's custody should be released on home visits, granted leaves of absence, and placed on convalescent status when their mental conditions have improved sufficiently.

2. Any person adjudicated as incompetent to stand trial is not a criminal. Indeed, if he were not mentally ill, an accused would, in most cases, be entitled to his freedom (on bail) pending his trial.

3. In any case where a person adjudicated as incompetent to stand trial is not receiving treatment in accordance with the needs of his particular condition, the patient, the Department of Mental Health, and the very purpose of the incompetency commitment, are being abused. Incompetency commitments should no longer be used as a means to dispose of difficult cases or as a device for preventive detention.

In part B of this section, it was suggested that for purposes of commitment to regional hospitals or commitment to Ionia, mentally incompetent defendants should be similarly situated with noncriminal mentally ill persons. Similarly, for purposes of treatment within the regional hospitals, mentally incompetent defendants who have been committed to the regional hospitals should be similarly situated with noncriminal mental patients in the regional hospitals. Because of the importance of this point, a statute should be drafted to the effect that:

ANY PERSON WHO HAS BEEN ADJUDICATED INCOMPETENT TO STAND TRIAL AND COMMITTED TO THE DEPARTMENT OF MENTAL HEALTH SHALL BE TREATED IN ACCORDANCE WITH THE NEEDS OF HIS MENTAL CONDITION, IRRESPECTIVE OF HIS LEGAL STATUS.

E. The Goals of Treatment and Periodic Judicial Review

The above recommendation is designed to ensure that mental hospital personnel dealing with incompetent defendants view their function as non-judgmental therapists treating mentally ill human
beings. While mentally ill incompetent defendants should be treated like all other mental patients, should the goal of treatment be the same? Should the goal be to restore the mentally incompetent patient's mental health and social competency, or should the goal be to provide the necessary treatment which will allow the patient to achieve legal competency? These questions are very significant because the choice of goal may affect the therapy given the patient. For example, if the goal is speedy restoration of legal competency, extensive shock or drug therapy might be utilized to render the defendant legally competent at the expense of his ultimate recovery to full mental health. This result should be avoided.\(^7\)

Drs. Hess and Thomas, in examining incompetency commitments to Ionia prior to the 1966 legislative amendments, made two relevant observations:

Considering the meaning and purpose of incompetency concepts, it would seem that if the court has any interest, it should be to ensure that the competent individual be tried as soon as he can be considered competent. With this in mind, we were amazed to learn of the almost total lack of interest the court took in the defendant after his commitment.

The confusion existing at the time of the incompetency hearing follows the defendant to the hospital. Cases were frequent in which the hospital staff disagreed with the diagnosis made by the examining psychiatrist at the time of the hearing. It was also not uncommon that the hospital staff, in view of the patient's mental status, could not understand why the patient had been committed. The label "incompetent" was a familiar one to hospital personnel, but the meaning and implications of this label were not clear. This being the case, it was not surprising that the goals of treatment were vague and inconsistent.\(^7\)

At the time of these comments, at least half the patients in Ionia were in the incompetent to stand trial category. If the Ionia personnel were confused as to the goal of treatment, the personnel at the regional hospitals, where only a very small percentage of the patients are in this category, are even more likely to be confused today.

These problems could be remedied by the adoption of the


following suggestions. First, the regional hospital personnel should be advised that, as specified by the proposed statute, they are to treat incompetent defendant patients exactly as they treat all other patients. The goal of treatment—restoration to mental health and social competency—should be the same for all patients. While treatment methods and goals should not differ, the personnel should be advised that whenever in the course of treatment they are of the opinion that a patient has regained legal competence, the appropriate court should be immediately informed of this fact and the patient returned to court. The Department of Mental Health should instruct its personnel about the test of competency and the fact that in many cases a person may be legally competent to stand trial before he is ready for release into society.

Second, a statute should be drafted to provide:

NO PERSON ADJUDICATED INCOMPETENT TO STAND TRIAL AND ADMITTED TO A DEPARTMENT OF MENTAL HEALTH HOSPITAL SHALL BE RETAINED IN THE CUSTODY OF THE DEPARTMENT FOR LONGER THAN SIX MONTHS EXCEPT AS AUTHORIZED BY COURT ORDER AT INTERVALS OF SIX MONTHS GRANTED AFTER NOTICE TO THE PATIENT AND AN OPPORTUNITY TO DEMAND A HEARING AS HEREAFTER PROVIDED.

IF THE SUPERINTENDENT OF THE HOSPITAL IN WHICH AN INCOMPETENT DEFENDANT IS CONFINED DETERMINES THAT THE PATIENT IS NOT YET COMPETENT TO STAND TRIAL AND REQUIRES RETENTION IN THE HOSPITAL FOR FURTHER TREATMENT OF HIS MENTAL CONDITION, HE SHALL APPLY WITHIN SIX MONTHS OF THE PATIENT'S ADMISSION TO THE CRIMINAL COURT FOR AN ORDER AUTHORIZING RETENTION. THE PATIENT AND HIS ATTORNEY SHALL BE NOTIFIED OF THE APPLICATION AND GIVEN AN OPPORTUNITY TO DEMAND A HEARING. IF THE COURT DETERMINES THAT THE DEFENDANT IS STILL INCOMPETENT TO STAND TRIAL, IT MAY ORDER HIM RETAINED FOR A PERIOD

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Under this writer's proposals, the probate court orders initial commitment of the incompetent defendant when he meets the criteria for civil commitability. However, since the defendant, when competent, is returned to the criminal court for trial, that court, which initially adjudicated him incompetent, should determine whether he has been restored to competency.
NOT TO EXCEED SIX MONTHS FROM THE DATE OF THE ORDER.
FURTHER ORDERS FOR CONTINUED RETENTION MAY BE APPLIED FOR AND ORDERED AS ABOVE.
AT ANY TIME WITHIN ANY SIX MONTH PERIOD, THE SUPERINTENDENT OR THE DEFENSE ATTORNEY MAY NOTIFY THE COURT THAT IN HIS OPINION THE ACCUSED HAS BEEN RESTORED TO COMPETENCY. UPON SUCH NOTIFICATION THE COURT SHALL IMMEDIATELY HEAR AND DETERMINE THE ISSUE OF COMPETENCY. IF THE COURT DETERMINES THAT THE DEFENDANT IS STILL INCOMPETENT TO STAND TRIAL, IT MAY ORDER HIM RETAINED FOR A PERIOD NOT TO EXCEED SIX MONTHS FROM THE DATE OF THE ORDER.

The principle of periodic judicial review, which was previously recommended for dangerously mentally ill patients transferred into Ionia, seems equally applicable where the issue is whether a defendant adjudicated as incompetent to stand trial by one court, and adjudicated civilly commitable by another court, is now competent to stand trial. Society cannot and should not expect physicians to play the role of judges and determine in every case when the defendant is competent to stand trial. The responsibility for application of this legal standard should rest with the courts.

The recommendation also takes into consideration the importance of defense counsel in the determination of competency to stand trial. Since a major portion of the test of competency concerns the accused's ability to assist his attorney in defending the criminal charge, defense counsel should be permitted to request a hearing on the issue when he is of the opinion that the accused has been restored to competency.

As a final safeguard, a statute should be enacted to provide:

THE CRIMINAL COURT IS AUTHORIZED TO APPROVE OR DISAPPROVE A COURSE OF TREATMENT SELECTED FOR A NONCIVILLY COMMITABLE INCOMPETENT DEFENDANT. THE TREATING PHYSICIAN OR THERAPIST SHALL BE PERMITTED TO INFORM THE COURT WHEN THE DEFENDANT HAS REGAINED LEGAL COMPETENCE. PERIODIC JUDICIAL REVIEW (AS OUTLINED ABOVE) SHOULD ALSO APPLY TO THIS SITUATION.
F. Incompetent Defendants as Voluntary Patients and Release of Incompetent Defendants on Convalescent Status

It was recommended in part B of this section that persons adjudicated incompetent to stand trial should not be automatically confined as involuntary patients in a mental hospital. Such confinement is not warranted where the individual’s mental condition does not meet the standard for involuntary civil commitment. If this recommendation is accepted, and if the recommendation that the goal of confinement be the treatment of the patient’s mental illness is also accepted, then the modern psychiatric approach of admission of patients to mental hospitals on a voluntary basis should logically apply to incompetent defendants. Nevertheless, regarding the release of incompetent defendant patients from the regional hospitals, the memorandum of September 26, 1968, from Dr. Anderson to the hospital Superintendents stated:

Thus it is clear that such patients, as has been previously stated, shall not be released on convalescent care or visit, and all indicated reasonable precautions shall be taken to prevent such patients from leaving the hospital without authorization.\(^7^3\)

There is a legitimate question as to whether an individual who is well enough to be considered for release on convalescent care, that is, well enough to maintain himself away from the hospital, can still be considered incompetent to stand trial. However, in an unusual situation, for example, where the individual has access to private therapeutic help and has a family to watch after him, a patient might be both capable of release on convalescent care and incompetent to stand trial. Such a person should not be denied release, and, if necessary, a statute should be drafted to so provide.\(^7^4\)

G. The Eighteen Month Commitment and Removal from “Accused” Status

Certain statutory provisions were designed to limit to eighteen months the treatment of an incompetent accused in a Department of Mental Health hospital.\(^7^5\) If a defendant becomes competent to

\(^7^2\) This directive was reiterated in a March 14, 1969, memorandum.

\(^7^3\) It should be noted that the concept of convalescent leave was severely abused under the pre-1966 legislation. “During the period July 1, 1965, to June 30, 1966, 275 paroles were granted for convalescence. . . while 452 persons were returned to court as competent to stand trial.” DMH-PSYCHIATRIC EVALUATION, supra note 46, at 11. Release on convalescent status instead of return to trial as a competent should rarely be necessary.

\(^7^4\) MICH. COMP. LAWS ANN. § 767.27a(6)-(8) (1968).
stand trial prior to or at the end of eighteen months, the statutes provide for his return to court for trial. However, if the Department of Mental Health determines that the defendant is still incompetent to stand trial at the end of eighteen months, a section provides that the Department shall certify its opinion to the probate court in the county from which the defendant was originally committed.\textsuperscript{76} That court is required to treat the certification as a petition for involuntary civil commitment. The probate court may make only one of two dispositions:\textsuperscript{77} it may order defendant civilly committed if he is civilly committable; or, if he is not civilly committable, it must return the defendant to the criminal court which initially ordered him committed as incompetent to stand trial. If the second alternative is followed, the criminal court, after holding a hearing, may make one of two dispositions: it may determine that defendant is now competent to stand trial and proceed to trial; or, reversing the probate court decision, it may order the defendant civilly committed. Time spent in Department of Mental Health custody, whether before or after the eighteen month period, is credited against any sentence imposed on the defendant in the pending criminal case, and the statute of limitations on the criminal charge begins to run upon entry of the order of commitment.\textsuperscript{78}

These statutes, taken together, attempt to eliminate a major abuse of pre-1966 legislation. No longer are defendants confined in a mental hospital for years or a lifetime in the status of incompetent defendant. However, this legislation, while progressive in purpose, suffers from a logical inconsistency, for it erroneously presumes that any person who is incompetent to stand trial is necessarily civilly committable. As mentioned above, the tests are not synonymous, and the statute is silent on the proper disposition of a patient who, after eighteen months, is incompetent to stand trial, but not civilly committable.\textsuperscript{79}

The 1966 amendatory statutes have also been subjected to a rather conservative construction by the Attorney General. Prior to 1966, if Ionia returned a patient to court as competent to stand

\textsuperscript{76} \textit{Id.} § 767.27a(7).

\textsuperscript{77} \textit{Id.} § 767.29(a)(8).

\textsuperscript{78} Thus, if a defendant is charged with a crime that carries a maximum sentence of two years, he will not be tried for that crime after he has spent two years in Department of Mental Health custody.

\textsuperscript{79} It should be noted that these statutes may also violate the equal protection clause of the fourteenth amendment, for \textit{Mich. Comp. Laws Ann.} § 767.27a(7) (1968) provides for civil commitment by the probate court in the county where the patient was initially committed and not the county of his residence. \textit{See} the discussion of a similar problem in text accompanying notes 56-58 \textit{supra}.
Mental Illness

trial and the court held that the defendant was still incompetent, it could order a new commitment to Ionia. According to Professor George, "[t]he hospital in turn might return the man immediately, and the badminton game continue indefinitely with the defendant as shuttlecock."\(^8\) The eighteen month maximum "time limit" on the incompetency commitment was designed to end this perverted game. However, on August 15, 1969, the Attorney General sent a letter to Dr. Anderson containing the following statement of the problem and the Attorney General’s opinion:

The department [of Mental Health] arrives at an opinion during the 18-month commitment period that the defendant is competent and so certifies the case to the original committing court. The court, as provided by statute, proceeds to determine the question of competence and in some instances makes a finding that the defendant is still incompetent to stand trial and returns the person to our jurisdiction by the issuance of a new order which usually by its terms again commits the patient for a period not to exceed 18 months.

Your question is whether the 18-month period as prescribed in the statute should run at the time the patient was originally committed or whether a new 18-month period begins at the time of the second commitment.

I advise you that the 18-month period cannot run as of the time that the patient was originally committed since the original commitment has been discharged by the act of the Department of Mental Health in certifying the patient back to the original committing court for the court’s present disposition. It follows that the order under the authority of which the Department of Mental Health now receives the patient is the order constituting the second commitment. The 18-month period provided by the statute therefore applies from and after the second order of commitment.

Thus, the badminton game, with the possibility of indeterminate—even lifetime—commitment, continues unabated.

The recommendations calling for periodic judicial review of the commitment of persons hospitalized after an adjudication of incompetency to stand trial\(^8^1\) eliminate the need for the eighteen month commitment provisions of the Michigan statute.\(^8^2\) The proposed changes properly recognize that civil commitment should not be automatic upon adjudication of incompetency to stand trial, and they recognize the court’s continuing respon-

\(^8^0\) George, supra note 66, at 19.
\(^8^1\) See text accompanying note 72 supra.
sibility for incompetent patients. If these recommendations are accepted, certain sections\textsuperscript{83} should be repealed. However, the section which provides for the crediting of time spent in a Department of Mental Health institution against any criminal sentence subsequently imposed\textsuperscript{84} should be retained. The statute of limitations on the pending criminal charge should start to run upon the adjudication of incompetency to stand trial, not upon the entry of an order of commitment, as the statute presently provides. In accord with a Bar Association of the City of New York recommendation on the subject,\textsuperscript{85} the following addition to the Michigan statutes is proposed:

THE CRIMINAL COURT SHALL DISMISS THE PROSECUTION AGAINST ANY DEFENDANT ADJUDICATED INCOMPETENT TO STAND TRIAL WHENEVER:

(1) THE DEFENDANT HAS BEEN HOSPITALIZED, VOLUNTARILY OR INVOLUNTARILY, FOR A PERIOD LONGER THAN THE MAXIMUM OR PROBABLE SENTENCE THAT SHOULD BE IMPOSED AGAINST HIM IF HE WERE CONVICTED OF THE CHARGE AGAINST HIM; OR

(2) THE PROSECUTOR NOTIFIES THE COURT OF HIS INTENTION NOT TO PROSECUTE THE CASE; OR

(3) THE COURT DETERMINES THAT IN THE INTEREST OF JUSTICE, THE ACTUAL OR PROSPECTIVE DELAY UNTIL TRIAL MAKES IT UNFAIR TO FURTHER POSTPONE THE CASE.


V. CRIMINAL IRRESPONSIBILITY

Mich. Comp. Laws Ann. § 767.27b (1968) provides:

Any person, who is tried for a crime and is acquitted by the court or jury by reason of insanity, shall be committed immediately by order of the court to the department of mental health for treatment in an appropriate state hospital.

\textsuperscript{83}Id.

\textsuperscript{84}Id. § 767.27a(9).

\textsuperscript{85}N.Y. BAR REPORT, supra note 20, at 120–21.
The insanity defense is raised in only about one-tenth of 1 percent of the criminal cases each year, and acquittals on that basis are a significantly rarer occurrence. The infrequent use of this defense may be explained by the existence of the mandatory commitment statute. A defendant charged with a minor offense is generally loathe to utilize the defense of insanity, because if his defense is successful, he can be confined indefinitely in Ionia. A short prison sentence is usually considered a preferable alternative, even though the defendant may have been criminally irresponsible at the time of the criminal act.

The statute quoted above may be constitutionally objectionable because it provides for mandatory commitment upon an insanity acquittal and permits the Department of Mental Health to administratively determine the place of confinement. Although it can be argued that mandatory commitment following acquittal by reason of insanity is justified by a "presumption" that insanity existing at the time of the crime continues through the verdict and supports an order of hospitalization, and that a defendant who is successful in establishing insanity as a defense cannot object to the "presumption" of continuing insanity, such a "presumption" cannot be supported on either theoretical or practical grounds.

In Michigan, once a defendant introduces sufficient evidence of mental irresponsibility to create a jury question on the issue, the prosecution must prove beyond a reasonable doubt that the defendant was not insane. Thus, a verdict of not guilty by reason of insanity does not mean that the jury found the defendant to have been insane, but only that the state did not satisfy its burden of proving that the defendant was sane. The attempted use of a "presumption" of continuing insanity arising from a verdict of not guilty by reason of insanity is not justified where there has never been a finding of insanity. At most, an acquittal by reason of

86 There are now nineteen patients in this category confined in the Ionia State Hospital. Prior to the enactment of Act 266, all persons acquitted by reason of insanity were required, by statute, to be confined in Ionia. In the twenty-five year period of 1949 to 1966, only nineteen persons were committed to Ionia following acquittal of murder, and the hospital averaged about two to three insanity acquittal commitments yearly for crimes less than murder. DMH-Psychiatric Evaluation, supra note 46, at 33.

A verdict of not guilty by reason of insanity is a prerequisite to commitment for treatment to the Department of Mental Health of a person acquitted of a crime by reason of insanity, and the statute cannot be applied where the jury merely returns a verdict of "not guilty," notwithstanding proper imposition of the insanity defense. People v. Way, 22 Mich. App. 473, 177 N.W.2d 729 (1970).


insanity reflects only a reasonable doubt that the defendant was sane at the time of the offense.

In *Bolton v. Harris,* the Court of Appeals for the District of Columbia, construing the District’s mandatory commitment statute, recognized the limitations of a verdict of not guilty by reason of insanity. The court, per Chief Judge Bazelon, relied on *Baxstrom v. Herold* for the principle that “[t]he commission of criminal acts does not give rise to a presumption of dangerousness which, standing alone, justifies substantial difference in commitment procedures and confinement conditions for the mentally ill.” Thus, committing a person found not guilty by reason of insanity without affording him the procedural safeguards established under the civil commitment scheme constituted a denial of equal protection of the laws. The court rejected the argument, previously rejected by the United States Supreme Court in *Baxstrom,* that expeditious commitment of various categories of non-convict mentally ill persons is somehow justified because of the dangerous or criminal propensities of the individuals involved. It must be shown in a civil commitment hearing that the defendant’s mental condition meets the criteria for involuntary civil commitment.

Judge Bazelon also relied on the Supreme Court decision in *Specht v. Patterson* to rule that the mandatory commitment statute was constitutionally suspect for failing to provide a hearing on the issue of present mental condition. The court held that a trial that results in a verdict of acquittal by reason of insanity only determines that there is a reasonable doubt as to the defendant’s sanity at the time of the criminal act. A new finding of fact is required for civil commitment, that is, the court must find that defendant’s mental condition currently meets the statutory criteria for civil commitment.

To save the District of Columbia statute from constitutional invalidity, Judge Bazelon construed the statute to authorize temporary detention of the individual for an examination to determine whether his current mental condition necessitates civil commitment.

Automatic, indeterminate institutionalization of defendants acquitted by reason of insanity should be ended. The following statute should be enacted to replace the present law:

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89 395 F.2d 642 (D.C. Cir. 1968).
90 *Id.* at 647.
91 The New York Court of Appeals, used similar reasoning and reached similar results in construing its mandatory commitment statute. People v. Lally, 19 N.Y.2d 27, 224 N.E. 2d 87, 277 N.Y.S.2d 654 (1966).
WHEN A DEFENDANT IS ACQUITTED OF A CRIME BY REASON OF INSANITY, THE COURT MAY ORDER HIM TRANSFERRED TO THE JURISDICTION OF THE PROBATE COURT IN THE COUNTY OF HIS RESIDENCE FOR AN EXAMINATION AND JUDICIAL DETERMINATION OF WHETHER HE MEETS THE STATUTORY TEST FOR CIVIL COMMITMENT. IF SO, THE INDIVIDUAL SHALL BE HOSPITALIZED, TREATED, RELEASED, AND DISCHARGED, IN ACCORDANCE WITH PROCEDURES ESTABLISHED FOR OTHER CIVIL PATIENTS.

The recommended statute also eliminates the possibility of administrative placement of acquitted defendants in Ionia. The legal and social policy considerations that argue against admission to Ionia of allegedly "dangerous" civil patients through administrative discretion are equally applicable to persons acquitted of crimes by reason of insanity. While it can be argued that an insanity acquittal requires proof that the defendant committed a criminal act, such proof is insufficient to demonstrate dangerousness of the individual to the patients or staff of the regional hospital—the standard for transfer of civil patients to Ionia.

Special mention must be made of the inadequacy of the existing treatment, release, and discharge provision of the insanity defense statute and the administrative practices promulgated thereunder. The provision now says that a person acquitted of a crime by reason of insanity and committed to the Department of Mental Health for treatment in a hospital is to be discharged in accordance with the statutes governing release of patients civilly committed. The statute then provides:

The person shall not be released on convalescent care or final discharge without first being evaluated and recommended for release by the center for forensic psychiatry.93

In a memorandum dated March 14, 1969, the Director of the Department of Mental Health set forth the Department's policy regarding not-guilty-by-reason-of-insanity patients:

Such patients...while in the hospital, have the same legal status as patients committed by the probate courts, and the superintendent is authorized to utilize his own best clinical

93 Id. The Center for Forensic Psychiatry is a facility of the Department of Mental Health. The primary responsibility of the Center is performing psychiatric evaluations on the issue of competency to stand trial for those defendants committed to the Center by the criminal courts.
judgment in the degree of security required. In view of the history of criminal involvement in these cases, the avoidance of unauthorized absence or escape is to be given priority consideration.

Although the statute requires treatment for patients mandatorily committed after acquittal by reason of insanity, it is apparent that they are not treated like other civil patients. By giving priority consideration to the prevention of escape, the Department’s policy has often resulted in confinement of these patients in special maximum security wards, even though, were they civilly committed, their mental condition would not warrant such close confinement.

Discrimination against these patients has also occurred when they are considered for release or discharge. Although the existing statute can clearly be construed to specify that individuals acquitted by reason of insanity are to be released from the mental hospital when they meet criteria for release established for other civil patients, the statutory requirement of approval by the Forensic Center prior to release has resulted in the application of different and more stringent criteria to these patients. In a letter dated August 17, 1970, Dr. Ames Robey, Director of the Center for Forensic Psychiatry, stated:

The criteria applied by the Center at the present time, in the absence of any definite statute have been as follows:

The patient may be approved for discharge when (1) the illness of which the criminal act was a product is in control, remission or cured; and (2) he may be certified within the bounds of reasonable medical certainty for the foreseeable future as no danger to the public or himself.

It is the second part of this test that has represented the greatest problem. Several cases are presently pending with writs of habeas corpus on the issue that the patient is no longer mentally ill, but with the Center holding that the risk for recidivism and danger to others is extremely high.

Even if it were assumed that the Forensic Center is statutorily empowered to utilize different release criteria for acquitted defendants, the criteria used are suspect. The Center may justify the continued confinement of nonmentally ill (although allegedly dangerous) persons in regional mental hospitals by placing reliance on the case of *Ex parte Dubina*. In *Dubina*, however, the Michigan

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94 311 Mich. 482, 18 N.W.2d 902 (1945).
Supreme Court merely affirmed the trial court’s order continuing the patient’s confinement, specifically ruling that the trial court’s conclusion that the patient was currently mentally ill (insane) was sustained by the record. The case, while discussing dangerousness as a relevant factor in the decision to release, does not stand for the proposition that the State can continue to confine in a mental hospital sane, although allegedly dangerous, persons. Such a policy would transform the regional hospitals into jails for the confinement, not treatment, of noncriminals. What the State was not able to accomplish by criminal trial, that is, the conviction and confinement of the defendant, cannot legally be accomplished by administrative prediction of potential future dangerousness.

The previously recommended statute, by equating mental patients acquitted of crime by reason of insanity with other civil mental patients in all respects—including treatment, release, and discharge—provides the desirable alternative.

VI. “OLD-LAW” CRIMINAL SEXUAL PSYCHOPATHS

A. Introduction

Effective August 1, 1968, the statutes by which persons were adjudicated criminal sexual psychopaths (hereinafter CSPs) and confined in Ionia, were repealed. Those statutes, commonly known as the Goodrich Act, were originally enacted in 1935.95 The Act was broadened and amended in 1937,96 declared unconstitutional by the Michigan Supreme Court in 1938,97 and reenacted in modified form in 1939.98 From 1939 to 1968, the Goodrich Act was subjected to numerous legislative amendments and court decisions. Today, persons charged with crimes who might have been adjudicated CSPs if the Act were still in existence are tried on the criminal charge and, if convicted, sentenced like other convicts.99

When the legislature repealed the Goodrich Act, it enacted

99 Mich. Comp. Laws Ann. § 750.10a (1968) contains a definition of the term “sexually delinquent person.” Other statutes provide that when a crime has been committed by a person who is a “sexually delinquent person,” an indeterminate sentence of one day to life may be imposed against him. A minor crime, such as “indecent exposure” which is punishable by a maximum of one year, theoretically may result in life imprisonment if committed by a sexually delinquent person. Mich. Comp. Laws Ann. § 750.335a (1968).

While a comprehensive discussion of the “sexually delinquent person” laws is beyond the scope of this article, it should be noted that constitutional questions involving vagueness of terminology, due process requirements for a determination of sexual delinquency, cruel and unusual punishment, etc., have resulted in virtual, if not total, non-use of the “sexually delinquent person” device.
Mich. Comp. Laws Ann. § 330.35b (Supp. 1971). That statute provides for the parole and discharge of persons who have been committed as CSPs pursuant to the Goodrich Act. The statute authorizes the hospital superintendent to "parole" any CSP, but stipulates:

No such person shall be paroled unless there are reasonable grounds to believe that the person has recovered from such psychopathy and is not a menace to the safety of himself and others. . . . No discharge shall be entered until such criminal sexual psychopathic person has been on parole in the open community for a continuous period of at least 2 years without recurrence of the criminal sexual psychopathic behavior which led to his original commitment.

There are 126 patients in the CSP category confined in Ionia.


Article 1, section 10 of the United States Constitution prohibits the states from passing "any ex post facto law." The Michigan statute is arguably such a law. The Goodrich Act, prior to its repeal, provided for confinement of a CSP only "until the superintendent of the institution shall have reasonable grounds to believe that such person has recovered from such psychopathy." The Department of Mental Health was statutorily empowered to release CSPs on parole, prior to discharge, under such conditions as it deemed warranted. However, the enactment of the new provision, by requiring complete recovery from psychopathy prior to parole, changed not only the conditions for parole, but of necessity, the conditions for discharge. Since CSPs were entitled under the Goodrich Act to discharge upon sufficient improvement in mental condition at the time they were adjudicated CSPs, the statutory change to the requirement of complete recovery cannot be condoned.


The early case of Calder v. Bull, 3 Dall. 386, 390, 1 L.Ed. 648, 650 (1798), defined ex post facto laws as:

1st. Every law that makes an action done before the passing of the law; and which was innocent when done, criminal; and punishes such action. 2d. Every law that aggravates a crime, or makes it greater than it was, when committed. 3d. Every law that changes the punishment, and inflicts a greater punishment, than the law annexed to the crime, when committed. 4th. Every law that alters the legal rules of evidence, and receives less, or different testimony, than the law required at the time of the commission of the offense, in order to convict the offender.


The parole provisions of the statute may also deprive CSPs of due process of law. In addition to requiring recovery from psychopathy before parole, the statute requires that the CSP not be a menace to the safety of himself or others. Pursuant to the Goodrich Act, a person charged with a criminal offense was adjudicated a CSP prior to and in lieu of criminal prosecution. Since the CSP has never been convicted of a criminal charge, continued institutionalization is warranted only for treatment of his psychopathic condition. By ruling that a CSP was constitutionally entitled to a criminal trial with all its due process safeguards before he could be confined to Jackson Prison, the Michigan Supreme Court in In re Maddox held that CSPs were not convicts. Therefore a statute which by its terms authorizes continued confinement of a nonconvict after recovery from the mental condition which warranted his confinement initially, is arguably an impermissible preventive detention statute.

Even if a prediction of future dangerousness could be used to detain a person prior to the proven commission of a criminal act, no statutory procedure exists to insure the accuracy of that prediction, and the individual is not accorded any procedural safeguards. For example, the phrase "menace to the safety of himself or others" is sufficiently vague to be suspect. If a person engages in consensual homosexual activity, is he a menace to his own safety? To the safety of others? Does the commission of incest menace the safety of others? Does "safety" refer to physical or psychological safety?

Even if the parole and discharge provisions of this statute were modified, the question remains as to whether it is permissible to continue to confine CSPs now that the Goodrich Act has been repealed. In 1967, the Special Committee on Mental Health Legislation for Criminal Cases made its Interim Report to the Michigan House of Representatives. The Committee's report is a piece of relevant legislative history on the repeal of the Act.

Among other things, the Committee was concerned with three problems: first, the proper definition of those persons who should

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104 Actually, the Goodrich Act provided for CSP adjudication of persons (1) charged with criminal offenses, (2) convicted (or pleaded guilty) and placed on probation, or (3) convicted (or pleaded guilty) but not yet sentenced. No. 165 [1939] Mich. Pub. Acts. Apparently, however, in practice the CSP adjudication was always made prior to conviction.


fall within the purview of CSP legislation; second, the constitutionality of the existing Goodrich Act and the proposed revisions of the Act; and, third, the proper and adequate treatment of CSPs.

With respect to the problem of defining CSPs, the Committee concluded:

In general, it can be stated that the statutory and medical concepts of the so-called psychopath are not identical, that both are vague, that the use of an outdated psychiatric term in a statutory test has produced confusion, and that the Goodrich Act has, as a result, been applied to a wide variety of individuals, ranging from extremely mentally ill persons to numerous troublesome and untreatable cases who were more properly subjects for conventional criminal sentencing.¹⁰⁸

These doubts as to the proper definition of the term CSP create a significant equal protection argument for persons who are still confined as fitting within its uncertain definition.¹⁰⁹

With respect to the constitutionality of the Goodrich Act, the Committee stated:

[The Goodrich Act] does not distinguish between minor personality disorders and extreme psychosis. It prescribes a civil, rather than criminal proceeding, for such persons, thereby eliminating the requirement for such basic rights as court-appointed counsel if indigent. Yet this civil commitment proceeding must be based on a criminal charge or conviction and results in a criminal label being placed on the person committed. Furthermore, the supposedly civil commitment proceeding has no purpose in the language of the law, beyond mere confinement; none of the many revisions made has added a requirement that the committed person receive treatment.

On such grounds alone, the Committee is advised, it is extremely doubtful that the Goodrich Act could survive a test in the higher courts today.¹¹⁰

¹⁰⁸ *Id.* at 121. See also *State of Michigan, Report of the Governor's Study Commission on the Deviated Criminal Sex Offender* 38 (1951). Elsewhere, the Committee stated that the very term 'criminal sexual psychopath' might be described as legal contradiction and a psychiatric anachronism. *Interim Report, supra* note 107, at 120.

¹⁰⁹ It should also be remembered that the CSP adjudication was a civil, not a criminal, proceeding. Today, persons who would fit within the CSP category are either civilly committed to regional hospitals and treated like other mental patients, or they are afforded the due process protections of a criminal trial before they are deprived of their liberty. Arguably, the *Baxstrom* case requires a similar civil commitment handling for "old-law" CSPs. As mentioned previously, they cannot be convicted of the criminal charges which set in motion the CSP adjudication.

¹¹⁰ *Interim Report, supra* note 107, at 120.
The Committee also recognized that any new or revised statute that combines a civil commitment with a criminal charge or conviction would be subject to the same constitutional objections.\textsuperscript{111} 

With respect to the problem of adequate treatment of CSPs, the courts in Michigan have required treatment, even though the Goodrich Act did not by its terms specifically mention treatment. In 1944, twenty-two years before the landmark opinion of Judge Bazelon in \textit{Rouse v. Cameron},\textsuperscript{112} the Supreme Court of Michigan mandated treatment for a CSP, stating: "It must be borne in mind that he is not being punished, that he is an unfortunate psychopath, and that he is entitled to such treatment as his condition requires."\textsuperscript{113} Notwithstanding the repeal of the Goodrich Act, the Court of Appeals of Michigan recently reaffirmed the right to treatment in a case involving an "old-law" CSP. The court stated: "We find that the right to treatment where detention is upon commitment for a mental disorder and not upon a finding of guilt on the substantive crime remains inviolate."\textsuperscript{114} 

As mentioned previously, the Michigan Supreme Court in 1958 ruled that since CSPs have been civilly committed and are not convicts, a prison is not an appropriate institution for treatment.\textsuperscript{115} Recent litigation now questions whether even Ionia is an appropriate institution. In a lengthy and strongly worded opinion, Judge Gilmore of the Wayne County Circuit Court recently stated:

\begin{quote}
It is clear from the record in this case that Mr. Bargy has not received even minimal treatment at the Ionia State Hospital, much less adequate treatment. It is shocking to consider the record in this case and to realize that the things that have happened to defendant could happen to a patient in a mental hospital in Michigan in the last half of the 20th Century. Not only has no psychiatric treatment been given him by a trained psychiatrist, he has been subjected to the most demeaning regulations, from being required to strip outside his room before retiring for the night, to being confined in a semi-correctional ward for no reason.

The lack of knowledge of patients' affairs by the physician and psychologist in charge is shocking. The lack of qualifications by the physician in charge of the criminal sexual psychopathic program is inexplicable. The lack of any pro-
\end{quote}

\textsuperscript{111} \textit{Id.} at 122.
\textsuperscript{112} 373 F.2d 451 (D.C. Cir. 1966).
\textsuperscript{113} \textit{In re} Kemmerer, 309 Mich. 313, 317–18, 15 N.W.2d 652, 653 (1944).
\textsuperscript{115} \textit{In re} Maddox, 351 Mich. 388, 88 N.W.2d 470 (1958).
gram to adequately treat and care for defendant is inhumane.\textsuperscript{116}

Although the Department of Mental Health publicly disputed Judge Gilmore's findings, the patient was placed on "parole" status before a hearing could be held on whether the court should order him transferred to a regional hospital for adequate treatment.

Even Dr. Birzgalis, Medical Superintendent of Ionia, has acknowledged the limitations of CSP treatment at Ionia:

\begin{quote}
Their treatment is difficult. Group psychotherapy is the most essential part of the treatment program for the CSPs. It should be continued only until the maximum benefit has been reached. Usually that would be for not more than two to three years because after that patients lose interest and motivation to participate and are regressing instead of progressing . . . . They cannot further benefit from psychiatric treatment and this hospital has to assume a more custodial role for them.\textsuperscript{117}
\end{quote}

\textbf{C. The Dilemma and Its Resolution}

The proper disposition of CSPs who have received the maximum benefit from treatment available at Ionia and who are currently receiving primarily custodial confinement at that institution is difficult to determine. Of course, those CSPs who are not "dangerous" should either be transferred to regional hospitals for further treatment or discharged. In recent years, Ionia has made an effort to reduce the CSP population of the hospital by paroling nondangerous CSPs.\textsuperscript{118}

As to those CSPs who, in the opinion of the Department of Mental Health, are still "dangerous," a dilemma arises. Both Dr. Vernon A. Stehman, Deputy Director of the Department of Mental Health, and Dr. Birzgalis are of the opinion that when CSPs

\begin{itemize}
  \item \textsuperscript{116} People v. Bargy, Case No. CR 32784, pp. 19–20 (Wayne Co. Cir. Ct., January 12, 1970).
  \item \textsuperscript{117} Birzgalis, supra note 31, at 10. Dr. Vernon A. Stehman, Deputy Director of the Department of Mental Health, stated on January 12, 1970:
    
    \begin{quote}
    It is not felt that further treatment at Ionia for these individuals will be of benefit. The only reason they are still institutionalized is because of our inability to assure the state, with reasonable certainty, that there will not be a recurrence of the acts for which they were initially committed.
    \end{quote}
  \item \textsuperscript{118} The number of CSPs in Ionia was reduced from 200 on August 1, 1968, to 156 on October 31, 1969, to 135 on January 15, 1970, to 126 on April 7, 1970, to 101 on August 17, 1970. It should be noted that few, if any, nondangerous CSPs have been transferred to regional hospitals for treatment, even though the Department of Mental Health is statutorily authorized to treat CSPs in hospitals other than Ionia.
\end{itemize}
Mental Illness cannot benefit from further psychiatric treatment, they should be transferred to a prison setting for security and custody.\textsuperscript{119} However logical such an approach is when applied to those individuals who, subsequent to the repeal of the Goodrich Act, will not be adjudicated CSPs but tried on the offense charged, this approach simply cannot be utilized retroactively on individuals who were adjudicated CSPs under the now-repealed Goodrich Act. As mentioned previously, the Goodrich Act itself prohibited trial or sentencing on the original criminal offense charged once the person was adjudicated a CSP. A CSP commitment is a civil commitment,\textsuperscript{120} and absent criminal trial and conviction, both the Michigan Supreme Court\textsuperscript{121} and the United States Supreme Court\textsuperscript{122} have prohibited confinement of civilly committed persons in a correctional institution.

The basic issue seems to be whether the State is justified in continuing to confine in Ionia "old-law" CSPs who will not benefit from further psychiatric treatment at that institution, when the alternative is releasing some potentially dangerous persons into society.

There is no ideal solution to this question. An acceptable compromise between polar positions is to repeal Mich. Comp. Laws Ann. § 330.35b (1965) and to enact a new statute which provides:

\begin{quote}
ANY PERSON WHO HAS BEEN ADJUDICATED A CRIMINAL SEXUAL PSYCHOPATH PURSUANT TO THE GOODRICH ACT AND WHO IS PRESENTLY CONFINED IN OR ON PAROLE FROM AN INSTITUTION UNDER THE JURISDICTION OF THE DEPARTMENT OF MENTAL HEALTH SHALL BE DISCHARGED FROM THAT STATUS AND TRANSFERRED TO THE JURISDICTION OF THE PROBATE COURT IN THE COUNTY OF HIS RESIDENCE FOR AN EXAMINATION AND JUDICIAL DETERMINATION OF WHETHER HE MEETS THE STATUTORY TEST FOR CIVIL COMMITMENT. IF SO, THE INDIVIDUAL SHALL BE HOSPITALIZED, TREATED, RELEASED, AND DISCHARGED, IN ACCORDANCE WITH PROCEDURES ESTABLISHED FOR OTHER CIVIL PATIENTS.
\end{quote}

The following arguments are offered in support of this recom-

\textsuperscript{119} Stehman, \textit{supra} note 117, at 5; Birzgalis, \textit{supra} note 31, at 10–11.

\textsuperscript{120} People v. Chapnian, 301 Mich. 584, 4 N.W.2d 18 (1942).

\textsuperscript{121} \textit{In re Maddox}, 351 Mich. 358, 88 N.W.2d 470 (1958).

mendation. First, society can justify continued confinement of "old-law" CSPs only by handling them like other nonconvicts. An attempt to continue commitment of "old-law" CSPs is certain to be subject to extensive litigation. The result of such a "holding" action may be a court order releasing all "old-law" CSPs.

Second, the assumption of continuing dangerousness of "old-law" CSPs is in need of reexamination. The Special Committee considering repeal of the Goodrich Act reported:

[Person]sons committed to mental hospitals under this Act were for the most part minor or nuisance sex offenders, while sex criminals of the violent and dangerous variety were generally sent to prison.

Yet ironically, . . . the sex offender sent to Jackson was nearly twice as likely to be paroled, within any given number of years, as his counterpart who ended up in Ionia.

Case histories of minor offenders subjected to incredibly long terms of confinement after being "Goodriched" into Ionia, although presenting no real danger to the public, could be cited but have already been repeatedly considered by former study committees and commissions.\textsuperscript{123}

The Special Committee's findings are still reflected in Ionia's August 17, 1970, patient statistics.\textsuperscript{124}

Dr. Birzgalis once stated that the 156 CSPs in Ionia on October 31, 1969, constituted "a concentration of dangerous CSPs"

\textsuperscript{123} \textit{INTERIM REPORT}, supra note 107, at 119.

\textsuperscript{124} Dr. Birzgalis has recently made available statistical data concerning the 101 "old-law" CSPs confined in Ionia on August 17, 1970. Letter and accompanying data from A. A. Birzgalis, M.D., Medical Superintendent, Ionia State Hospital, August 25, 1970. The last CSP admitted to Ionia who still remained confined in the institution as of August 17, 1970, was admitted on September 26, 1968—a total of two years of continuous confinement. Sixty-one of the 101 patients were first admitted to the institution in 1965 or before—a minimum of five years under the jurisdiction of the Ionia State Hospital. [This does not necessarily mean that they have been continuously confined for the entire period. Some were released on parole but subsequently returned to the institution.] Twenty-eight patients were first admitted to the institution in 1960 or before—a minimum of ten years under the jurisdiction of the Ionia State Hospital. Two patients were first admitted to the institution in 1940—a total of thirty years under the jurisdiction of the Ionia State Hospital. One of the individuals committed in 1940 was charged with, but not convicted of, the crime of "indecent liberties." If he had been convicted, the maximum sentence that could have been imposed was ten years. He has been continuously confined in Ionia since 1940. The other individual committed to Ionia in 1940 was charged with, but not convicted of, the crime of "gross indecency." If he had been convicted, the maximum sentence that could have been imposed was five years. With the exception of one day when he appeared in court on a writ of habeas corpus, he has been continuously confined in Ionia since 1940.

Of the 101 "old-law" CSPs, 30 had been charged with (but not convicted of) "indecent liberties." This is by far the largest single category. Other minor sex charges included 12 charged with "gross indecency," 5 charged with "indecent exposure," and 2 charged with incest. As to the major crimes, 6 were charged with (but not convicted of, murder, and 16 with rape (including statutory rape).
and that they "require a long hospitalization." 125 Nevertheless, within ten months of that statement, Ionia cut the CSP population by fifty-five patients. These facts raise important questions as to whether Ionia personnel have been and are properly determining "dangerousness" in their decision to retain or release "old-law" CSPs. The proposed statute, by handling CSPs as civil patients, attempts to insure that release criteria will be applied consistently and accurately to all patients.

Third, treatment of CSPs has to date occurred almost exclusively in Ionia. There are, however, treatment opportunities available in the regional hospitals that are not available in Ionia. The apparent assumption that all CSPs should be confined in Ionia for treatment is questionable. In individual cases, treatment in regional hospitals may be appropriate. 126 In any event, the proposed statute, by requiring treatment as a civil patient in a regional hospital when warranted by the individual's mental condition, provides a middle ground between continued custodial confinement in Ionia and absolute discharge from all confinement.

VII. MENTALLY ILL CONVICTS

A. Transfer of Mentally Ill Convicts to Ionia—Procedural Safeguards

Michigan law provides that whenever a physician at any Michigan penal institution certifies to the warden

125 Birzgalis, supra note 31, at 7.
126 Not all of the 101 "old-law" CSPs confined in Ionia on August 17, 1970, have been diagnosed as "psychopaths." Thirteen patients have been diagnosed as suffering from schizophrenia and 2 have been diagnosed as mentally retarded. Letter and accompanying data from A. A. Birzgalis, M.D. Medical Superintendent, Ionia State Hospital, August 25, 1970. Interestingly, the Goodrich Act specifically excluded "feebleminded" persons from the CSP definition. No. 165, § 1 [1939] Mich. Pub. Acts. Over one-half of the patients in the regional hospitals have been diagnosed as suffering from schizophrenia [Of the 13,944 patients in the regional hospitals during the fiscal year 1967-68, 7,325 were diagnosed as suffering from schizophrenia. Raw data supplied by Mr. James Foster, Associate Director of Operations Analysis and Research Division, Michigan Department of Mental Health, April 29, 1970.], and this writer would anticipate no overwhelming difficulty in placing 13 similarly diagnosed individuals into those hospitals. Similarly, the 2 mentally retarded "CSPs" could be handled in the state home and training schools.

As to the remaining 86 CSPs, New York's recent experience may be illuminating. When Operation Baxstrom required the transfer of ex-convict mental patients from Dannemora to the regional hospitals, Central Islip State Hospital received 72 patients. That hospital changed 13 diagnoses, the most significant being the reclassification of 9 diagnoses from "psychosis with psychopathic personality" to "schizophrenia." The change in diagnosis was explained as reflecting "the general trend in nosological classification, which avoids the diagnosis of psychopathy as a catch-all that is of little value as a descriptive term." White, Krumholz, & Fink, supra note 19, at 38. These patients presented no unique problems for the staff of the civil hospital. Id.

As to those "old-law" CSPs who cannot be reclassified to other psychiatric classifications, it should be noted that in the 1967-1968 fiscal year, the regional hospitals treated 269 patients diagnosed as suffering from "personality disorders." Raw data supplied by
that any inmate therein is insane, it shall be the duty of such officer in charge to make immediately a full examination into the condition of such inmate, and if fully satisfied that he is insane, such officer in charge, where said inmate is confined, shall forthwith cause such inmate to be transferred to the Ionia state hospital.\textsuperscript{127}

There are 112 patients in this category confined in Ionia.

This statute is objectionable in that, first, it authorizes an administrative determination of mental illness; and, second, it requires that all mentally ill convicts transferred to the Department of Mental Health for treatment of their illnesses be confined in Ionia.

Although there is no Michigan case law concerning the type of procedural safeguards required prior to the transfer of mentally ill convicts to Ionia, recent appellate cases in New York and the District of Columbia indicate the developing trend. Prior to 1962, the New York statutes for transfer of mentally ill convicts to Dannemora and Matteawan state hospitals were virtually identical to the existing Michigan statute. In \textit{People ex rel. Brown v. Johnston},\textsuperscript{128} a mentally ill convict challenged the validity of his administrative transfer into Dannemora. The New York Court of Appeals ruled:

Although under ordinary circumstances a mere transfer (as distinguished from a commitment for insanity) is purely an administrative matter, and a prisoner has no standing to choose the place in which he is to be confined, we do not feel that the court should sanction, without question, removals, in cases of alleged insane prisoners, which can conceivably be uncontrolled and arbitrary.

The issue here is... whether the courts below may properly refuse to even inquire into the nature of his condition and the possibility that [the prisoner] may be illegally confined with deranged persons who are liable to harm and/or adversely affect him.\textsuperscript{129}

The \textit{Brown} decision signaled the end of administrative transfers of mentally ill convicts in New York.

In \textit{United States ex rel. Schuster v. Herold},\textsuperscript{130} the Second
Circuit reiterated the holding of the *Brown* case and defined the procedural safeguards required prior to transfer. The court phrased the problem as follows:

[W]e are faced with the obvious but terrifying possibility that the transferred prisoner may not be mentally ill at all. Yet he will be confined with men who are not only mad but dangerously so. As the New York Courts have themselves indicated, he will be exposed to physical, emotional and general mental agony. Confined with those who are insane, told repeatedly that he too is insane and indeed treated as insane, it does not take much for a man to succumb to some mental aberration.\(^{131}\)

The court concluded that mentally ill convicts are entitled to the same procedural safeguards as are provided in civil commitment proceedings, including proper examination, a hearing upon notice, periodic review of the need for commitment, and trial by jury.\(^{132}\)

In *Matthews v. Hardy*, the Court of Appeals for the District of Columbia examined the stigma attached to persons who are "twice-cursed" as mentally ill and criminal, the numerous restrictions and routines imposed on mental patients in a mental hospital that would not be imposed on a convict in prison, and the possibility that a convict transferred to a mental hospital might be incarcerated for a longer time than if he remained in prison, and concluded:

We think the differences in the two types of incarceration are simply too great to treat transfer [of a convict] to a mental hospital as a routine administrative procedure. The consequences of a mistake are sufficiently great to warrant giving prisoners the same protections as non-prisoners receive.\(^{134}\)

The logic of the *Brown, Schuster*, and *Matthews* cases is compelling. Michigan should adopt a statute requiring that before prisoners can be involuntarily admitted to a mental hospital they must be accorded the same procedural safeguards accorded mentally ill noncriminals. As a first step, the present statutory policy which provides for administrative placement of mentally ill prisoners into Ionia should be abandoned.

**B. Treatment of Mentally Ill Convicts—A Proposal**

In the historic movement to dissociate mentally ill persons from criminals, the pendulum has swung too far. Since society autho-

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\(^{131}\) Id. at 1078.

\(^{132}\) Id. at 1073.

\(^{133}\) 420 F.2d 607 (D.C. Cir. 1969).

\(^{134}\) Id. at 611.
rizes the involuntary treatment of seriously mentally ill persons, all persons who are seriously mentally ill are entitled to equal treatment regardless of any other status, such as "criminal," that has been attached to them.

The Brown, Schuster, and Matthews cases did more than merely recognize the right of nonmentally ill prisoners to attack administrative determinations of mental illness and consequent placement in a mental hospital. There is language in the cases suggesting that convicts who are admittedly mentally ill must be treated like nonconvict mentally ill persons. For example, in Brown the New York Court of Appeals emphasized that

any further restraint in excess of that permitted by the judgment or constitutional guarantees should be subject to inquiry. An individual, once validly convicted and placed under the jurisdiction of the Department of Correction...is not to be divested of all rights and unalterably abandoned and forgotten by the remainder of society.135

The court’s assertion that convicted sentence-serving convicts are not divested of all their rights questions the validity of transferring mentally ill convicts to a maximum security mental hospital such as Ionia. Confinement in Ionia without the opportunity for adequate treatment at a regional hospital may be viewed as a “further restraint” in excess of constitutional guarantees.

When a prisoner becomes physically ill, his illness is treated in the prison itself. However, the unique nature of serious mental illness requires interruption of a prisoner’s confinement and transfer to a mental hospital or psychiatric ward for treatment of that illness. Under this circumstance, there is no valid basis for distinguishing between the treatment accorded him and the treatment accorded other mentally ill individuals. The typical civil mental patient is hospitalized in a regional mental hospital for only two months. Mentally ill convicts, forced to undergo treatment at Ionia, average two and one-half years of confinement at that institution.136 The obvious disparity in treatment potential can only be explained by the convict’s status as a “criminal.” However, proper treatment for mental illness depends not on the patient’s status, but on considerations of the diagnosis and pathology of the individual’s illness.

No person convicted of a crime is sent directly to Ionia. The statute137 presumes that the convict will have been sent initially

136DMH-PRELIMINARY PROSPECTUS, supra note 28, at 12.
to a prison from which the mental commitment process originates. The law assumes that the mental illness that required removal from the prison environment "developed" while the convict was confined within the prison. Because of this change in mental condition, the convict is no longer the person he was at the time he committed the crime, and, until his mental illness subsides, he is no longer a fit subject for punishment. His criminal status should dissolve, albeit temporarily, and he should be treated like any other mental patient. The possible need for security does not logically depend on a "criminal" label that preceded the patient's mental illness. A criminal may be regarded as a person who is too dangerous to live in society, and for this reason, society may require his confinement in prison. But when the sentence-serving criminal is transferred out of the prison for purposes of treatment, the question of "dangerousness" becomes relevant only to the mental hospital, not to the community. Nevertheless, in an obvious inconsistency, Michigan law imposes a maximum security confinement on all its mentally ill convicts by permitting transfer from prison only to Ionia.

Of course, mental illness in convicts does not necessarily develop after confinement in prison. Many mentally ill persons are convicted of crimes daily. In some instances the commission of the crime was a manifestation of underlying mental illness. The important point, however, is that the determination of whether a mentally ill convict requires maximum security confinement cannot be made by an analysis of when the illness developed.

It has never been determined that convicts suffer from different kinds of mental illnesses than persons who are civilly committed. A nonconvict who becomes sufficiently mentally ill may be committed to a mental hospital because he also is too dangerous to live in society. Whether security measures will be imposed on a civil mental patient is determined by the inability of the patient to comprehend and respect the rights of other patients, hospital staff, and the community should he escape. These considerations, which depend upon the pathology and severity of the particular illness, are the only rational considerations and should be applied to "criminal" mental patients as well.

For all of the above reasons, mentally ill convicts should receive the same opportunity to be treated in the regional hospitals as is received by civilly committed mental patients. Moreover, requiring maximum security confinement of a mentally ill convict in Ionia when it is neither necessary nor therapeutically desirable may constitute cruel and unusual punishment. The Supreme Court implicitly recognized the soundness of this position in Rob-
inson v. California. In holding a California statute unconstitutional for punishing persons on the basis of their status as drug addicts, the Court analogized drug addiction to mental illness. Mr. Justice Stewart, writing for the majority, stated:

It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill. . . . To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. Even one day in prison would be cruel and unusual punishment for the "crime" of having a common cold.

Confinement of a mentally ill convict in a maximum security institution like Ionia without a determination of the need for such security based on the considerations of the illness is, in effect, punishment for the convict's mental illness. This cannot be constitutionally condoned. Mr. Justice Douglas, concurring in Robinson, reasoned that a mentally ill person must be treated as a sick person and added:

We would forget the teachings of the Eighth Amendment if we allowed sickness to be made a crime and permitted sick people to be punished for being sick. This age of enlightenment cannot tolerate such barbarous action.

In light of the potential litigation involving the constitutional validity of "segregating" mentally ill convicts from other mentally ill persons and affording them inferior treatment for their mental conditions, the lack of moral and psychiatric justification for such policy, and the expressed willingness of the Department of Mental Health to treat mentally ill criminals in the regional hospitals, the present statute should be replaced by a statutory policy which provides:

MENTALLY ILL CONVICTS WHOSE MENTAL CONDITIONS MEET THE CRITERIA FOR CIVIL COMMITMENT SHALL BE ADMITTED TO, TREATED AT, RELEASED AND DISCHARGED FROM REGIONAL MENTAL HOSPITALS IN AC-

\[139\] Id. at 666-67.
\[140\] Id. at 674.
\[141\] Id. at 678.
\[142\] The Michigan Department of Mental Health has stated that from the viewpoint of the mental health specialist "there is no valid psychiatric reason for isolating mentally ill criminal offenders from other mentally ill patients. . . ." DMH-PRELIMINARY PROSPECTUS, supra note 26, at 1. For a similar conclusion, see MEDICAL AUDIT, supra note 30, at 5.
CORDANCE WITH PROCEDURES ESTABLISHED FOR OTHER MENTAL PATIENTS.

New problems and new questions are posed by this recommendation. In the following portion of this article, an attempt is made to resolve these issues, offering one approach to the implementation of the proposal.

VIII. THE FUTURE OF IONIA

A. Introduction

The Ionia State Hospital Medical Audit Committee, citing the lack of a valid psychiatric reason for isolating mentally ill criminals from other mentally ill patients and "the inherent and practically insolvable problems associated with the Ionia State Hospital," made the following recommendation:

Ionia State Hospital should be phased out insofar as its present function is concerned. The responsibility for treating mentally ill offenders should be decentralized to the Regional State Mental Hospitals in accordance with the concept of the Community Mental Health Centers. Patients who cannot be discharged from the Ionia State Hospital should be treated the same as other patients to the extent possible. The necessary changes in the State statutes should be made to permit this change.

Although the Medical Audit Committee discussed possible improvements in the short-term operation of Ionia, the Committee was adamant in its recommendation to phase out Ionia.

In January 1966, the Department of Mental Health expressly concurred with the long-range phase out of Ionia recommended by the Medical Audit Committee. The Department cited the heterogeneous collection of persons committed to Ionia and the legal controls imposed as making it impossible to establish a program within that hospital appropriate to the needs of all the patients.

The Mental Health Committee of the House of Representatives in its February 17, 1966, Report to the Legislature, recog-
nizing that responsibility for treating mentally ill offenders should be decentralized to the regional state mental hospitals, recommended "[t]hat immediate legislative and administrative steps be taken to terminate the present function of the Ionia State Hospital as an institution solely for the treatment of the criminal mentally ill."

Two problems need to be explored and resolved before Ionia can be phased out. First, are the regional hospitals currently able to handle an influx of Ionia's mental patients, and, if not, can the regional hospitals be restructured to accommodate them without imposing a significant cost or burden? Second, what should be done with the buildings that now constitute the Ionia State Hospital; can they be utilized realistically for a new public mission? It would appear that an affirmative answer can be given to both questions.

B. Treatment of the Ionia Patient Population in the Regional Hospitals

In deciding whether Ionia's patient population can be moved to the regional hospitals, it should first be noted that not all Ionia patients are necessarily both mentally ill and dangerous. For example, the existing statute requires that all convicts transferred to the Department of Mental Health be treated in Ionia without regard to their danger or lack of it. Furthermore, this article has repeatedly focused on the question of whether administrative placement of patients without judicial scrutiny results in maximum security confinement "too easily" in some cases. All patients currently in Ionia have been placed there through the exercise of the administrative discretion of the Department of Mental Health. Many of these patients may not be truly "dangerous" and could be transferred to and handled adequately in regional hospitals.

There is some data available indicating that the regional hospitals are currently able to handle Ionia's case load without a major reorganization of their structures and operations. The following evidence supports that conclusion:

(1) From July 1961 to December 31, 1964, all patients confined in Ionia for at least six months were reevaluated in staff conferences. This process resulted in the discharge of 987 patients from Ionia. Of this number, 222 patients were transferred

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to the civil mental hospitals. These hospitals were able to absorb this large number of Ionia patients without significant difficulty.

(2) Since 1967, the regional hospitals have been receiving patients found incompetent to stand trial. In the period of July 1, 1967, to June 30, 1970, the Department of Mental Health reported that 173 incompetent defendant patients have been admitted to regional hospitals, while only 133 have been admitted to Ionia. Although concern over deficiencies in regional hospital treatment of incompetent defendant patients has been expressed, at least the personnel of the regional hospitals have become more familiar with the problems in treating these “criminal” order patients.

(3) While the regional hospitals have, in recent years, become more open and permissive, they are still capable of offering considerable security when patients’ conditions warrant. For example, the percentage of patients on open wards in the six regional hospitals on February 28, 1970, was:

<table>
<thead>
<tr>
<th>Regional Hospital</th>
<th>% of Patients on Open Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalamazoo</td>
<td>24.4</td>
</tr>
<tr>
<td>Newberry</td>
<td>44.0</td>
</tr>
<tr>
<td>Northville</td>
<td>7.7</td>
</tr>
<tr>
<td>Pontiac</td>
<td>43.7</td>
</tr>
<tr>
<td>Traverse City</td>
<td>33.8</td>
</tr>
<tr>
<td>Ypsilanti</td>
<td>39.0</td>
</tr>
</tbody>
</table>

The closed wards in the regional hospitals may offer the only security needed for many of Ionia’s patients. As noted by the Ionia Medical Audit Committee, there is a distinction between “need for control” and “dangerousness.” Many of Ionia’s patients need some kind of security because of their own psychological deficiencies. Others need security because they are truly dangerous. These two classes should be handled in very different ways.

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150 Birzgalis, supra note 31, at 2.
151 See text accompanying notes 62–72 supra.
152 Raw data supplied by Mr. James Foster, Associate Director of Operations Analysis and Research Division, Michigan Department of Mental Health, April 29, 1970.
153 MEDICAL AUDIT, supra note 30, at 18.

The regional hospitals currently utilize mechanical restraint or seclusion for the more dangerous or disturbed patients. As of February 28, 1970, the regional hospitals reported the following average daily number of patients in restraint or seclusion:

<table>
<thead>
<tr>
<th>Regional Hospital</th>
<th>Average Daily Number in Restraining or Seclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalamazoo</td>
<td>10.0</td>
</tr>
<tr>
<td>Newberry</td>
<td>6.0</td>
</tr>
</tbody>
</table>
(4) Through an emergency civil commitment procedure, the regional hospitals regularly receive patients who are as dangerous as any patients confined in Ionia.\textsuperscript{154} The Department of Mental Health has experienced little difficulty in handling these patients in the regional hospitals. Ionia's patients should not be deprived of the opportunity for regional hospital psychiatric treatment when many of them have not even manifested homicidal or other dangerous tendencies.

Even if it were assumed that a substantial portion of Ionia's patient population is both mentally ill and dangerous and that some restructuring of the regional hospitals would be necessary to accommodate these patients, such restructuring would be warranted. The Bar Association of the City of New York has contrasted the central high-security facility concept with the regional facility concept and has found that the latter offered a more desirable approach to confinement and treatment of dangerous mental patients. The Bar Association found that a central security institution accepting patients on a statewide basis: (1) impedes visiting and social work; (2) is inconsistent with the localized approach to hospitalization; (3) involves severe restrictions upon the patient's freedom; and (4) carries with it a stigma of dangerousness.\textsuperscript{155}

By comparison, the Bar Association found that the establishment of high-security wards at the regional hospitals, while not being a costly procedure, did offer several distinct advantages:

Existing facilities designed for the care and custody of patients only temporarily dangerously mentally ill could be adapted to the needs of longer-term patients. This solution would avoid the geographic drawbacks of a central institution, as well as the probable stigma associated with it. It is possible, moreover, that gradual reintegration of the patient into the rest of the hospital population might be more easily accomplished for patients recovering from long-term dan-

\begin{center}
\begin{tabular}{|l|c|}
\hline
Northville & 2.2 \\
Pontiac & 17.5 \\
 Traverse City & 5.0 \\
Ypsilanti & 12.0 \\
\hline
\end{tabular}
\end{center}

Ionia reported a daily average of 0.6 patients in restraint or seclusion. Raw data supplied by Mr. James Foster, Associate Director of Operations Analysis and Research Division, Michigan Department of Mental Health, April 29, 1970.

\textsuperscript{154} \textsc{Mich. Comp. Laws Ann. § 330.19 (1967)} authorizes the emergency admission of "a person believed to be mentally ill manifesting homicidal or other dangerous tendencies." This provision was recently amended by No. 13, § 1 [1969] Mich. Pub. Acts, which emphasized that the purpose of emergency admission is psychiatric treatment. The Department of Mental Health strongly supported this amendment.

\textsuperscript{155} \textsc{N.Y. Bar Report, supra} note 20, at 66.
gerous mental illness than would be possible by retransfer to an "open door" hospital from a central institution with maximum security throughout. We recognize that the need for sustained security, even though only partial, would be generally out of character for "open door" institutions. However, if the department is properly to be charged with full responsibility for the hospitalization of all civil patients, an accommodation suiting the medical and custodial needs of all its patients must be reached.\textsuperscript{156}

Nevertheless, the establishment of maximum security wards within the regional hospitals should not be viewed as an end in itself, for it is not desirable to perpetuate the problems that have plagued Ionia by creating "little Ionias" within the regional hospitals. The purpose of hospitalization is treatment. Even when security measures must be undertaken because of a patient's mental condition, the emphasis of the hospital should remain on treatment, not on security. The creation of maximum security wards in regional hospitals is justified only as an adjunct to providing treatment to all mental patients within the hospital.

Certain measures should be undertaken to insure that the creation of maximum security wards in regional hospitals results in more, not less, treatment for the hospitals' patients. The District of Columbia recently faced the problem of providing adequate treatment for patients confined within the maximum security wards of its hospital. The Ad Hoc Committee for the Evaluation of Security Programs and Facilities at Saint Elizabeths Hospital reported:

The security facilities seem to be islands of autonomy, hardly linked to each other and markedly shielded from the rest of the Hospital. They hardly share each other's resources and seem deprived from sharing those from the Hospital at large.\ldots\ A semiautonomous status of security services would facilitate implementation of those matters largely peculiar to the section, e.g., relationships to law enforcement agencies and the courts. Integration of clinical services should be accomplished to the end that all treatment modalities within Saint Elizabeths Hospital will likewise be available for the security patients.

\ldots\ldots\ldots\ldots\ldots

In other words, the separation of so-called "criminally insane," in a special unit separate and apart from the rest of the patient population at Saint Elizabeths Hospital, should be considered as a temporary and transitional measure which

\textsuperscript{156} Id. at 68.
eventually will lead towards complete integration of both
groups of patients within a uniform and therapeutic hospital
program.\textsuperscript{157}

If the suggestion for integration of clinical services is adopted
by the Michigan Department of Mental Health, no statutory
change is necessary to insure adequate treatment for those
patients who have been confined in maximum security wards of
the regional hospitals. However, a question remains whether
procedural safeguards should be accorded patients before they are
transferred into the maximum security ward. Ordinarily, the
movement of a patient from ward to ward within a single in-
stitution is essentially a medical matter. However, where a par-
ticular ward (maximum security ward of a regional hospital) is
functionally distinct from other wards and placement there in-
volves added risks and increased restraints on personal liberty,
the patient should be protected against arbitrary transfers. The
recommendations made previously\textsuperscript{158} for the elimination of ad-
ministrative placement of dangerous civil patients into Ionia
should be made applicable to this situation. Specifically, statutes
should be adopted to provide:

\begin{quote}
1. PRIOR TO THE TRANSFER OF ANY PATIENT
IN A REGIONAL HOSPITAL TO A MAXIMUM SE-
CURITY WARD WITHIN THAT OR ANOTHER HOS-
PITAL, A JUDICIAL HEARING SHALL BE RE-
QUIRED AND JUDICIAL APPROVAL SHALL BE OB-
TAINED. THE PATIENT SHALL RECEIVE PROCE-
DURAL SAFEGUARDS INCLUDING, BUT NOT
NECESSARILY LIMITED TO: NOTICE OF THE AL-
LEGATION, RIGHT TO COUNSEL, RIGHT TO IN-
DEPENDENT PSYCHIATRIC EXAMINATION (AT
THE STATE'S EXPENSE IF THE INDIVIDUAL IS IN-
DIGENT), RIGHT TO CONFRONT AND
CROSS-EXAMINE WITNESSES, AND THE PRIVI-
LEGE AGAINST SELF-INCrimination. THE BUR-
DEN OF PROOF THAT THE INDIVIDUAL MEETS
THE STATUTORY CRITERIA FOR TRANSFER
SHALL BE PLACED ON THE STATE. ADDITION-
ALLY, THE STATE SHALL BEAR THE BURDEN OF
EXPLORING POSSIBLE ALTERNATIVES TO
\end{quote}

\textsuperscript{157} Ad Hoc Committee for the Evaluation of Security Programs and Facilities at Saint
Elizabeths Hospital, The Evaluation of Security Programs and Facilities at Saint Eliza-
beths Hospital (1968) as found in Appendix to Covington v. Harris, 419 F.2d 617, 633
(D.C. Cir. 1969).

\textsuperscript{158} See text accompanying notes 35–43 supra.
TRANSFER (THAT IS, THE STATE SHOULD BE FORCED TO PROVE THAT NO LESS DRASTIC ALTERNATIVE, SUCH AS INCREASED DOSAGE OF TRANQUILIZERS IS APPROPRIATE TO THE INDIVIDUAL'S CASE.)

2. NO PATIENT SHALL BE TRANSFERRED TO A MAXIMUM SECURITY WARD UNLESS THE REGIONAL HOSPITAL PROVES BEYOND A REASONABLE DOUBT THAT THE PATIENT, WHILE A PATIENT IN THE REGIONAL HOSPITAL, COMMITTED AN ACT OR ACTS WHICH HAVE RESULTED IN, OR IF CONTINUED WILL NECESSARILY RESULT IN, SERIOUS BODILY INJURY OR DEATH TO OTHER PATIENTS OR HOSPITAL PERSONNEL AND THAT THERE WAS NO JUSTIFICATION FOR SUCH BEHAVIOR. FURTHER, THE HOSPITAL MUST PROVE THAT IT HAS UNDERTAKEN ALL REASONABLE EFFORTS TO PREVENT REOCURRENCE OF THE CONDUCT AND THAT SUCH EFFORTS HAVE FAILED TO DETER THE PATIENT AND THAT THERE IS REASON TO BELIEVE THAT THE PATIENT'S INJURIOUS CONDUCT WILL CONTINUE AND BE REPEATED IN THE FUTURE.

3. NO PATIENT ADMITTED INTO A MAXIMUM SECURITY WARD SHALL BE RETAINED IN MAXIMUM SECURITY CONFINEMENT FOR LONGER THAN SIX MONTHS EXCEPT AS AUTHORIZED BY COURT ORDER AT INTERVALS OF SIX MONTHS GRANTED AFTER NOTICE TO THE PATIENT AND AN OPPORTUNITY TO DEMAND A HEARING AS HEREINAFTER PROVIDED.

IF THE SUPERINTENDENT OF THE REGIONAL HOSPITAL DETERMINES THAT ANY PATIENT ADMITTED TO A MAXIMUM SECURITY WARD REQUIRES RETENTION IN MAXIMUM SECURITY CONFINEMENT BECAUSE OF DANGEROUS MENTAL ILLNESS, HE SHALL APPLY WITHIN SIX MONTHS OF THE PATIENT'S ADMISSION FOR AN ORDER AUTHORIZING RETENTION. THE PATIENT SHALL BE NOTIFIED OF THE APPLICATION AND GIVEN AN OPPORTUNITY TO DEMAND A HEARING. THE PATIENT SHALL BE ACCORDED ALL PROCEDURAL SAFEGUARDS ACCORDED AT THE PREVIOUS HEARING [See recommendation 1 supra]. THE STANDARD FOR RETENTION SHALL BE THE SAME FOR INITIAL ADMIS-
SION TO THE MAXIMUM SECURITY WARD [See recommendation 2 supra]. THE COURT MAY ORDER RETENTION OF THE PATIENT (WHEN THE STANDARD IS MET) FOR A PERIOD NOT TO EXCEED SIX MONTHS FROM THE DATE OF THE ORDER.

FURTHER ORDERS FOR CONTINUED RETENTION MAY BE APPLIED FOR AND ORDERED AS ABOVE.

C. A New Mission for Ionia

There appears to be little agreement about the future function of Ionia. The Ionia Medical Audit Committee, while recommending a phase out of Ionia's security function, made no recommendation as to the prospective use of the institution. The Committee, among other things, noted that the hospital's physical plant was not conducive to modern psychiatric therapy. Nevertheless, the Mental Health Committee of the House of Representatives recommended that Ionia continue as a facility of the Department of Mental Health with a change from its special role as an essentially correctional institution to a general psychiatric hospital of approximately 800 to 900 beds. The Department of Mental Health recently expressed its plans for Ionia as follows:

Pending further changes in the law or the development of new facilities and programs, the Department plans to continue to use the Ionia State Hospital as its security facility, and as its resident load declines, use the resulting space for the care and treatment of long-term care mentally ill patients selected and transferred from other hospitals. In the longer range and after the security functions of this hospital have been closed out, the hospital plant may well be used for both mentally ill and/or mentally retarded patients.

Proposals to transform Ionia into a regional hospital should be rejected. The institution is located in an extremely remote and isolated part of the State. It is difficult to recruit doctors and other personnel, and the institution has no natural patient catchment district. Visitation by relatives poses obvious difficulties.

Proposals to continue Ionia as a maximum security mental hospital should also be rejected. If in the future security measures

159 Medical Audit, supra note 30, at 4.
160 Id. at 29.
161 Mental Health Committee, supra note 148, at 6.
162 DMH-Preliminary Prospectus, supra note 28, at 8.
are imposed on a patient only when necessitated by his mental condition and not because of some "criminal" status, there would not be a sufficient number of dangerous mental patients to warrant the continued existence of a single maximum-security mental institution. The Ionia Medical Audit Committee estimated that a facility with about 200 beds would serve the maximum security needs of the State.\textsuperscript{163} In addition, the previously mentioned problem of the availability (or lack thereof) of treatment opportunities to patients confined in a single maximum-security institution must be considered. Confinement of dangerous patients within maximum security wards of regional hospitals seems to be a more desirable alternative.

The crux of the problem concerning the future function of Ionia is found with the mentally ill convict. The proposal to treat him within the regional hospitals is likely to be viewed as "revolutionary." However, such treatment seems logical when several factors are considered. First, the characteristics of today's mentally ill convict are substantially different from those of the mentally ill convict of several years ago. Dr. Fred J. Pesetsky, Director of the Michigan Corrections Psychiatric Clinic, has observed that the type of convict received into the Department of Corrections has dramatically changed from a prevalence of professional criminals to a preponderance of emotionally disturbed youthful offenders whose criminal behavior is more an expression of social and emotional turbulence rather than a criminal career orientation.\textsuperscript{164}

The statistics confirm his observation. Of the 3,849 individuals committed to correctional facilities in 1969, 2,056 were in the fifteen to twenty-four age group; 733 were in the fifteen to nineteen age group.\textsuperscript{165}

\textsuperscript{163} \textit{Medical Audit, supra} note 30, at 33. The Department of Mental Health has accepted and utilized this figure. \textit{DMH-Preliminary Prospectus, supra} note 28, at 13.

\textsuperscript{164} Pesetsky, \textit{The Corrections Specialist, A New Discipline, Corrections Q.} 15, 17 (February 1969).


All male convicts received by the Department of Corrections are evaluated initially in the Reception-Diagnostic Center. The Center is attached to the State Prison of Southern Michigan (Jackson Prison), but operated as a separate unit. The Reception-Diagnostic Center examined 4,452 convicts in 1969 and found the following mental problems:
- 77 convicts were classified as psychotic (mentally ill)
- 194 convicts were classified as mentally retarded;
- 355 convicts were classified as alcholics;
- 491 convicts were classified as narcotic addicts;
- 602 convicts were classified as having a character disorder;
- 1,357 convicts were classified as having a character defect.
As to "treatment" within the general prison confines, Dr. Pesetsky has stated:

The organization of [penal] institutions that was predicated upon servicing the needs of older professional offenders offers little in therapeutic programming and handling techniques to meet the needs of the younger offender. The problems of youth, and particularly the emotionally disturbed, require the rapid advancement of specialized techniques, programs, and personnel that are only being developed in very limited fashion in corrections departments throughout our nation.166

The Michigan Corrections Psychiatric Clinic was established in 1953 as a treatment facility for mentally disturbed inmates. Though located at Jackson Prison, the Clinic serves as a "department of mental health" for the entire Department of Corrections. The workable capacity of the Clinic is sixty-five and the maximum capacity is seventy-one patients. The Clinic employs no full-time psychiatrists; in fact, the Clinic employs no full-time physicians (M.D.'s). The Clinic utilizes the services of a psychiatric consultant and a psychology consultant. However, in the period of July 1967 through June 1968, total consultation hours averaged less than nine and one-half hours per week.167

The Clinic is not only inadequate in size and professional staffing, but also in the quality of treatment it provides. For example, the Clinic relies heavily on inmate personnel for its nursing attendants.168 The Clinic is essentially a short term facility, and patients who demand extensive treatment are reassigned to one of the several residential wards within the prison. Only if the patient remains disfunctional while on this "outpatient" status, is he transferred to the Ionia State Hospital.169 In the last five years, transfers of mentally ill convicts to Ionia have averaged only thirty-one per year. This hardly seems an appropriate figure in light of the conspicuous inadequacies in treatment available in the Department of Corrections.

On the other hand, if large numbers of mentally ill convicts were transferred to the Department of Mental Health, the Department would be overwhelmed with many convicts who are un-

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166 Pesetsky, supra note 164, at 17.
168 Id. at 12.
169 Id. at 14.
treatable by known psychiatric means and with available psychiatric resources. For example, regarding just one psychiatric problem, Dr. Anderson has stated that many if not most habitual criminals could be labeled "sociopaths." Dr. Alexander P. DuKay, Superintendent of Ypsilanti State Hospital, has indicated that perhaps 80 percent of the inmates of Jackson Prison are sociopaths.

The question of "How many convicts have a psychiatric problem?" should not be determinative. The real issue is: "Should those convicts who have psychiatric problems that are treatable by known psychiatric means available in the regional hospitals be deprived of this treatment opportunity merely because they have been convicted of crimes?"

For all of the above reasons, Ionia State Hospital should be converted into a Center for the Psychiatric Diagnosis and Evaluation of Convicts. The following examples are offered as illustrative of the services such a Center could provide.

First, the Ionia Center could be utilized to diagnose and evaluate for transfer to regional hospitals, those convicts sent to it by the Department of Corrections facilities. Similarly, the Center could evaluate those convicts sent to it by the regional hospitals for possible return to prison.

Second, Ionia Center personnel could regularly visit the correctional facilities of the State for the purpose of screening convicts for possible transfer for psychiatric treatment.

Third, the Ionia Center could operate a psychiatric clinic within the facilities of the Department of Corrections. Alternatively, Ionia Center personnel could provide consulting and staff-training services to a psychiatric clinic operated by the Department of Corrections.

Fourth, the Ionia Center could perform competency to stand trial and other psychiatric evaluations currently performed by the Center for Forensic Psychiatry. Perhaps the Forensic Center

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170 American Psychiatry Association, Standard Nomenclature (1952), as found in J. Katz, J. Goldstein, & A. Dershowitz, Psychoanalysis, Psychiatry & Laws, 513 (1967), defines "Sociopathic Personality Disturbance" as follows:

Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals. However, sociopathic reactions are very often symptomatic of severe underlying personality disorder, neurosis, or psychosis, or occur as the result of organic brain injury or disease.

171 Interim Report, supra note 107, at 121.
functions and staff could be incorporated into the Ionia Center with a broader conceptual and statutory base.\textsuperscript{172}

Fifth, the Ionia Center could be used to perform evaluations of convicts after conviction but before sentencing. The Final Draft of the Revised Criminal Code contains a similar provision authorizing a criminal court to commit a convicted defendant to the Forensic Center or other diagnostic center of the Department of Mental Health for such an evaluation.\textsuperscript{173} The Ionia Center should be authorized to recommend civil commitment in lieu of correctional confinement in appropriate cases.\textsuperscript{174}

Sixth, the Ionia Center could be utilized to resolve, on a case-by-case basis, the difficult problem of handling mentally ill convicts in the regional hospitals. For example, if a mentally ill convict is considered to be a civil patient in all respects, does he have a right to be released from the hospital on convalescent care? If so, should he be released to the community or returned to prison? If the fact of institutionalization \textit{in a prison} was the precipitating cause of a convict’s mental illness, would not returning him to that same institutional environment be psychiatrically harmful? If institutional life itself initially caused a convict’s mental illness, should he be transferred from one institution (prison) to another (mental hospital) or should he be treated solely on an outpatient basis? There are no answers to these questions that can be uniformly applied to all mentally ill convicts.

Finally, the Ionia Center could conduct research on some of the ultimate, and largely unexplored questions of deviant behavior. The “sphere of influence” of the mental health professional should not remain entirely detached from the “sphere of influence” of the corrections specialist. Answers must be sought to the following questions: Can successful mental health programs and treatment methods provide insight for rehabilitation of criminal offenders? Does prison life cause mental illness or extreme psychological stress in a substantial number of prisoners? If so, should such confinement be eliminated? What other noninstitu-

\textsuperscript{172} In an interview conducted on September 18, 1970, Dr. Ames Robey, Director of the Center for Forensic Psychiatry, estimated that in 55 to 60 per cent of the cases where a defendant is sent to the Forensic Center for an evaluation of competency to stand trial, the prosecutor, defense counsel, or the criminal court is attempting to gain information unrelated to the issue of competency which the Center is not statutorily empowered to provide.\textsuperscript{173} Special Comm. of the Mich. State Bar for the Revision of the Crim. Code, Mich. Revised Crim. Code 110 (§ 1220 (2)) (Final Draft).\textsuperscript{174} The Final Draft of the Revised Criminal Code contains a provision outlining a procedure to be followed for civil commitment in lieu of sentence. \textit{Id.} at 112 (§ 1225).
tional alternatives are potentially available to the convicts; to any mentally ill person?

D. A Proposed Joint Facility

Recently, the Department of Mental Health and the Department of Corrections have issued a program statement proposing the construction of a joint mental health-corrections facility. As envisioned by the Departments, the facility would contain a 150-170 bed maximum security hospital, a 50 bed forensic center under the jurisdiction of the Department of Mental Health, and a reception-diagnostic unit housing 600-650 newly sentenced prisoners under the jurisdiction of the Department of Corrections. The Departments have suggested locating the new facility on the grounds of the Ypsilanti State Hospital.

While the expressed willingness of the two Departments to cooperate in this new venture is encouraging, the plan to construct a new physical plant is premature. To date, the Departments have not properly evaluated and adequately treated mentally ill criminal offenders. There is no assurance that a proposed joint facility would do more than merely house dangerous mental patients and nonmentally ill convicts under one roof. Use of the Ionia Center as recommended appears to be a more logical, and less costly, first step. Successful cooperation there might then merit a more ambitious undertaking, such as a joint facility.

IX. CONCLUSION

The enactment of new laws will not by itself alter people's attitudes or end their irrational fears. At most, legislation can only authorize a desirable course of action by establishing a workable framework for that action. Whether statutes based on this writer's recommendations will operate successfully depends upon the people implementing those statutes—primarily the people within the Department of Mental Health.

Admittedly, the recommendations here presented were not designed for the administrative convenience of the Department of

175 Letter from Gus Harrison, Director, Department of Corrections and William H. Anderson, M.D., Director, Department of Mental Health, to Mr. Glenn S. Allen, Jr., Executive Assistant, re: Joint Mental Health and Corrections Department Facility, January 2, 1968. See also DMH-PRELIMINARY PROSPECTUS, supra note 28.
176 DMH-PRELIMINARY PROSPECTUS, supra note 28, at 14.
Mental Health. The goal of the recommendations is adequate and equal treatment for all of Michigan's mentally ill citizens. While the specific recommendations are subject to debate and modification, adequate and equal treatment cannot be compromised. Most assuredly, problems will arise, and difficult decisions will have to be made. However, if an honest attempt is made to achieve this goal, the problems will not be insolvable.