

ESSAY

Observations on the Insanity Defense and Involuntary Civil Commitment in Europe

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In May 1983, the author participated in an interdisciplinary Law and Mental Health Delegation sponsored by the People-to-People Foundation which visited England, Sweden, Hungary, Switzerland, and France to examine, among other concerns, how their legal systems structure the insanity defense for mentally ill offenders and provide for involuntary civil commitment of the mentally ill. The delegation consisted of psychiatrists, psychologists, social workers, mental health advocates, judges, and law professors from Canada and the United States. The participants met intensively with psychiatrists, psychologists, lawyers, government officials, members of legislatures, professors, and judges in each of the countries, and visited several major mental health facilities. This article is based on presentations by, and discussions with, those experts in their respective countries.

I. INTRODUCTION

Most societies are concerned with mental illness and, in fact, formally take it into account in their legal systems in at least two important ways. First, mental illness is generally considered a significant factor in assessing the criminal responsibility of persons charged with committing crime and in determining the proper disposition of mentally ill offenders.¹ Second, the state, in certain situations, will deprive the mentally ill of their freedom and place them involuntarily in mental health facili-

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1. See generally A. GOLDSTEIN, *THE INSANITY DEFENSE* (1967); H. FINGARETTE & A. HASSE, *MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY* (1979).

ties.² Observing how selected countries in western and eastern Europe take mental illness into account on these important questions provides an invaluable opportunity not only to learn how different societies solve common problems, but also to determine if there might be better ways of addressing those problems within our own society.

There are, of course, several perspectives from which one could analyze the insanity defense and involuntary civil commitment in foreign legal systems. However, the comparative perspective on which this article is based will focus on:

- a) how foreign legal systems formulate and administer the insanity defense;
- b) how the power of the state is defined to civilly commit mentally ill persons;
- c) who makes the important decisions and when and how they are made; and,
- d) what happens to offenders who are considered mentally ill and to others who are considered mentally ill and suitable for involuntary commitment.

II. THE UNITED STATES

In order to provide a basis of comparison and contrast, it is useful to set forth very generally the manner in which our own legal system addresses these problems.

A. *The Insanity Defense*

In the United States, most states make the defense of insanity available to persons charged with criminal offenses. There are two primary tests used to formulate the defense: the M'Naghten test³ and the A.L.I. test.⁴ Both tests require that the defendant must have been mentally ill at the time of the offense.

The M'Naghten defense is satisfied if, in addition to being mentally ill at the time of the offense, the defendant did not know the nature or quality of the act or that it was wrong.⁵ This test focuses on the absence of cognitive ability as a result of

2. See La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499 (1981).

3. M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1849).

4. MODEL PENAL CODE § 4.01 (Tent. Draft No. 4, 1955).

5. M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1849).

mental illness. It is premised on the notion that knowledge is necessary for individual choice. Therefore, a mentally ill defendant who did not possess requisite knowledge concerning his behavior or its criminality is not a fit subject for retribution, nor is his conduct deterrable by the threat of punishment.

The A.L.I. test also requires that the defendant be mentally ill at the time of the alleged defense. In addition, it provides that if, as a result of such illness, a defendant's capacity either to know that his conduct was wrong or to conform his conduct to the requirements of the law was substantially impaired, he may then be excused from criminal responsibility. This test permits substantial impairment either in cognitive or volitional control to exculpate a criminal defendant. The philosophic premise of this formulation is that a defendant who did not know, or could not control himself even if he did know, did not choose to do wrong.

Both tests require not only that an individual was mentally ill at the time of the offense, but that the illness generated a specific type of mental incapacity which indicated that a necessary condition for personal responsibility was not present. Given such psychological impairments, most purposes of punishment would not be served by punishing this particular defendant.⁶

Since the presence or absence of mental illness is essential to this inquiry into criminal responsibility, our system relies heavily on the expert opinion of mental health specialists. In most cases psychiatrists or psychologists will, at the request of either the prosecution or the defense, evaluate the defendant prior to trial, and at trial give their professional expert opinion as to the mental health of the defendant at the time of the crime. As with all crucial facts relevant to criminal responsibility, however, our adversarial, due process model of criminal justice leaves the task of ultimate fact-finding to the jury (or to the judge in some cases). Thus, experts give their opinions before a jury in a court of law where their testimony is subject to rigorous confrontation and extensive cross-examination by legal counsel for the government and for the defendant.⁷ Frequently, their opinions are contradictory and manifest pronounced disagreement among themselves.

6. See J. FEINBERG, *DOING AND DESERVING* (1970); H. HART, *THE MORALITY OF THE CRIMINAL LAW* (1964).

7. See *Washington v. United States*, 390 F.2d 444 (D.C. Cir. 1967).

If a criminal defendant is found not guilty by reason of insanity, he frequently is sent to a mental health institution for further evaluation to ascertain whether he is still mentally ill and dangerous.⁸ He may be released from such an institution by the medical staff whenever it is determined that either of these conditions no longer exist.⁹ Increasingly, though, the approval of a court is also needed.¹⁰ Judicial review of continued confinement in a mental health institution is almost always available to such an individual.¹¹

B. Involuntary Civil Commitment

In the United States, a mentally ill person can be committed involuntarily under the police power¹² or the *parens patriae* power¹³ of the state. The police power permits the state to protect the public from harm. The *parens patriae* power authorizes the state to protect and care for those persons incapable of taking care of themselves. In most state mental health systems, qualified treatment personnel¹⁴ can authorize involuntary admis-

8. Recently, there has been controversy in the United States over how long and on what grounds a person acquitted by reason of insanity may be confined in a mental health facility. Prior Supreme Court cases indicated that such a person could not be confined beyond the maximum term for which he could have been sentenced unless, at the end of such term, he was committed involuntarily under the state civil commitment authority. *Humphrey v. Cady*, 405 U.S. 504, 510-11 (1972); *Baxtrom v. Herold*, 383 U.S. 107, 110 (1966). In a recent case, however, the Supreme Court held that, under certain circumstances, a person acquitted by reason of insanity can be held beyond the maximum term for which he could have been sentenced without being subjected to substantially the same standards and procedures used to commit persons being civilly committed. *Jones v. United States*, 51 U.S.L.W. 5041 (1983).

9. See, e.g., CONN. GEN. STAT. ANN. § 17-192 (West Supp. 1983); DEL. CODE ANN. tit. 16, § 5009 (Supp. 1983).

10. See, e.g., ARIZ. REV. STAT. ANN. § 36-543(F) (West Supp. 1983); CAL. PENAL CODE § 1026.2 (West Supp. 1983); N.Y. CRIM. PROC. LAW § 330.20(12) (McKinney 1983).

11. See, e.g., *Bolton v. Harris*, 395 F.2d 642, 652 (D.C. Cir. 1968).

12. The state, as sovereign, has the authority to enact laws that will protect the public health, safety, morals, and welfare. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 20 (1905). See La Fond, *supra* note 2, at 501-03; *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1223-25 (1974) [hereinafter cited as *Developments—Civil Commitment*].

13. The state is authorized under its *parens patriae* power to act on behalf of mentally ill persons who are incapable of protecting their own welfare. See La Fond, *supra* note 2, at 504-06; *Developments—Civil Commitment*, *supra* note 12, at 1207-22.

14. The term "mental health professional" is usually defined by statute and generally refers to any person with training in the field of human behavior who is authorized to recommend or initiate involuntary civil commitment. It can include persons with a wide range of competence and training in the mental health field. See, e.g., WASH. REV. CODE § 71.05.020 (1981), which includes within its definition such diverse professionals

sion of a mentally ill person to a mental health facility for evaluation (and sometimes for treatment) for a relatively short period of time. Within a reasonable time after such *ex parte* commitment, an involuntary patient is entitled to rather expansive due process protections, including representation by counsel and judicial review of his confinement.¹⁵ Medical personnel may release the committee whenever they determine he is no longer subject to the state's commitment power, and courts can also order release if they independently determine that confinement is no longer justified.¹⁶

III. THE INSANITY DEFENSE AND INVOLUNTARY CIVIL COMMITMENT IN EUROPE

With the exception of Sweden,¹⁷ all of the countries visited provide an insanity defense to criminal defendants. All formulations of the defense focus on whether the defendant was mentally ill at the time of the alleged offense, but they vary greatly on what, if any, other elements are required for a defendant to be considered legally insane. As will be seen, some countries such as England¹⁸ consider mental illness to be excusing only if such illness results in specified psychological impairment. Others, such as France,¹⁹ seem to consider the mere presence of mental illness a sufficient basis for excusing a defendant without regard to specific incapacitating consequences of mental illness. The countries also vary as to whether the insanity defense will be adjudicated together with all other issues bearing on criminal responsibility. For example, in England²⁰ the insanity defense is adjudicated together with other factual issues. In other countries, such as Hungary,²¹ insanity is ascertained before issues of guilt or innocence are resolved. When the latter approach is used, criminal offenders, if found insane, are usually switched

as psychiatrists and persons holding a masters degree in social work.

15. See generally *Addington v. Texas*, 441 U.S. 418 (1979); *Lessard v. Schmidt*, 349 F. Supp. 1078, (E.D. Wisc.), *vacated and remanded*, 414 U.S. 473, *order reinstated on remand*, 379 F. Supp. 1376 (E.D. Wisc. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (E.D. Wisc. 1976); *Phagen v. Miller*, 29 N.Y.2d 348, 278 N.E.2d 615, 328 N.Y.S.2d 393 (1972).

16. See, e.g., *Logan v. Arafah*, 346 F. Supp. 1265 (D. Conn. 1972).

17. See *infra* notes 31-33 and accompanying text.

18. See *infra* text accompanying notes 24-25.

19. See *infra* note 44 and accompanying text.

20. See *infra* notes 23-24 and accompanying text.

21. See *infra* text at section VI.A.

out of the criminal justice system and into the mental health system without substantial additional fact-finding in the criminal proceeding.

All five countries also have systems of involuntary civil commitment. In each country, the state is empowered to confine persons against their will in mental health facilities if they are mentally ill and either need treatment or pose a danger to themselves or to others. The mental health systems observed reflect a rather broad spectrum of substantive criteria which control entry into, and release from, the systems. They range from Switzerland's broad *parens patriae* power over persons who are mentally ill and need treatment,²² to Hungary's emphasis on police power and the prevention of harm.²³

In order to appreciate more fully the breadth and diversity of approaches to the insanity defense and involuntary civil commitment, it is useful to consider how each of the countries visited treats these issues.

IV. UNITED KINGDOM

A. *The Insanity Defense*

The United Kingdom is a common law realm that relies, in theory, on the adversary system of fact-finding. As the progenitor of the M'Naghten rule,²⁴ English law retains the concept of "not guilty by reason of insanity" and uses the M'Naghten test as the applicable criteria of nonresponsibility. As a *practical* matter, however, criminal defendants are simply not accorded this defense. Very few defendants invoke the defense and, of those who do, very few are successful.

There are several reasons for this phenomenon. First, the prevailing attitude in both the medical and legal communities is that mental illness is relevant not to an assessment of responsibility but rather to the question of disposition. Consequently, prosecutors and trial judges resist assertion of the insanity defense quite vigorously. Even defense counsel, recognizing their uphill struggle with the defense, often urge compromise through guilty pleas. Second, defendants themselves usually prefer to remain in the criminal justice system rather than be switched

22. See *infra* text at section VII.B.

23. See *infra* text at section VI.B.

24. See M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1849).

into the mental health system via a verdict of "not guilty by reason of insanity." In 1982, there were only three or four successful insanity acquittals in England and Wales. This appears to be an astonishingly small number.²⁵

In England, mental illness can also be relevant to a finding of guilt as a reductive matter. When England abolished capital punishment in 1957, it imposed mandatory life sentences for persons convicted of first degree murder.²⁶ As part of its statutory reform of the criminal law, England also provided the partial defense of "diminished responsibility" to persons charged with first degree murder. Thus, mental illness is generally used at trial as a partial defense to reduce a charge of first degree homicide to manslaughter. It is seldom used as a complete defense which will excuse a person altogether.

A convicted criminal defendant who is considered mentally ill, although not legally insane, can be sent either to a prison or to a hospital. If a person is sent to a mental health hospital, it is usually for an indeterminate period. The court can and usually does impose a "restriction order" on such a person if it considers him dangerous. If a person is not subject to a restriction order, the hospital staff can release a mentally ill offender when they determine that he is safe enough to be in the community. If a person is subject to a restriction order, however, the Home Secretary²⁷ must concur in the decision to release. Thus, the release of a mentally ill offender from a psychiatric facility or from a prison in England is usually a combined medical-political decision. Courts have virtually no control over the decision.

In reviewing British practice, some surprising observations can be made. First, by effectively suppressing assertion of the insanity defense and making mental illness relevant to placement of the offender, the British system disregards the theory and substance of its own law and adopts, instead, a pragmatic, utilitarian approach to the problems posed by the mentally ill offender. It is much less concerned with assessments of moral blameworthiness and doing justice in the individual case, and much more concerned with the appropriate disposition of the

25. In 1980 the estimated population of England and Wales was 49,244,300. 1 *THE EUROPA YEAR BOOK* 1982, at 1311 (1982).

26. The Homicide Act, 1957 5, 6, Eliz. 2, ch. 11, § 2; Murder (Abolition of Death Penalty) Act, 1965 ch. 71, § 1.

27. The Home Secretary is a cabinet officer in Great Britain with extensive responsibilities over law enforcement functions.

criminal offender. Second, it seems to emphasize as its primary social objective the safety and security of the community and minimizes the interests of the mentally ill offender in liberty and an early return to the community. As a consequence, the role played by courts and lawyers in the process is quite minimal when compared to our system.

B. *Involuntary Civil Commitment*

A person can be civilly committed in England if he is mentally ill and either dangerous to others or in need of treatment.²⁸ Commitment can be initiated either upon the recommendation of two physicians or upon court order. A committee is entitled to automatic, periodic review by an administrative tribunal²⁹ having a mixed composition.³⁰ A committee is not entitled to judicial review of his continued confinement, and he seldom has assistance of counsel in seeking his release. Release from a mental health facility is invariably determined by the medical staff. The staff also enjoys broad treatment authority over patients.

Involuntary civil commitment in England is primarily an administrative decision with substantial delegation of commitment authority to medical personnel. There is quasi-independent administrative review of the commitment on a regular basis, but there is virtually no recourse to courts with the assistance of counsel. The medical-administrative model provides the basic architecture of the system. As a consequence, there is extraordinary reliance on medical expertise with minimal confrontation or challenging of that expertise in an adversary, due process decisionmaking scheme. Moreover, there is virtually no legal assistance provided indigent committees who seek their release from confinement in mental health institutions.

28. Thus, Britain permits involuntary civil commitment under either the police power or the *parens patriae* authority of the state. See *supra* notes 12-13 and accompanying text.

29. Mental Health Act, 1983, ch. 20, § 73. Under this legislation a multidisciplinary tribunal consisting of at least one judge, one psychiatrist, and a lay person will review the appropriateness of continued commitment of every involuntary patient every six months for the first year of commitment and annually thereafter. The tribunal has the power to discharge all involuntary patients without obtaining the consent of the Secretary of State. See *supra* note 27 and accompanying text.

30. Before the new Mental Health Act, see *supra* note 29, a judge did not sit as a member of the tribunal. It was composed primarily of staff members from the hospital.

V. SWEDEN

A. *The Insanity Defense*

After extended legislative study, Sweden abolished the insanity defense in 1965. Thus, there is no "impunity" defense available to persons charged with criminal offenses in Sweden.³¹ Instead, Sweden has passed unitary legislation which applies to all mentally ill persons, including persons charged with committing criminal offenses and persons who may be subjected to involuntary commitment.

If a person charged with a crime is suspected of having suffered from mental illness at the time of the offense, the court can order a psychiatric evaluation of the defendant in a public health facility.³² This examination, however, cannot be conducted unless the prosecutor has proven that the defendant has committed the criminal act or unless the defendant has confessed to the act. At the public health facility, psychiatrists will examine the defendant and submit in writing to the court their opinion as to whether the defendant was suffering from mental illness at the time of the offense.³³ Invariably, the court accepts the opinion of the independent mental health experts concerning the defendant's mental health at the time of the offense. The defendant can appeal the court's finding to a national review board.

If the court finds that the defendant committed the criminal act but was suffering from mental illness, the defendant is

31. For a comprehensive review of Sweden's treatment of the mentally ill offender see Moyer, *The Mentally Abnormal Offender in Sweden: An Overview and Comparison with American Law*, 22 AM. J. COMP. L. 71 (1974). Connecticut has abolished the insanity defense. See, CONN. GEN. STAT. ANN. § 53a-13 (West Supp. 1983-84). Several other states have added "guilty but mentally ill" as an alternative verdict. See, e.g., GA. CODE ANN. § 27-1503 (1982); ILL. ANN. STAT. ch. 38, §§ 6-2, 113-4 to -5, 115-1 to -4, -6, 1005-2, -6 (Smith-Hurd Supp. 1983-84); IND. CODE ANN. § 35-36-2-3 (Burns Supp. 1983); KY. REV. STAT. § 504.130 (Supp. 1982); MICH. COMP. LAWS ANN. § 768.36 (1982); N.M. STAT. ANN. § 31-9-3 (Supp. 1983). See also Stelzner & Piatt, *Guilty But Mentally Ill Verdict and Plea in New Mexico*, 13 N.M. L. REV. 99 (1983); Comment, *Guilty But Mentally Ill: An Historical and Constitutional Analysis*, 53 J. URB. L. 471 (1976); Note, *The Guilty But Mentally Ill Verdict and Due Process*, 92 YALE L.J. 475 (1983).

32. For this purpose, there will be approximately 600 complete mental health evaluations conducted annually in a mental health facility. (Statistical information provided by Dr. Karl-Eric Torquist, forensic psychiatrist, in an address at Stockholm, Sweden on May 20, 1983.)

33. Customarily, the experts do not appear in court to present their opinion, though the court will occasionally request their presence. A typical report may run from 25-30 pages and may include reports of psychologists and social workers.

found guilty but he cannot be sent to jail. Rather, the court is limited to choosing from among the following dispositional alternatives: (1) confinement in a closed hospital; (2) probation; or, (3) pecuniary penalties. If the court further finds, based on the experts' opinion, that treatment is necessary or appropriate, it can send the offender to a closed hospital for psychiatric treatment. This commitment to a psychiatric facility is for an indefinite period and the court does not determine when the mentally ill offender will be released. That decision is exclusively a medical decision to be made by the medical staff. Usually two psychiatrists must agree that release is appropriate. A mentally ill offender can appeal a negative release decision to a hospital review board and, if unsuccessful, to a national review board.

B. Involuntary Civil Commitment

Sweden utilizes an administrative system of involuntary civil commitment. Two physicians (one of whom is usually a psychiatrist) can commit a person to a psychiatric facility if they determine that a person is mentally ill and dangerous *or* needs treatment *or* does not care for himself. Commitment is for an indefinite period. Two physicians must also agree that the patient can be released. Continued confinement is automatically reviewed on a periodic basis by a hospital board and the patient can also appeal to a national review board.

It should be noted that Sweden has one of the highest involuntary treatment rates in Europe. This should come as no surprise, since the commitment criteria are very broad and the process permits two experts to commit a person without any judicial participation or review. On the other hand, the average length of stay for mental patients has been diminishing substantially in Sweden.³⁴

Sweden's legal system has some interesting features. In theory, Sweden holds all criminal offenders responsible for their antisocial acts; yet, many persons who commit serious crime are sent to hospitals for psychiatric treatment rather than to prison for punishment. The delegation of the coercive civil commitment power of the state to experts is expansive and there is substan-

34. In 1960, the average length of stay for both voluntary and involuntary patients was 290 days. In 1979, the average stay was 81 days. (Statistical information provided by Dr. Ulf Brinck, psychologist, in an address at Stockholm, Sweden on May 20, 1983.)

tial reliance on medical ethics rather than on the courts³⁵ for regulating the behavior of these experts. Independent medical experts effectively make most of the crucial decisions concerning mental illness, disposition, and release of criminal offenders and committees with minimal judicial supervision or control and without significant confrontation by the individuals involved.

VI. HUNGARY

A. *The Insanity Defense*

Hungary provides criminal defendants with an insanity defense. A defendant is not considered responsible for his conduct if he was mentally ill at the time of the offense and was "unable to realize the consequence of his act or to proceed in accordance with such realization."³⁶ Any participant in the proceeding can raise the insanity defense, including the police, the judge, the prosecutor, or the defendant.³⁷ If insanity is raised, the criminal proceedings are held in abeyance while the court orders an independent psychiatric examination. A lawyer will be appointed for the defendant at this juncture. Two psychiatrists

35. Sweden also permits the Ombudsman, a special investigator, to investigate patient complaints. Gellhorn, *The Swedish Justitieombudsman*, 75 YALE L.J. 1, 20 (1965).

36. This formulation appears to focus both on cognitive and volitional capacity. See M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1849); MODEL PENAL CODE § 4.01 (Tent. Draft No. 4, 1955); see also note 6 and accompanying text.

37. In the United States, jurisdictions have split on whether the trial court can impose the insanity defense on a defendant who does not want it raised. Compare, e.g., *State v. Jones*, 99 Wash. 2d 735, 664 P.2d 1216 (1983) (en banc) (a trial court may rarely, if ever, impose a plea of not guilty by reason of insanity over the objections of a defendant who is competent to stand trial); *State v. Dodd*, 70 Wash. 2d 513, 424 P.2d 302, cert. denied, 387 U.S. 948 (1967) (if a defendant has sufficient intelligence to rationally choose whether to stand trial, plead guilty, or enter a plea of mental irresponsibility, the choice is his, not that of his attorney, for Washington constitution [art. 1, § 22] gives him the right to appeal and defend either in person or by counsel); *Friendak v. United States*, 408 A.2d 364 (D.C. 1979) (court held that the underlying philosophy of *North Carolina v. Alford*, 400 U.S. 25 (1970) and *Faretta v. California*, 422 U.S. 806 (1975) mandates that the defendant be permitted to make fundamental decisions about the course of proceedings), with, e.g., *State v. Smith*, 88 Wash. 2d 639, 564 P.2d 1154 (1977) overruled by *State v. Jones*, 99 Wash. 2d 735, 664 P.2d 1216 (1983) (unanimous decision upholding broad discretion of trial court to enter *sua sponte* the plea of not guilty by reason of insanity in pursuit of justice); *Whalem v. United States*, 346 F.2d 812 (D.C. Cir.), cert. denied, 382 U.S. 862, reh'g denied, 382 U.S. 912 (1965) (leading case holding that in the pursuit of justice, a trial judge must have the discretion to impose an unwanted defense on a defendant and the consequent additional burden on the Government prosecutor, because "if a man is insane in the eyes of the law, he is blameless in the eyes of society and is not subject to punishment in the criminal courts").

will evaluate the defendant and submit their opinion in writing to the court. If the experts cannot agree, additional experts may be requested to examine the defendant. If the judge disagrees with the expert opinion, he may send the defendant to a legal-medical committee for further evaluation. A defendant can also request, but cannot demand, that another expert examine him. Normally, the judge follows the recommendation of the experts.

If the defendant is found by the court to have been insane at the time of the offense, the criminal proceedings are terminated and the focus shifts to considering what disposition should be made of the defendant. If the defendant is still mentally ill and (1) the crime was one of violence against the person, or (2) the crime created a public danger, or (3) the punishment for the crime would have been confinement in prison for more than a year, the defendant may be sent to a psychiatric hospital for treatment. A violent offender may also be treated in a hospital within a prison. Alternatively, a defendant may be released on probation and treated as an out-patient. Commitment to an in-patient psychiatric facility is for an indeterminate period. Except for one hospital in Hungary, release from a psychiatric facility is exclusively a medical decision to be made by the staff. Release from this one other hospital requires approval of the court.

Hungary also permits the defendant to use mental illness as a reductive defense under the theory of diminished responsibility. Thus, mental illness is relevant to the presence or absence of *mens rea*. This is similar to the United Kingdom's approach to permitting a defendant to use mental illness to reduce a first degree murder charge to manslaughter.³⁸

B. Involuntary Civil Commitment

A person may be involuntarily committed if he is mentally ill and dangerous to himself or others. Any person can initiate the process, including the family or neighbors of the individual. Hungary permits the formal process in some cases to be initiated by summons.³⁹ If the individual does not respond to the summons by reporting to the mental health facility for an evalua-

38. See *supra* note 26 and accompanying text.

39. Washington has recently struck down as unconstitutional a summons procedure initiated by a mental health professional without prior judicial approval. See *In re Harris*, 98 Wash. 2d 276, 654 P.2d 109 (1982).

tion, the mental health staff can visit the individual in his home.

Generally, two experts, usually psychiatrists, can commit a person to a psychiatric facility for 8 days. A court supervises the commitment and will review the patient's continued hospitalization. A court may also decide that a guardian should be appointed for the mentally ill person. Lawyers can assist patients in seeking their release from psychiatric facilities, and a court can appoint an attorney to assist an indigent.

The Hungarian experts who met with the delegation maintained that psychiatry is not used to stifle political dissent, as western experts have alleged occurs with some frequency in the Soviet Union.⁴⁰ They assert that Hungary, because of the destruction that occurred during World War II, lacks psychiatric facilities. Consequently, there is an acute shortage of psychiatric beds throughout the country.⁴¹ Therefore, the mental health system emphasizes out-patient care whenever possible and seeks to minimize the duration of patient stays in psychiatric institutions.

Hungary's mental health system appears to be strikingly similar to that of the United States. It provides both an insanity defense and diminished responsibility defense, and emphasizes the police power of the state in its involuntary commitment scheme. Lawyers representing the individual seem to participate significantly in the process, and courts appear to monitor the process with some degree of vigilance. The emphasis on out-patient treatment whenever possible parallels the "least restrictive alternative" philosophy that is strongly espoused in the United States.⁴² This theory requires the state to take no more drastic measures than are necessary to accomplish the state's purpose and, in many cases, might require the state to treat a

40. See, e.g., Comment, *Soviet Abuse of Psychiatric Commitment: An International Human Rights Issue*, 9 CAL. W. INT'L L.J. 629 (1979); Reich, *The World of Soviet Psychiatry*, N.Y. Times, Jan. 30, 1983, § 6, at 20. For an interesting case history of a self-proclaimed political offender in the United States, see Resnick, *The Political Offender: Forensic Psychiatric Considerations*, 6 BULL. AM. ACAD. PSYCHIATRY & L. 388 (1978).

41. This raises an interesting question of "supply side" economics. Throughout the countries visited, foreign hosts frequently observed that their experience indicates that psychiatric beds in mental health facilities tend to be filled. They suggested that any serious attempt to reduce involuntary civil commitment should begin by reducing the number of psychiatric beds available in the mental health system.

42. See generally Chambers, *Alternative to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972); Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977).

mentally ill person on an out-patient basis or in a more open mental health facility.

VII. SWITZERLAND

A. *The Insanity Defense*

Switzerland also provides persons charged with a crime with an insanity defense. If a defendant was mentally ill at the time of the offense and had no capacity to appreciate the wrongfulness of his act or to conform his conduct to the requirements of the law, he has a personal excuse which precludes his being punished for his conduct. This formulation of the insanity defense is very similar to the A.L.I. test.⁴³ If insanity is raised, the trial can be stopped while a psychiatric evaluation of the defendant is conducted.

The court will appoint an expert to examine the criminal defendant. The expert usually submits his opinion to the court in the form of a written report. A defendant can retain his own expert to evaluate him, but the report of this expert is frequently greeted with a fair degree of skepticism. If there is a jury trial, the court appointed expert may have to testify in person, and both the jury and the defendant's lawyer can ask him questions. The judge invariably follows the opinion of its own appointed expert, however.

If the defendant is found to have been insane at the time of the offense, the defendant can be released outright or placed in a prison or in a hospital. Release from confinement is usually a medical decision which must generally be approved by an executive authority. A defendant can appeal a negative release decision but it is seldom done.

B. *Involuntary Civil Commitment*

A person can be involuntarily committed in Switzerland if he is mentally ill and in need of treatment. Dangerousness to self or to others is not a necessary condition for commitment. Any single physician (not necessarily a psychiatrist) can commit an individual to a mental health facility. No court order is required. Within ten days after his commitment a patient can appeal to a three-person tribunal consisting of a judge, a doctor, and a third person. He can retain a lawyer for this review, but

43. See *supra* note 4 and accompanying text.

none is appointed. If a doctor considers that a patient's health might be endangered by his presence at the review proceeding, he can order the patient excluded.

Switzerland's system of involuntary civil commitment is extraordinarily inclusive. It is premised almost exclusively on a pure medical model in that a determination by a single physician that a person suffers from mental illness subjects that individual to the coercive power of the state. There appears to be minimal judicial or political control over the system. Surprisingly to foreign observers, there seems to be minimal discontent with this model, or agitation for reform.

VIII. FRANCE

A. *The Insanity Defense*

France's insanity defense is of long standing origin. Article 64 of the French Penal Code provides simply that:

If the person charged with the commission of a felony or misdemeanor was then insane or acted by absolute necessity, no offense has been committed.⁴⁴

The criteria for legal insanity seems to be met if the defendant was mentally ill at the time of the offense. No specific mental impairment or incapacity must be established, nor must any causal relationship between the mental illness and the behavior be proven.

If insanity appears to be an issue, the court will appoint an attorney as an officer of the court to conduct an inquiry into the mental health of the defendant at the time of the offense. He will prepare a file on the defendant for submission to the court. In order to prepare this report, he will have the defendant examined by experts, usually two forensic psychiatrists selected from a court-approved list of recognized experts. A defendant can request that he be examined by additional experts but he cannot have his own expert examine him. The court-approved experts, based on their evaluation of the defendant, form an opinion of his sanity at the time of the offense. Psychiatric evaluations are done routinely in cases of the worst crime. The judge is the final decision-maker, but he usually follows the recommendation of the experts.

44. THE FRENCH PENAL CODE, Art. 64, (G. Mueller ed. 1976).

If a defendant is found insane, he is evaluated further to ascertain if he is presently mentally ill and dangerous. If he is found mentally ill and dangerous, he is sent either to a prison or to a hospital and he remains under the jurisdiction of the executive. Release is both a medical decision and a political decision by an executive authority. A defendant can appeal a negative release decision to a special judicial tribunal which can release the defendant over the objection of the executive. This evidently does not occur often.

B. Involuntary Civil Commitment

A person can be committed involuntarily if he is mentally ill and dangerous or in need of care and treatment. The executive (usually the police) frequently initiates a police power commitment based on dangerousness while family or friends usually initiate commitment for care and treatment.

Any single doctor can sign a commitment certificate authorizing coercive confinement of a patient for therapeutic purposes within a psychiatric facility. Within 24 hours of commitment, however, another certificate affirming the need for continued confinement must be obtained from the physician in charge of the facility. Commitment at this juncture is indeterminate, although the patient can appeal (without the assistance of a lawyer) his continued commitment to a special tribunal. The prefect⁴⁵ can initially commit a person as mentally ill and dangerous to others. The medical staff of a mental health facility then examines the patient and informs the prefect whether they consider the patient to be mentally ill and dangerous. Usually, the prefect follows the recommendation of the psychiatrists. Only the prefect, however, has the authority to release such a person. A negative release decision may be appealed to a special judicial tribunal. Such executive commitment and release appears unusual in Europe.

IX. CONCLUSION

Not surprisingly, most of the European legal systems observed formally take mental illness into account in assessing

45. The prefect is the most important local official in the administration of France's territories. Prefects perform numerous functions, including administration, execution of policies, and decisions and coordination of the territory's civil servants. B. SCHWARTZ, *FRENCH ADMINISTRATIVE LAW AND THE COMMON-LAW WORLD* 82-83 (1954).

the criminal responsibility of mentally ill persons charged with committing a criminal offense. With the exception of Sweden, every criminal defendant is provided by law with an opportunity to have the defense of insanity considered. Even more importantly, however, these legal systems consider mental illness crucial in determining the proper disposition of a person charged with committing a crime. Compared to the United States, they seem generally less concerned with making accurate and individualized assessments of moral blameworthiness and more concerned with ensuring that persons who have committed acts proscribed by law will not commit other such acts in the future. They are also more concerned that such persons are effectively treated so as to achieve that objective.

All five countries also provide in their legal system for involuntary civil commitment of the mentally ill. Each state is authorized to confine and treat mentally ill persons without their consent in mental health facilities. The purposes of involuntary civil commitment range from the purely therapeutic—the restoration of the patient's mental health—to the preventive—the prevention of harm to the community or to the individual. There the similarities to the United States stop and the differences become quite sharp.

Viewed from a broad perspective, the mental health legal systems observed in Europe are firmly grounded in the medical model. Their legal systems delegate major decisionmaking on questions of criminal responsibility, coercive confinement and treatment in psychiatric institutions, and individual freedom to medical experts. The underlying assumptions seem to include confidence in the claimed expertise of the medical specialist and confidence in this particularly quasi-scientific model of human behavior. It should be noted that virtually every mental health expert from the United States participating in the delegation expressed intense discomfort with mental health specialists being granted such broad and unchecked authority to make such difficult and important decisions.

Compared to the United States, there is minimal recognition of the political, philosophic, and moral nature of these fundamental questions involving personal responsibility and individual autonomy. Consequently, judicial monitoring of the decisionmaking process in Europe appears minimal. The relative absence of judicial participation in and control over how these decisions are made in Europe may also be explained by our pref-

erence in the United States for adversarial, due process decision-making which encourages a dispute between the parties as to the truth and surfaces disagreement among the experts. This is in stark contrast to the continental model of inquisitorial truth-seeking which frequently masks any disagreement among experts.

In the selected European countries, there also appears to be less emphasis on and concern with freedom of the individual and his civil rights as important values. Clearly, the European systems observed manifested a strong preference for the state to act effectively in preserving community safety, preventing harm, and acting in the individual's assumed self-interest. Utilitarianism and paternalism dominate in Europe. The intellectual and political history of the United States, on the other hand, is much more distrustful of such state action.

There also seems to be more confidence in Europe that the government and, more importantly, its appointed experts are properly discharging their responsibilities. The European approach may actually allocate more of the available resources to therapy and to the accomplishment of the substantive public policy goals rather than consuming them in "inefficient," due process decisionmaking. On the other hand, one is struck by the somewhat cavalier attitude that mistakes are not a significant problem and occur very infrequently in these European systems.

The mental health legal systems of these countries recall the state of the law and practice in the United States in the 1950's. In that era, medical experts had broad grants of authority from the state which they exercised virtually without challenge, and there was minimal political or judicial supervision exercised over these experts. Lawyers were not significant actors in the process because there were almost no "rights" recognized under our law. Of course, the 1960's saw a virtual explosion in the United States in social and legal concern about our law and mental health system resulting in increased constitutional scrutiny of this apparatus of social control. Courts, legislatures, and lawyers have been involved intensely ever since. More recently, however, the pendulum of public and legal opinion here seems to be swinging back somewhat to the "hands off" attitudes observed in Europe.

The European countries observed seem remarkably comfortable with their present systems and there appears to be min-

imal agitation or pressure for change. Whether the pendulum of public opinion will swing in Europe remains to be seen.