CASE REPORT

Michael A. Norko,[1] M.D.; Howard V. Zonana,[2] M.D.; and Robert T. M. Phillips,[3] M.D., Ph.D.

Prosecuting Assaultive Psychiatric Patients

REFERENCE: Norko, M. A., Zonana, H. V., and Phillips, R. T. M., "**Prosecuting Assaultive Psychiatric Patients,**" *Journal of Forensic Sciences*, JFSCA, Vol. 37, No. 3, May 1992, pp. 923–931.

ABSTRACT: For many reasons, inpatient psychiatric units are increasingly faced with treatment and management of violent individuals. This fosters a need to consider potential institutional responses to patient violence. This paper focuses on one response—prosecution of these persons. The existing literature on this topic is reviewed. In addition, the case history of a difficult but successful prosecution of an assaultive patient is presented. This case highlighted the development of guidelines, which are outlined herein, for determining the appropriateness of seeking legal action against patients. The paper concludes with an assessment of the benefits and risks associated with patient prosecution.

KEYWORDS: psychiatry, violence, jurisprudence, hospitals, patient assaults, prosecution, hospital policy

For a variety of reasons, inpatient psychiatric units are increasingly faced with the treatment and management of violent individuals. Non-assaultive patients have been deinstitutionalized, more patients are hospitalized because of dangerousness, more patients are hospitalized with criminal charges, and more patients are hospitalized in the exercise of Tarasoff duties [*1–5*]. Tarasoff and its progeny cases have created an atmosphere of fear of civil liability among psychiatrists. Consequently, psychiatrists are more reluctant to release patients who have been violent [*6*] and are more likely to admit individuals solely for the purpose of preventing violence [*7*]. Such individuals frequently have psychiatric disorders that are not responsive to acute treatment and may thus be subject to long stays on inpatient units. With a growing number of jurisdictions prohibiting the use of involuntary medications, even treatable violent patients may experience pro-

This paper was among the 1991 Award Winning and Honorable Mention Papers of the Psychiatry and Behavioral Science Section Awards: Research by Fellows in Forensic Psychiatry and Psychology.
Some of the ideas contained within this manuscript were presented in preliminary form to the 142nd Annual Meeting of the American Psychiatric Association, San Francisco, CA, 7–11 May 1989.
[1]Chief, Intermediate Treatment Unit, Whiting Forensic Institute, and assistant clinical professor, Psychiatry, Yale University School of Medicine, New Haven, CT.
[2]Associate professor of Psychiatry and director, Law and Psychiatry Division, Yale University School of Medicine, New Haven, CT.
[3]Director, Office of Forensic Services, State of Connecticut Department of Mental Health and assistant clinical professor of Psychiatry, Yale University School of Medicine, New Haven, CT.

Copyright © 1992 by ASTM International

longed hospitalization [*8*]. Thus, there is a growing need to consider potential institutional responses to patient violence.

This discussion focuses on one response that is seldom used and infrequently discussed—seeking legal action against patients who assault other patients or staff. It is timely to explore the traditional institutional posture against prosecuting violent patients. This analysis begins with a presentation of a literature review of this topic, placing particular emphasis on identifying systems issues which might be related to the prevailing reluctance to prosecute. Next, the case history of a difficult but successful prosecution of an assaultive insanity acquittee is presented. This case highlighted the development of guidelines, presented here, for determining the appropriateness of seeking legal action against patients. Finally, possible risks and benefits associated with prosecuting patients are outlined.

There is a remarkable dearth of material in both the medical and legal literature on prosecuting psychiatric inpatients. The few documented cases focused primarily on prosecuting patients for escape from psychiatric institutions [*9,10*]. One case involving prosecution of a patient for violent behavior was dismissed by the New Jersey State Superior Court, which concluded that the assault was a manifestation of a manic episode and questioned the appropriateness of prosecuting patients for behaviors which precipitated their hospitalizations [*11*].

The psychiatric literature contains few discussions on indications for prosecution, factors involved in the decision to prosecute, theoretical constraints against prosecuting, and legal and treatment outcomes of prosecution [*5,12–17*]. Among the arguments advanced in these works in support of taking legal action are those suggesting that prosecution for violent behavior:

- encourages patient responsibility and is therefore therapeutic [*12,15,17*],
- represents a type of reality therapy by limit-setting intervention [*5,14–17*],
- improves staff morale and ability and willingness to treat violent patients [*5,15,16*],
- deters violent behavior [*13,17*],
- allows for public scrutiny of violence in institutions [*13,15*], and
- may be a just consequence for injurious acts [*15*].

Arguments against prosecution include those suggesting it:

- subverts the therapeutic alliance [*18*],
- invites countersuit by patients [*18*],
- is an acting-out of countertransference on the part of staff [*13*],
- is impractical [*13*],
- scapegoats patients for inadequacies in the treatment environment [*14*],
- may permanently alienate patients from the care system [*14*], and
- may violate patient confidentiality [*18*].

Another line of research showed that patient assaults are underreported [*19–21*] and clinicians avoided the problem through denial [*22–25*]. Many reasons have been postulated to explain these phenomena: lack of formal training in dealing with violence, fear of or distaste for legal entanglements, and personal dynamic factors that make clinicians uncomfortable dealing with violence.

Other more disturbing factors have been suggested. These arise from public myths or prejudices against the mentally ill [*26*] (for example, the assumption that violence is an unavoidable part of mental illness; or that patients are uniformly dangerous, incompetent, and not responsible for their actions). These misperceptions suggest that criminal law does not exist within the walls of mental institutions because there are few societal expectations for lawful behavior by the hospitalized mentally ill. The law simply stops at the door of "the asylum." Indeed, it is ironic that in the contemporary paradigm of

deinstitutionalization, community services and normalization, the psychiatric hospital has outgrown the concept of asylum as a "benevolent institution affording shelter and support to some class of the afflicted" [27] but not the centuries-older concept of asylum as "a sanctuary or inviolable place of refuge and protection for criminals and debtors, from which they cannot be forcibly removed without sacrilege" [27].

These misperceptions are not only adopted by lay people, but by mental health administrators as well. Hospital administrators who routinely avoid filing complaints against violent patients take part in the perpetuation of this stigmatizing notion that individuals who are mentally ill and hospitalized should not or cannot be held accountable for their actions.

Further, such administrators adopt the stance that staff must tolerate being assaulted as "part of the job." Staff members are frequently expected to deal with patient violence on units with limited staffing and ever-increasing service demands. Often, little training is offered in the management of violence. This increases the likelihood that staff members (out of frustration and fear) will develop more powerful countertransferences and be more likely to act out these feelings in a nontherapeutic manner. The lack of attention to assaults on staff may lead to morale, performance, and health problems [28], as well as increased costs incurred when staff are injured during an assault.

The lack of clearly formulated institutional policy regarding patient violence makes it more likely that staff will respond in an individualized and punitive manner to assaultive patients. Of primary concern is the deleterious effect this process has on patients. Punitive attitudes held by staff are generally counter-therapeutic and may exacerbate pathology. When prosecution is pursued unsystematically, patients perceive this individualization as staff prejudice, hostility, or vindictiveness. When legal interventions are avoided in favor of transfers, patients are rejected and extruded. Because the problem is neither confronted nor resolved, it is passed along to be reexperienced in the next environment. The staff's unwillingness or inability to control the patient's behavior may create disturbing fantasies of worthlessness, destructive omnipotence, or reinforce antisocial and undesirable behaviors by the patient.

Finally, it must be recognized that societal punishment of a psychiatric patient is not equivalent to, and does not necessarily entail, the acting out of punitive countertransferences by hospital staff. Even if no therapeutic value can be ascribed to the prosecution and punishment of an individual patient, there might be legitimate societal justification for doing so. The criminal law recognizes several purposes of punishment (retribution, general deterrence, special deterrence, and incapacitation) that have nothing to do with the health or well-being of the offender [29]. These societal purposes should not be obviated by hospital admission, and the recognition by the hospital that these purposes exist should not be construed as a reactionary stance.

Case History

The following example case is offered of a highly institutionalized insanity acquittee who was successfully prosecuted for two assaults on other patients.

Mr. B is a 31-year-old single black male who has spent less than 4½ months living in the community since the age of 18. The product of a broken home and a chaotic childhood, he has been placed in 12 different institutions since the age of 14 and has experienced at least 62 changes in residence or treatment setting. Since age 18 he has spent over 3½ years in correctional facilities and approximately 10 years in psychiatric facilities. He has been admitted 27 times to one state psychiatric hospital, 13 times to the state forensic hospital, 4 times to other psychiatric hospitals, and 11 times to correctional facilities for crimes, including breach of peace, criminal mischief, threatening, robbery, and assault.

At various times, Mr. B has been diagnosed as suffering from schizophrenia, bipolar

disorder, impulse control disorder, factitious disorder, malingering, depression, mental retardation, mixed substance abuse, antisocial personality disorder, borderline personality disorder, passive-aggressive personality disorder, and mixed personality disorder.

Mr. B's admissions to the maximum security forensic hospital were precipitated by acts of property or personal violence or both while he was a patient at the state hospital. The medical record documents that he committed at least 16 assaults, set fires at least 8 times, and made at least 5 bomb threats at the state hospital. The hospital, however, pressed charges only once. This occurred when he assaulted two staff members who had denied him admission—that is, the hospital pressed charges only when he was not their patient.

At the age of 21, Mr. B was found not guilty by reason of insanity for attempted bank robbery while on pass from the state hospital. He was committed to the Department of Mental Health for a period of 10 years. During this time, he committed many of the assaults mentioned above, and was repeatedly hospitalized at the Whiting Forensic Institute, the maximum security forensic hospital for the state of Connecticut.

In 1986, Whiting was organized under a new administration with the explicit directive to improve the quality of psychiatric forensic care at the Institute. Concern over the high number of reported incidents involving patient violence and the increasing number of patient-on-patient and patient-on-staff assaults led to the development of a policy which would hold patients accountable for their actions when their mental state did not preclude their criminal responsibility. Coincident in time with the administrative decision to pursue patient accountability for such actions, Mr. B committed two assaults on other patients in which the victims sustained serious medical injury. Accordingly, upon clinical and administrative review, the decision was made to file a criminal complaint. The treatment team's clinical opinion, as reflected in the medical record, was that at the time of the assaults, Mr. B knew what he was doing, knew that it was wrong, and was able to control his behavior when he so wanted.

The prosecuting attorney was initially reluctant to pursue the case given the fact that not only was this a mental patient but one who was hospitalized because he had been found not guilty by reason of insanity for a prior offense. He eventually agreed to prosecute after discussions with the administration about the variability of mental illness and the facts of this individual patient's case. Mr. B was found guilty of two charges of assault and sentenced to two years in the state prison.

After a period of 4½ months, Mr. B was transferred to Whiting Forensic Institute from the prison following an acute psychotic decompensation. Although he was back in the same facility in which he committed the assaults, there was a significant change in his behavior. He committed only one subsequent assault. This occurred soon after his return while he was still acutely ill. Since then he has been functioning better than ever before and is making slow but steady progress.

Recommended Guidelines for Determining Appropriateness of Patient Prosecution

A rational approach to the problem of patient violence begins with attention to prevention. Many authors have commented that attention to clinical treatment and to establishing a well-controlled milieu are the most effective means of dealing with violent patients [*5,14,16,18,23,30*]. Although a broad range of treatments have been recommended for violent patients [*23,30*], good clinical care does not prevent all assaults especially when hospitals are increasingly forced to admit individuals not primarily because of acute psychiatric illness or potential for psychiatric treatment, but because of dangerousness and the need for confinement. Patient discharge or transfer is often not an optimal or available option. Thus, the institutional approach to patient violence must go further. The following guidelines are suggested.

1. *Every psychiatric hospital should clearly present patient rights and patient responsibilities to individuals upon admission.* While written documentation of patient rights is widely available, a presentation of patient responsibilities is generally absent. Among the responsibilities should be the expectation that patients will respect the rights of others (patients and staff) and exhibit lawful behavior. There should be a clear statement that the hospital, as well as other patients, may file criminal complaints against patients who violate the law. Patients should be warned that if a complaint is filed, then some information such as the fact of their hospitalization and the basis for the complaint will be released to authorities.

This important step in policy formulation achieves several goals. First, it ties patients' responsibilities to patients' rights. This is a significant message to patients that can be used as the opening move in therapeutic processes that help patients examine and take responsibility for their behavior and treatment. A therapist's statements about expectations are an integral part of the process for maximizing the patient's capacity to meet those expectations, as is the consistency with which those messages are given [*31*].

Not to be minimized are the deterrent effects a clearly stated prosecution policy has in preventing violence. (For example, after Mr. B's prosecution, there was a significant drop in the occurrence of violent behavior in the institution.) However, because many patients have never been held legally accountable for their behavior during prior hospitalizations, all should receive a "fair warning." A uniform notification process also is necessary to insure consistent application of the policy. Finally, a declaration of patients' rights and responsibilities is also a declaration of the institution's rights and responsibilities. While the institution may reserve the right to file criminal charges, it also bears the prerequisite responsibility to insure the adequacy of the treatment environment.

2. *The criteria for pursuing prosecution should be established as a matter of hospital policy.* Each hospital must decide what criteria are most appropriate for its needs and purposes. In general, relatively minor acts should not be included. Policy that mandates prosecution for all criminal activity is as ill-conceived as policy which forbids all prosecution. It is important not to burden the legal system with frivolous complaints. For example, the chief of police at Whiting Forensic Institute estimates that two to three arrests could be made per day among a population of approximately 100 patients on charges such as breach of peace.

The purpose of establishing these criteria is to address those behaviors that present a serious threat to the safety of patients and staff or significantly interfere with the therapeutic work of the hospital. The following represent one possible set of criteria:

(*a*) serious injury to the victim,
(*b*) any sexual assault, or
(*c*) repeated antisocial acts of a violent nature.

3. *Violent incidents by patients should be reviewed by clinician(s) not involved with their treatment.* This guideline recommends both a review of the incident and an assessment of the patient's mental state at the time of the incident, considering jurisdictional criteria for criminal responsibility as part of the evaluation process. This screening review is a clinical/administrative tool, not a legal determination; its purpose is to decrease the likelihood of prosecuting patients for clear manifestations of their illness and also to increase the institution's ability to persuade a prosecutor or the police that a filed complaint is legitimate.

Certainly a policy permitting prosecution is not meant to scapegoat patients for inadequacies in the treatment milieu, nor to provide an avenue for acting out in the countertransference. Conducting a review of the incident allows administrators and clinicians to detect evidence of such processes. This review can then also become part of an institution's overall attempts to *prevent* violence through debriefing of violent events,

followed by correction of any discovered clinical inadequacies. If an institution is to file credible criminal complaints, it must provide an adequate treatment environment.

The institution must be prepared to educate police and prosecutors that mental disorders are highly variable over time and that hospitalization in a mental health facility alone does not preclude criminal responsibility. This education should occur proactively to encourage dialogue about such issues well before the need to seek legal recourse. Concomitantly, local legal authorities might be included in the initial formulation of the institution's policy about prosecution in order to identify potential difficulties.

There are at least two methods for assessing the patient's mental status at the time of the incident: either through a direct interview or an indirect chart review. A direct clinical interview by an independent clinician solely to determine a patient's mental state might be the most effective method. However, the information obtained from such an interview would probably not be confidential. Having the physician read "Miranda warnings" to the patient would probably satisfy legal requirements.

However, ethical questions still exist regarding prearraignment examinations. Specific ethical proscriptions have been enunciated regarding the examination of individuals already charged with crimes [*32*]. In this circumstance, prearraignment examinations are considered unethical before defendants obtain legal representation. However, with regard to the present topic, when patients have not yet been arrested it is not clear if the ethical proscription applies. Because the outcome of an evaluation may result in the decision to press charges, the intent of the American Psychiatric Association (APA) ethical mandate might be interpreted to disallow such direct evaluations for such purposes.

Some appraisal of the patient's mental state is necessary because an active psychotic state or serious mental disorder affecting the individual's behavior should preclude a decision to go forward with charges. An independent clinician's indirect assessment of mental state by chart review and interview of staff may be preferable for the purposes of this screening evaluation and the decision about filing charges.

These precautions should not be construed to limit the treatment team's ability to interview the patient for clinical purposes (for example, incident reviews or quality-of-care assessments). However, the boundaries between these clinical purposes and the investigative activities of the independent clinician(s) must be kept clear. The staff interviews and chart review are conducted to help determine the patient's state of mind, not as a method of prearraignment examination. Further, this inquiry into state of mind is used only for hospital administrative purposes in deciding whether to file a complaint, not as a legal determination of criminal responsibility. The patient/defendant may not raise the issue of criminal responsibility at all, in which case the patient's medical information may not be released at trial.

Treating clinicians should also be aware that reporting incidents of criminal behavior or testifying as ordinary (as opposed to expert) witnesses to such incidents does not generally violate confidentiality. Not everything that a patient does in a hospital is protected under confidentiality statutes. An assault on another patient in a hallway, for example, would not be considered part of a privileged communication to a therapist. A clinician who witnessed such an assault might report or testify about the physical incident without releasing the chart or other medical information, thus not violating ethical or legal principles. However, the clinician would not be free to discuss what the patient later revealed in therapy about any planning that he made for that assault, for example, unless the patient placed his mental state at issue at trial.

No matter how carefully these matters are handled, the process of staff discussing the patient's mental state with an independent clinician-reviewer involves some disclosure of information that would be deemed confidential. The best that can be done is to inform patients in their admission information or at the time of an incident that such inquiry may take place as part of the hospital's response to dangerous or criminal behaviors. If

the decision to prosecute is made, then the amount of information to be released to the police must be carefully reviewed to be sure that only information necessary to make the complaint is released. Any intrahospital release should be minimal since material is provided only to a nontreating clinician employed by the hospital and to hospital administrators who might be aware of much of the information because of routine peer review, quality assurance, and risk management procedures.

4. *The findings of the screening evaluation should be reviewed by the hospital administration and clinical director.* During this review, the facts of the case are evaluated against the hospital's established criteria for pursuing prosecution. Attention must be given to applying the stated policy consistently throughout the institution and over time. In addition, the consistency of information about the incident should be assessed as another check of accuracy and the absence of scapegoating. Particular attention should be focused on any conflicting data. Following a careful, thorough review, the decision to file a criminal complaint can be made.

5. *When the decision is made to go forward with the complaint, the treatment staff should not be responsible for filing the criminal complaint.* The treatment staff should not be responsibile for decisions about prosecuting or for the actual complaint. This would create serious conflicts of interest, and increase the risk that the process would be abused. Further, to the extent possible, the ability of the treatment team to continue to work with the patient throughout this process should be preserved. This ability is enhanced by removing the treatment team from the adversarial process between the state and the patient-defendant. If the team can remain relatively neutral, it can more easily support the patient and continue to help the patient identify and modify maladaptive behaviors. Any victim (patient or staff) always maintains the right to file a complaint if he or she wishes, apart from any administrative decision or process.

Risks/Benefits

Prosecuting patients for assault and other violent behaviors, like all interventions, requires a balancing of associated risks and benefits. Prosecution may destroy an existing therapeutic alliance [*14,18*]. Alternatively, it may be the violence itself that destroys the alliance, not a response to the violence. Successful prosecution and conviction do not necessarily destroy a therapeutic alliance. The patient can become more amenable to treatment after learning that his actions have consequences and that the staff is serious about issues of personal responsibility [*5,14,15*].

Another potential risk of prosecuting patients centers on possible victimization by the criminal justice system. This could occur in situations where impoverished or disenfranchised individuals receive inadequate legal assistance, or where jails provide inadequate supervision and psychiatric care following transfer of patients to these settings [*5,17*]. While no psychiatric hospital can assume responsibility for conditions within other systems, it would be prudent to attend to such issues when formulating a comprehensive prosecution policy. For example, procedures for consultation with correctional facilities may need to be established in order to facilitate continued treatment.

There is also the risk that patients can be scapegoated for the inadequacies existing in clinical treatment settings [*14*]. Quality assurance mechanisms can provide some amelioration of this risk. Other methods for minimizing this possibility include staff "debriefing" after violent incidents and the screening evaluation recommended above. However, because the risk exists for abuse of a prosecution policy (for example, through differential reporting of violent incidents), administrative review of all incidents is necessary.

There are also specific risks associated with avoiding or evading the issue of patient violence. At the very least, a psychiatric hospital that tolerates an attitude that violence

must be accepted as part of the territory adopts public misperceptions about the mentally ill and perpetuates the stigma of mental illness. This tolerance puts patients and staff at greater risk for injury, and puts staff at greater risk for morale and countertransference problems. Bringing the law within the walls of the institution is a more normalizing and respectful way to treat mentally ill patients. It encourages personal responsibility and instructs patients about societal expectations.

Beneficial considerations in adopting prosecution policies include the following. An institution's overall policy on prevention and management of violence becomes more comprehensive by addressing the prosecution option. Indeed, it may be more consistent with therapeutic goals to confront a patient's violence by prosecuting the patient, rather than avoid the confrontation by extruding the patient. A thoughtful institutional policy on patient violence is more likely to be preventive rather than reactive. It encourages action that is uniform, more rational, and consistent with therapeutic goals rather than *ad hoc* actions that are more personalized and more prone to the influence of individual dynamics. By formulating coherent policies before the need arises, individual patients are less likely to feel singled-out or to serve as "examples" to other patients.

A formulated policy will also improve the consistency with which prosecution is pursued. When patients are held accountable for their actions sporadically or inconsistently, it becomes more difficult for them to alter their behavior, and their behavior may actually worsen [*31*].

The risks of prosecuting patients are real, but so too are the benefits. Also real are the risks of not going forward with prosecution when it is warranted. Circumstances may dictate different appraisals of the balance of those risks and benefits in different hospitals. Because patient violence has become so commonplace, all psychiatric hospitals are encouraged to adopt a comprehensive approach to this problem. A carefully considered policy concerning prosecution for unlawful behavior can be a significant tool in preventing violence and a significant addition to the therapeutic intervention with a given patient. Such policies can enhance our ability to rehabilitate psychiatric inpatients and prepare them better for community life.

Acknowledgment

The authors wish to thank Dr. Ezra Griffith and Dr. Carl Chi for their review and comments, and Ms. Marjorie Getz for her editing and assistance with manuscript preparation.

References

[*1*] Sosowsky, L., "Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationships Between the State and the Mentally Ill," *American Journal of Psychiatry*, Vol. 135, 1978, pp. 33–42.

[*2*] Melick, M. E., Steadman, H. J., and Cocozza, J. J., "The Medicalization of Criminal Behavior Among Mental Patients," *Journal of Health and Social Behavior*, Vol. 20, 1979, pp. 228–237.

[*3*] Huber, G. A., Roth, L. H., Appelbaum, P. S. et al., "Hospitalization, Arrest, or Discharge: Important Legal and Clinical Issues in the Emergency Evaluation of Persons Believed Dangerous to Others," *Law and Contemporary Problems*, Vol. 45, 1982, pp. 99–123.

[*4*] Johansen, K. H., "The Impact of Patients with Chronic Character Pathology on a Hospital Inpatient Unit," *Hospital and Community Psychiatry*, Vol. 34, 1983, pp. 842–846.

[*5*] Miller, R. D. and Maier, G. J., "Factors Affecting the Decision to Prosecute Mental Patients for Criminal Behavior," *Hospital and Community Psychiatry*, Vol. 38, 1987, pp. 50–55.

[*6*] Miller, R. D., Doren, D. M., Van Rybroek, G. et al., "Emerging Problems for Staff Associated with the Release of Potentially Dangerous Forensic Patients," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 16, 1988, pp. 309–320.

[*7*] Appelbaum, P. S., "The New Preventive Detention: Psychiatry's Problematic Responsibility for the Control of Violence," *American Journal of Psychiatry*, Vol. 145, 1988, pp. 779–785.

[8] Perlman, B. B., "Prosecuting Patients," (letter), *Hospital and Community Psychiatry*, Vol. 38, 1987, p. 673.
[9] *State v. Kyles*, 166NJ, New Jersey Superior Court 343, Appeals Division, 1979.
[10] Trenkner, T., "Escape from Public Employee or Institution Other than Correctional or Law Enforcement Employee or Institution as Criminal Offense," *American Law Reports*, 3rd ed., 1969, pp. 625–654.
[11] *State v. Cummins*, 168NJ, New Jersey Superior Court 429, 433 A2d 67, 69, 1979.
[12] Schwarz, C. J. and Greenfield, G. P., "Charging a Patient with Assault of a Nurse on a Psychiatric Unit," *Canadian Psychiatric Association Journal*, Vol. 4, 1978, pp. 197–200.
[13] Phelan, L. A., Mills, M. J., and Ryan, J. A., "Prosecuting Psychiatric Patients for Assault," *Hospital and Community Psychiatry*, Vol. 36, 1985, pp. 581–582.
[14] Hoge, S. K. and Gutheil, T. G., "The Prosecution of Psychiatric Patients for Assaults on Staff: A Preliminary Empirical Study," *Hospital and Community Psychiatry*, Vol. 38, 1987, pp. 44–49.
[15] Mills, M. J., Phelan, L. A., and Ryan, J. A., "In Reply," (letter), *Hospital and Community Psychiatry*, Vol. 36, 1985, pp. 1321–1322.
[16] Rachlin, S., "Toward a Definition of Staff Rights," *Hospital and Community Psychiatry*, Vol. 33, 1982, pp. 60–61.
[17] Stein, L. I. and Diamond, R. J., "The Chronic Mentally Ill and the Criminal Justice System: When to Call the Police," *Hospital and Community Psychiatry*, Vol. 36, 1985, pp. 271–274.
[18] Gutheil, T. G., "Prosecuting Patients," (letter), *Hospital and Community Psychiatry*, Vol. 36, 1985, pp. 1320–1321.
[19] Lion, R., Snyder, W., and Merrill, G., "Underreporting of Assaults on Staff in a State Hospital," *Hospital and Community Psychiatry*, Vol 32, 1981, pp. 497–498.
[20] Tardiff, K. and Sweillam, A., "Assaultive Behavior Among Chronic Inpatients," *American Journal of Psychiatry*, Vol. 139, 1982, pp. 212–215.
[21] Madden, D. J., Lion, J. R., and Penna, M. W., "Assaults on Psychiatrists by Patients," *American Journal of Psychiatry*, Vol. 133, 1976, pp. 422–425.
[22] Lanza, M. L., "The Reactions of Nursing Staff to Physical Assault by a Patient," *Hospital and Community Psychiatry*, Vol. 34, 1983, pp. 44–47.
[23] Lion, J. R., Madden, D. J., and Christopher, R. L., "A Violence Clinic: Three Years' Experience," *American Journal of Psychiatry*, Vol. 133, 1976, pp. 432–435.
[24] Brizer, D. A., Convit, A., Krakowski, M. et al., "A Rating Scale for Reporting Violence on Psychiatric Wards," *Hospital and Community Psychiatry*, Vol. 38, 1987, pp. 769–770.
[25] Lion, J. R. and Pasternak, S. A., "Countertransference Reactions to Violent Patients," *American Journal of Psychiatry*, Vol. 130, 1973, pp. 207–210.
[26] Steadman, H. J. and Cocozza, J. J., "Public Perceptions of the Criminally Insane," *Hospital and Community Psychiatry*, Vol. 29, 1978, pp. 457–459.
[27] *Oxford English Dictionary*, Oxford University Press, Oxford, UK, 1971.
[28] Scott, J. R. and Whitehead, J. J., "An Administrative Approach to the Problem of Violence," *Journal of Mental Health Administration*, Vol. 8, 1981, pp. 36–40.
[29] Perkins, R. M. and Bayce, R. N., *Criminal Law: Cases and Materials*, 3rd ed., Foundation Press, New York, 1982.
[30] *Clinical Treatment of the Violent Person*, L. H. Roth, Ed., Guilford Press, New York, 1987.
[31] Halleck, S. L., "The Concept of Responsibility in Psychotherapy," *American Journal of Psychotherapy*, Vol. 36, 1982, pp. 292–303.
[32] *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, Section 4, No. 13, American Psychiatric Association, Washington, DC, 1989.

Address requests for reprints or additional information to
Michael A. Norko, M.D.
Whiting Forensic Institute
P.O. Box 70
Middletown, CT 06457

Erratum

In the article, "The Trial of Louis Riel: a Study in Canadian Psychiatry" (Vol. 37, No. 3, May 1992, p. 852), I erred in stating that Valentine Shortis was found not guilty of homicide, a verdict supported by the cabinet. In actuality, the insanity defense failed and Shortis was sentenced to death. The cabinet was evenly split over a recommendation for clemency. The Governor General, Lord Aberdeen, then commuted Shortis to "imprisonment for life as a *criminal lunatic* (italics mine), or otherwise as may be found fitting." This action exacerbated the discontent of French-Canadians over the Riel case. This decision in the Shortis case may have been a factor in the election of a Liberal, Wilfrid Laurier, who became the first French-Canadian prime minister of Canada in 1986.

Shortis remained incarcerated for 42 years; in the earlier years, he was frequently described as mentally ill. In his later years, he apparently functioned quite well and was released at age 62 in 1937; in 1941 he died suddenly of a heart attack.

Both the Jackson and Shortis cases reflect the fact that Canadian authorities were not adverse to considering the impact of mental illness in deciding the disposition of offenders, a step that was rejected in the Riel case.

I wish to thank Abraham L. Halpern, M.D., for bringing this error to my attention.

Irwin N. Perr, MD, JD

Erratum

The articles that appeared in the May issue of the journal under the Psychiatry and Behavioral Science Section Awards were erroneously labeled Case Reports on the title page.

Copyright © 1992 by ASTM International