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Roger Peele M.D.

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BOOK REVIEWS

MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION. By Alan A. Stone, M.D.[1] Rockville, Maryland: National Institute of Mental Health. 1975. Pp. xiv, 266.

Reviewed by Roger Peele, M.D.[2]

Mental Health and Law: A System in Transition is a succinct and rich overview of psychiatry and the law by a psychiatrist who is highly respected by the psychiatric community and who teaches medicine and law at Harvard University. This book should prove very useful to both professions, since the needs and viewpoints of both are addressed well.

The introductory chapter of the book is a balanced overview of the relationship between the two professions and the difficulties they face in their interaction. Although Stone regards the recent efforts to impose the due process model of the criminal system onto the civil judicial-psychiatric interface as "imposing one terrible system on another" (p. 3), he underscores the need for reform in delivering mental health services. He suggests that the Professional Standard Review Organizations (PSROs) should become a device for upgrading services.

Many involuntary commitment statutes require that the prospective patient be decreed dangerous to himself or others by a physician, raising the issue of whether a psychiatrist or other physicians have sufficient expertise in this area. In a recent review, Dr. William H. Dobbs observed that the standard psychiatric texts contain no references to dangerousness.[3] What one cannot find in the thousand plus pages of standard textbooks, however, can be found in this small book. Stone not only questions the predictability of dangerousness, but adds that if the only persons committed are those

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1. Professor of Law and Psychiatry, Harvard University.
2. Acting Superintendent, Saint Elizabeth's Hospital, Washington, D.C. A.B., 1955, University of North Carolina; M.D., 1960, University of Tennessee.
3. Comments by Dr. William H. Dobbs, Director, Division of Forensic Programs at Saint Elizabeth's Hospital, Washington, D.C., Meeting of the Washington Psychiatric Scientific Society, Oct. 23, 1975.

deemed dangerous beyond a reasonable doubt, then we are moving towards releasing those persons whom the mental health system can treat and committing those it cannot (p. 37). Stone's arguments regarding dangerousness to others are especially persuasive. Psychiatry can at best predict dangerousness to oneself, and that largely in terms of a person's mental inability to care for himself. The majority of involuntary admissions are in this latter category.[4]

After three chapters, Stone has satisfied the reader that the judiciary and the mental health systems have feet of clay. With this understanding, he reviews civil commitment in much detail. Having considered the rationales and problems inherent in civil commitment, he advances his "Thank You Theory" of civil commitment as one approach that makes sense (p. 70). Essentially, the "Thank You Theory" is a criterion of acceptable commitment that asks whether a former patient, after recovering his rationality, would say: "Thank you for incarcerating and treating me against my will." Stone sees a number of conditions that would need to be established to insure a "thank you," including assurance of effective treatment. For that he again pins his hopes on an improved peer review mechanism (*id.*).

Although sympathetic to many of the arguments in favor of judicial decisions on the right to treatment, Stone ends his chapter entitled "Right to Treatment" with the suspicion that this tendency may lead to wholesale deinstitutionalization (p. 94). He believes that a removal of legal restrictions to health insurance and a creation of "national health insurance which does not exclude inpatient [*sic*] mental hospital care" (*id.*) would be more useful.

While not very enamored of the utility of the judicial role in the "right to treatment" area, Stone does see a place for the courts in determining the right to refuse treatment; he develops this idea in chapter six. In questions of psychosurgery, electroconvulsive treatment, insulin therapy, behavior modification's aversive therapy, carbon dioxide inhalation therapy, and prescriptions for highly addictive medications, he would recommend a judicial hearing before the treatments were administered to a protesting patient (pp. 104-06).

Many forensic psychiatric books afford the insanity defense great emphasis. Stone does not give it such emphasis, but his book still contains many insights not found elsewhere. Discussing *Durham v. United States*,[5] he

4. *See* Peele, Chodoff & Taub, *Involuntary Hospitalization & Treatability: Observations From the District of Columbia Experience*, 23 CATH. U.L. REV. 744, 746 (1974).
5. 214 F.2d 862 (D.C. Cir. 1954).

notes that the decision "failed to define mental disease or defect, and in the current state of psychiatric art it is rare that any criminal defendant examined by a psychiatrist will escape being labeled with some diagnosis" (p. 224). Actually, less than one out of five forensic examinations at Saint Elizabeth's Hospital result in a diagnosis of mental illness, and it was not too long ago that the percentage was closer to one out of ten.[6] One of the characteristics separating many forensic psychiatrists from other clinicians is their higher threshold for ascribing "mental illness."

Later in his discussion of the insanity defense, Stone points out that such a

> defense is the contradictory juncture between a deterministic modern theory of the causes of action, and an enduring free-will theory of the morality of action. I conclude that the contradiction is insoluble, because the epistemological structures rise on different foundations (p. 227).

This is an extraordinarily noteworthy point. Concepts are operational tools for the clinician; only those concepts that can predict the consequences of an intervention are of real use. In short, only deterministic concepts are of any clinical value, regardless of their worthiness in other settings.

Despite Stone's hope that PSROs will upgrade the clinical efforts, this monograph is not a call to return to prior relationships. Nor does he see any merit in relying on the traditional judicial machinery or traditional lawyer roles. Instead,

> the future mental health attorney must face an existential crisis. That is to say two things: at the same time he is stripped free of guidelines for his conduct, he is burdened by the duty of formulating new social roles for himself; and the existence of these new professional roles depends upon a reformulation of his personal relation to the objects of his work (p. 246).

Stone goes on to state:

> Thus, the emerging roles of the mental health lawyer will require that he be willing at times to establish a closer relation with the patient—as a person and not just as a client. The lawyer may no longer be merely the aloof and secretive court-performer; he will explain to the patient, allay his fears, provide a continuing sense that someone is following his daily life in the institution, interview the family, compile information, investigate alternatives, negotiate with staff, and so on. These roles will require a complex of personal qualities and attitudes which lawyers have generally not striven to cultivate. In addition, these represent lower status roles than the lawyer may be accustomed to; this, too, may be a difficult

6. Conversation with Dr. William H. Dobbs, Dec. 31, 1975.

> adjustment. The existential crisis fundamentally means that the attorney must forsake the comfortable, structured hierarchy of the attorney-client relation in favor of a far more complex and shifting array of relations. There will, of course, be strong temptations to revert to traditional behavior; thus the tendency of the ombudsman project to gain most through litigation (p. 247).

One ombudsman model that he feels is pointed partially in the right direction is Albert Broderick's ombudsman work for Catholic University Law School at Saint Elizabeth's Hospital.[7] He would have liked to see the ombudsman function more as quoted above and would like clarity as to his constituency. He mentions the executive or the legislature as the appointing authorities. Out of some ignorance about what has been tried in the past, I will venture to state that a legislative appointee would seem to meet the great need to improve public-to-patient ties.

The role envisioned by Stone for the legal profession in working with the mentally ill has a clinical ring. Persons in the clinical professions, especially psychiatrists and social workers, will need to consider whether they want to lose their prior exclusivity in these care-giving roles. If not, they will need to develop additional skills and traditions to regain the patient's and the public's confidence. Stone makes it clear that there is no turning back.

This monograph is exceptionally valuable because it is very timely, extremely thoughtful, and thoroughly concerned with the welfare of the patient. The austerity surrounding government publications means there is no index, but even that is a definite gain if it forces one to read every word.

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7. For a description of this project, see Broderick, *Justice in the Books or Justice in Action—An Institutional Approach to Involuntary Hospitalization for Mental Illness*, 20 CATH. U.L. REV. 547 (1971); Broderick, *One-Legged Ombudsman in a Mental Hospital: An Over-the-Shoulder Glance at an Experimental Project*, 22 CATH. U.L. REV. 517 (1973).