Treating the Mentally Disordered Offender: Society’s Uncertain, Conflicted, and Changing Views

Thomas L. Hafemeister
John Petrila

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TREATING THE MENTALLY DISORDERED OFFENDER:  
SOCIETY'S UNCERTAIN, CONFLICTED, AND  
CHANGING VIEWS  

THOMAS L. HAFEMEISTER AND JOHN PETRILA  

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TREATING THE MENTALLY DISORDERED OFFENDER: SOCIETY'S UNCERTAIN, CONFLICTED, AND CHANGING VIEWS

THOMAS L. HAFEMEISTER* AND JOHN PETRILA**

My mother groaned! my father wept.
Into the dangerous world I leapt:
Helpless, naked, piping loud,
Like a fiend hid in a cloud.¹

I. INTRODUCTION

An examination of the legal aspects of the treatment of the mentally disordered offender (MDO), results in a clear consensus that the world is indeed a dangerous, confusing, cloud-shrouded place. MDOs may find themselves engulfed by a bewildering system, which although ostensibly devoted to their treatment, appears to provide little actual help. The general public may perceive MDOs as dangerous individuals assigned to a "treatment" system that neither reduces the likelihood of future dangerousness nor protects society from such behavior. Finally, the mental health professional, trying to respond simultaneously to the treatment needs of MDOs and the security needs of the community, may feel required to assume a role which appeases neither, but exposes the therapist to legal attack by both.

It must be kept in mind, however, that the law is more than mere constitutional standards, legislative enactments, governmental regulations, and judicial rulings. The law, regardless of the source, is a reflection of the society that generates it. The current attitudes, fears, and beliefs of the community about the world around it, accurate or not, are reflected in the law that governs at any given time. And when there is more than one accepted and forceful perspective at work, the law can become a complex matrix as it attempts to accommodate

¹ William Blake, Infant Sorrow, st. 1.
these competing perspectives in a variety of circumstances. As a result, one perspective may prevail in a given situation, while a different perspective may govern in another. Furthermore, as the relative strengths of these competing perspectives may change over time, the law may vary on a particular issue as time passes.

In perhaps no other area of the law is this interplay between competing interests reflected more clearly than in the law pertaining to the treatment of the MDO. Because of a criminal act, substantiated or merely alleged, the MDO becomes a focal point of the legal system. Ordinarily, the processing of a criminal act is relatively routine. However, when an individual's mental disorder becomes an issue, either as part of the initial criminal prosecution or subsequent to conviction, that individual's treatment becomes a matter of great concern.

For the community, associating criminal acts with a mental disorder evokes pronounced visceral and emotional reactions. For many members of the general public who envision these individuals violently, unpredictably, and without reason attacking innocent victims, MDOs provoke utter terror. For others, MDOs trigger sympathy and concern for individuals perceived as victims of uncontrollable impulses caught up in a system that fails to respond to their unique needs. For those attempting to treat the MDO, the response is often one of confusion and bewilderment. They may be uncertain how to alleviate the MDO's disorder and unclear about what society expects them to do with such individuals.

In part because of these strongly felt concerns, and in part because of the continuing visibility and controversy of MDOs, the treatment of the MDO has received close scrutiny in recent years. Nevertheless, this scrutiny apparently has not resulted in greater stability in the relevant law, but has instead contributed to its wide fluctuation and variability.

II. Changing Nature of the Underlying Premises of the Law

A. Historical Treatment

The treatment of the MDO was not always closely scrutinized. Historically, society ignored MDOs partially and perhaps primarily, because of social systems that virtually removed such individuals from the public eye. The criminal justice and mental health systems were given broad discretion to quickly and quietly remove a dangerous
"crazy" person from the community, often times in anticipation of a criminal act rather than subsequent to it.\footnote{See Michael L. Perlin, Mental Disability Law: Civil and Criminal 37-48 (1989 & Supp. 1993).}

For example, the criminal justice system was afforded considerable prerogative in the performance of its duties which allowed it to discreetly "sweep up" MDOs. Sanctions could be imposed for "status offenses," such as vagrancy, even though a specific criminal act had not occurred.\footnote{Imposing punishment for a status offense was an attempt by the criminal justice system to gauge an individual's propensity to commit a criminal act and take steps to prevent the commission of anticipated criminal behavior.} Law enforcement officials similarly had wide latitude in their investigations of crimes, with relatively few protections provided to a criminal suspect (e.g., little scrutiny was given to the circumstances under which a confession was given). Following conviction, criminal sentences varied widely and could be increased for individuals perceived as particularly threatening. Finally, once incarcerated, the focus was on assuring secure custody at minimal cost.

On the mental health side, there was a similar tendency to cast a wide net. Civil commitment criteria tended to be broad and applied liberally.\footnote{See Perlin, supra note 2, at 37-48.} Once the process was initiated, commitment was difficult to resist. Treatment staff generally had exclusive control over admission and release decisions, with few incentives to terminate custody and an absence of external checks on their decisions. Long-term commitment tended to be the norm.\footnote{See, e.g., Greenwood v. United States, 350 U.S. 366, 375 (1956) (upholding commitment to state psychiatric facility of individual found incompetent to stand trial, U.S. Supreme Court noted, "The fact that at present there may be little likelihood of recovery does not defeat federal power to make this initial commitment of the petitioner").} The individual subjected to civil commitment had few individual rights and little involvement in the decision-making process. The system placed emphasis on minimizing any danger such individuals might pose for the community.

These broad mandates meant that where society felt frightened or uneasy about a "crazy" person, ready avenues were available for removing that person from society. Because society was effectively insulated from such individuals and because such individuals had virtually no voice of their own and no advocates lobbying on their behalf, there was little societal or legal attention paid to them.

B. Civil Rights Movement

During the 1960s and 1970s, the rights and interests of groups of individuals who had traditionally been voiceless and powerless, in-
cluding MDOs, received increased attention, effectively diminishing the priority given to protecting society.

On the criminal justice side, the United States Supreme Court found punishment for a status offense, such as simply being a drug addict, unconstitutional. Sanctions were reserved for specific forbidden acts, with apparent or anticipated dangerousness generally considered an insufficient basis for criminal prosecution. The Court also struck down broad, sweeping laws that had the potential for arbitrary and discriminatory enforcement (e.g., vagrancy laws) as unconstitutional under the void-for-vagueness doctrine. Indigents were guaranteed counsel, and close review was taken of the knowing and voluntary nature of confessions and waivers of rights in general. The Court, in addition to recognizing a series of rights associated with arrest and trial, carefully scrutinized a defendant’s competence to participate in the trial process and to assist his or her attorney.

6. See Robinson v. California, 370 U.S. 660, 666 (1962) (striking down statute making “status” of narcotic addiction a criminal offense). In Robinson, the U.S. Supreme Court stated, “It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill. . . . A State might determine that the general health and welfare require that the victims of these and other afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.” Id.

7. See Powell v. Texas, 392 U.S. 514, 533 (1968) (plurality, Marshall, J.) (“The entire thrust of Robinson’s interpretation of the Cruel and Unusual Punishment Clause is that criminal penalties may be inflicted only if the accused has committed some act, has engaged in some behavior, which society has an interest in preventing”).

8. See Papachristou v. City of Jacksonville, 405 U.S. 156, 170 (1972) (“Those generally implicated by the imprecise terms of the ordinance—poor people, non-conformists, dissenters, idlers—may be required to comport themselves according to the lifestyle deemed appropriate by the Jacksonville police and the courts”).

9. See Gideon v. Wainwright, 372 U.S. 335, 344 (1963) (ruling Sixth Amendment guarantee of counsel applicable to states under Fourteenth Amendment, Supreme Court stated, “[any person haled into court, who is too poor to hire a lawyer, cannot be assured a fair trial unless counsel is provided for him”); Argersinger v. Hamlin, 407 U.S. 25 (1972); In re Gault, 387 U.S. 1 (1967).


11. See, e.g., Illinois v. Allen, 397 U.S. 337 (1970) (right to be present at trial); Duncan v. Louisiana, 391 U.S. 145 (1968) (right to a jury trial where the potential punishment was imprisonment for six months or more); Washington v. Texas, 388 U.S. 14 (1967) (right to compulsory process for obtaining witnesses in one’s favor); Klopfer v. North Carolina, 386 U.S. 213 (1967) (right to a speedy trial); Pointer v. Texas, 380 U.S. 400 (1965) (right to confront opposing witnesses); Malloy v. Hogan, 378 U.S. 1 (1964) (right to be free of compelled self-incrimination); Mapp v. Ohio, 367 U.S. 643 (1961) (rights to be free from unreasonable searches and seizures and to have excluded from criminal trials any evidence illegally obtained).

The proportionality of sentences was examined more vigilantly, and a criminal defendant could not be held indefinitely while waiting for trial, even after an initial judicial determination of incompetency to stand trial.

Although many of these rulings did not address the MDO specifically, they did reduce the likelihood that such individuals would be subject to criminal sanctions. As procedural and substantive requirements grew more stringent, the ability to utilize the criminal justice system as an avenue to remove the MDO from the community diminished.

Later in this era, a series of landmark cases (albeit often issued by lower federal courts) placed similar restrictions on using the mental health system to remove individuals from the community. As the negative implications of civil commitment for an individual received increased attention, narrower and more precise criteria for commitment were imposed, such as requiring a simultaneous showing of both mental illness and dangerousness. Some courts also required proof of a recent overt act demonstrating the need for commitment, thereby diminishing the ability to commit an individual in anticipation of dangerous behavior. A greater evidentiary showing was re-
quired, making it more difficult to prove that an individual met the commitment criteria. The decision-making process shifted from an informal, unrecorded hospital decision to an adversarial hearing either before a judge or with ready recourse to a judge. Notice and an opportunity to be heard were mandated, and maximum periods of time were established for detaining an individual without a hearing.

Among the other rights recognized during this period were: a right to be present at the hearing, a right to be free from drugs that might dilute or destroy the individual's ability to assist in the presentation of a defense, the right to confront and cross-examine witnesses, and the right to present evidence and compel the attendance of witnesses. The individual was usually guaranteed the right to an attorney or other assistance, a privilege against self-incrimination was sometimes recognized, and traditional rules of evidence were

or another." Furthermore, the court added, "Even an overt attempt to substantially harm oneself cannot be the basis for commitment unless the person is found to be 1) mentally ill and 2) in immediate danger of the hearing of doing further harm to oneself."


20. See Doremus, 407 F. Supp. at 509 (upholding use of administrative board, while noting availability of prompt de novo review by district court).

21. See, e.g., Kendall, 391 F. Supp. at 413; Doremus, 407 F. Supp. at 509; Bell, 384 F. Supp. at 1085; Lessard, 349 F. Supp. at 1093;


25. Id.

26. Id.


imposed at the hearing, including the exclusion of hearsay.\textsuperscript{29} Less restrictive alternatives to involuntary hospitalization sometimes had to be formally considered,\textsuperscript{30} with mandatory periodic reviews of a commitment decision and standardized means for committed individuals to challenge their custody.\textsuperscript{31} Finally, although not widely recognized, some courts did assert that a "right to treatment" accompanied involuntary civil commitment.\textsuperscript{32} These changes, at least facially made it more difficult to impose and maintain the involuntary hospitalization of an individual.\textsuperscript{33}

As these developments in the criminal justice and mental health systems progressed, little attention was initially given to their impact on the MDO, an individual who, while a candidate for both systems, was in many ways appropriate for neither. However, with these developments, the processing and treatment of the MDO ultimately received closer review, and, from the mid-1960s through the 1970s, a similar evolution occurred affecting the treatment of the MDO. Courts began increasingly to recognize the rights of the MDO even where this reduced the security that could be guaranteed the community. Four different premises underlying judicial decisions evolved during this era, each leading the courts to shift the balance away from the security interests of the community and towards the individual rights of the MDO.

1. \textit{Entitled to Equal Protection of the Law}

First, regardless of their antecedent criminal behavior, MDOs were found generally to be entitled to the same substantive and procedural rights as other similarly situated individuals. For example, in 1966 the Supreme Court ruled that a prison inmate, upon the completion of his prison term, could not be directly placed in a psychiatric facility without being afforded the same procedural protections as any other


\textsuperscript{30} See, e.g., Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); \textit{Lessard}, 349 F. Supp. at 1093.

\textsuperscript{31} See \textit{Fasulo v. Arafeh}, 378 A.2d 553 (Conn. 1977).


\textsuperscript{33} \textit{See RALPH REISNER \& CHRISTOPHER SLOBOGIN, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS} 694 (1990) ("Do criminal-type procedural rules have any effect on outcome? Empirical research on the issue is ambiguous. Some studies show that reforms of both the substantive criteria and procedural rules have reduced hospital admissions. But a number of studies indicate little change in outcome. Most importantly for purposes of the topic at hand, the research indicates that commitment hearings are usually adversarial in name only even in the most legalistic states.").
individual being civilly committed in that state.\textsuperscript{34} The Court reasoned:

Classification of mentally ill persons as either insane or dangerously insane of course may be a reasonable distinction for purposes of determining the type of custodial or medical care to be given, but it has no relevance whatever in the context of the opportunity to show whether a person is mentally ill \textit{at all}. (emphasis in original)\textsuperscript{35}

Six years later, the Court rejected a procedure allowing for the indefinite commitment to a psychiatric facility of an individual found incompetent to stand trial on criminal charges and noted that various courts had found criminal inmates, insanity acquittees, and sex offenders all to be entitled to the same procedural and substantive protections against indefinite psychiatric commitment as civil patients.\textsuperscript{36}

2. \textit{Disparagement of Clinician's Diagnostic Skills}

A second premise frequently appearing during this era was that clinical diagnostic and prognostic skills were generally unreliable. This concept received impetus from a series of law review articles that disputed the validity of relying on a clinical diagnosis as the basis for the involuntary commitment of a mentally ill individual.\textsuperscript{37} This argument was subsequently addressed in a series of judicial opinions discussing legally permissible dispositions for MDOs.\textsuperscript{38}

The Supreme Court of California provided an in-depth discussion of this premise.\textsuperscript{39} In discussing the proper standard of proof for com-

\begin{itemize}
\item \textsuperscript{34} See Baxstrom v. Herold, 383 U.S. 107 (1966).
\item \textsuperscript{35} Id. at 111-12.
\item \textsuperscript{36} See Jackson v. Indiana, 406 U.S. 715 (1972).
\item \textsuperscript{38} Questions regarding the validity of clinical diagnoses and prognoses had been addressed by the U.S. Supreme Court before this era but interpreted in a very different manner and used as a basis for upholding a court's decision to involuntarily hospitalize an MDO. See, e.g., Greenwood v. United States, 350 U.S. 366, 375-76 (1956).
\item The record shows that two court-appointed psychiatrists found petitioner sane and competent for trial. While the District Court did not accept their conclusion, their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment, even about a situation as unpromising as petitioner's . . . . Certainly, denial of constitutional power of commitment to Congress in dealing with a situation like this ought not to rest on dogmatic adherence to one view or another on controversial psychiatric issues. \textit{Id.} \textsuperscript{eb}
\item \textsuperscript{39} People v. Burnick, 535 P.2d 352 (Cal. 1975).
\end{itemize}
mitting a mentally disordered sex offender, the court, after extensively reviewing research on the subject, asserted:

In light of recent studies it is no longer heresy to question the reliability of psychiatric predictions. Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that psychiatrists still experience considerable difficulty in confidently and accurately diagnosing mental illness. Yet those difficulties are multiplied manyfold when psychiatrists venture from diagnosis to prognosis and undertake to predict the consequences of such illness. (emphasis in original)  

As a result of skepticism of the diagnostic and predictive abilities of clinicians, courts tended to heighten the showing required for the involuntary commitment of MDOs.

3. Judiciary as the Primary Decision Maker

A third recurring theme in many of these judicial opinions was that judges or juries, rather than doctors, should be the primary decision maker in determining whether an MDO should enter the mental health system. Two underlying rationales were generally incorporated within this assertion. It was implied that doctors were not sufficiently reliable or unbiased to be entrusted with a decision with such great ramifications for the freedom of an individual. In addition, it was

40. Id. at 365.
41. For a discussion of the limitations of clinical diagnoses and prognoses, and their impact on the willingness of courts to commit MDOs, see Moss v. State, 539 S.W.2d 936, 950-51 (Tex. Civ. App. 1976): The inherent weakness of the conclusions of psychiatrists on the issue of dangerousness . . . when offered without supporting data has been judicially recognized (citations omitted). It has even been seriously argued on the basis of case studies that psychiatric opinions, diagnoses, and predictions are so inaccurate and unreliable that they should not even be admissible . . . and that the testimony of psychiatrists should be limited to descriptive statements of what the psychiatrist has personally observed (citations omitted). Although we do not go that far, we are not convinced that a psychiatrist, physician, or any other expert is sufficiently qualified by training or experience in the prediction of human behavior that his bare opinion of 'potential danger' is sufficient to justify the court in depriving a person of his liberty. Id.; see also, Cross v. Harris, 418 F.2d 1095 (D.C. Cir. 1969); and Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969) (series of opinions by Judge Bazelon of the U.S. Court of Appeals for the District of Columbia interpreting Washington D.C. sexual psychopath statute); Millard v. Harris, 406 F.2d 964 (D.C. Cir. 1968); State v. Michaud, 276 N.W.2d 73 (Minn. 1979) (use of predictions of dangerousness to extend prison terms); Bethea v. United States, 365 A.2d 64 (D.C. 1976), (assessing standards for establishing an insanity defense) cert. denied, 433 U.S. 911 (1977). State v. Krol, 344 A.2d 289 (N.J. 1975) (insanity acquittal followed by subsequent commitment to psychiatric hospital for indefinite period of time).
argued that this was not a medical decision per se, but rather a societal determination regarding the necessity for removing an individual from the community for the safety of the individual or others. As such, it was appropriate and necessary to assign this responsibility to a body of individuals more fully representing society, that is, judges and juries.  

4. Least Restrictive Alternative

A fourth theme given some, albeit hesitant, recognition was the concept that the least restrictive alternative (LRA) should be used when imposing treatment upon an MDO. Although this approach received more attention in civil commitment cases, it did carry over to MDO cases to some degree. Judges recognizing a right to an LRA argued that because an order of commitment had the potential to greatly curtail the individual's liberty and carried an implicit promise of treatment, fairness dictated that the courts consider those treatment alternatives that minimized this infringement. Perhaps the

42. See, e.g., Humphrey v. Cady, 405 U.S. 504, 509 (1972) (in determining dangerousness of individual committed to psychiatric facility pursuant to Wisconsin Sex Crimes Act, "jury serves the critical function of introducing into the process a lay judgment, reflecting values generally held in the community, concerning the kinds of potential harm that justify the State in confining a person for compulsory treatment"); Cross v. Harris, 418 F.2d 1095 (D.C. Cir. 1969) (holding judiciary must remain final arbiter of likelihood of future dangerousness under sexual psychopath statute, rather than letting decision devolve by default to expert witnesses, including psychiatrists); Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968) (statute rejected that left ultimate decision to release hospitalized insanity acquittee in hospital's hands); Millard v. Cameron, 373 F.2d 468 (D.C. Cir. 1966) (overturning civil commitment of individual found to be a sexual psychopath after he pled guilty to indecent exposure; trial court incorrectly relied solely on conclusory statements of two psychiatrists and failed to inquire into bases for their conclusions); Krol, 344 A.2d at 302. (reviewing commitment of insanity acquittees)

It should be emphasized that while courts in determining dangerousness should take full advantage of expert testimony presented by the State and by defendant, the decision is not one that can be left wholly to the technical expertise of the psychiatrists and psychologists. The determination of dangerousness involves a delicate balancing of society's interest in protection from harmful conduct against the individual's interest in personal liberty and autonomy. This decision, while requiring the court to make use of the assistance which medical testimony may provide, is ultimately a legal one, not a medical one.

Id.

43. See, e.g., Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (widely recognized as first case to recognize right to least restrictive alternative as part of civil commitment; also placed burden on state to explore possible treatment alternatives where the individual did not have resources to explore independently).

44. See, e.g., Cross, 418 F.2d at 1107 (on remand trial court must consider whether equal protection and due process clauses require consideration of less restrictive alternatives to hospital confinement for individual committed under Sexual Psychopath Act; while not making a final decision, "[t]he record here contains uncontradicted expert testimony that appellant's
courts hesitated to endorse the LRA concept with regard to MDOs because the approach had considerable potential for placing an MDO immediately back into the community. During this era there tended to be a limited number of alternatives to institutional confinement for MDOs, and from the community's perspective, those that did exist (e.g., supervised community placement) were virtually indistinguishable from total discharge. Despite a growing recognition of the individual rights of the MDO, some may have perceived this approach as having the greatest potential for placing the community at risk from the MDO.\footnote{In a sense, the LRA approach was a harbinger of things to come. By comparing treatment alternatives, the courts' attention was focused, at least briefly, on the internal workings of the psychiatric facility and the care provided there. Nevertheless, although cases of the 1960s and 1970s provided greater recognition of the liberty interests of MDOs, once the MDO was placed for psychiatric care, mental health professionals were generally given wide latitude in making their treatment decisions, even where the LRA doctrine was incorporated. As will be discussed, only later was the discretion of treat-}

\footnote{See, e.g., In re Kesselbrenner v. Anonymous, 305 N.E.2d 903 (N.Y. 1973) (striking down statute that allowed for transfer of dangerous mentally ill civil patient to secure facility operated by Department of Corrections, court ruled the restriction in freedom entailed in such a facility was contrary to purpose for which civil patient was committed, although also noted its conclusion might have been different if statute allowed transfer to some less restrictive alternative placements).}
ment professionals regularly questioned.  

5. Impact

During the 1960s and 1970s, there was a pronounced shift in the balance between the individual rights of the MDO and the security interests of the community. Paralleling a general trend that increasingly recognized the interests of the traditionally underprivileged, the rights of MDOs received greater attention, which contributed to a number of changes in the processing of MDOs. For example, a number of jurisdictions began to decentralize their forensic services, i.e., moving from a maximum security model for the evaluation and treatment of MDOs to a mixed model paradigm providing services in a range of environments. MDOs were more frequently placed in less secure settings and cared for on the same basis as civilly committed psychiatric patients. Evaluations were done increasingly in outpatient settings. In addition, a wide range of procedural protections were instituted to insure that the MDO received a fair hearing on commitment and release decisions.

However, changes primarily focused on selected aspects of the legal system's response to the MDO. Courts mainly attended to the appropriateness of the initial steps taken to remove the MDO from the community, and to a lesser extent, the likelihood of his or her indefinite retention in a psychiatric facility. Generally, little attention was given to the care provided after the decision was made to remove the individual from society, i.e., the sufficiency and appropriateness of the therapeutic intervention. In the era that followed, this issue would assume greater importance. At the same time, courts would ease barriers to the involuntary commitment of MDOs and become more reluctant to order release.

C. Premises of the 1980s and 1990s

During the 1980s and 1990s, judicial attitudes towards the MDO changed, particularly among the federal courts from which many of the rulings of the preceding era had emanated. To those who advocate greater rights for MDOs, this change may be attributed to a gen-

47. See discussion infra part III.
eral "chilling" of America resulting in less interest in protecting or assisting the troubled or disadvantaged. To those who argue for greater recognition of society's interests, the explanation for this change may be a general "heating-up" of America where the typical citizen is seen as vulnerable to and in need of protection from violent and dangerous individuals.

At a more pragmatic level, the shift in federal judicial attitudes may be attributable to the appointment by former Presidents Ronald Reagan and George Bush of about three-fourths of the federal judges in the country, ostensibly sharing their conservative viewpoints. Indeed, where previously the federal courts had been viewed as the most favorable forum for advancing the individual rights of clients such as MDOs, state courts now may be more amenable to such proposals. However, as will be discussed, state courts as well currently place great weight on protecting the community from potential dangers posed by the MDO.

Nevertheless, advocates for the civil rights of MDOs have had a continuing impact on judicial attitudes. Although courts in general may be less reluctant to involuntarily commit an MDO for psychiatric treatment and more reluctant to release the individual back into the community, the courts have often recognized that MDOs are entitled to better treatment in the course of their forced stays. This latter position may be due to a belief that improved treatment will optimize the individual's recovery thereby offsetting the imposition resulting from changes that allow for readier commitment and restricted release. Alternatively, it may be that more efficacious treatment is seen as minimizing the likelihood that such individuals will pose a danger upon release.

Whatever the specific cause, three premises seem to guide judicial opinions of the 1980s and the early 1990s regarding the treatment of the MDO, some of them radically different from the premises accepted just a short time before.

1. All Patients Are Not Equal

Led by the United States Supreme Court, the courts have reversed their earlier position which had suggested that all patients were

51. See discussion infra part III.
equal.52 Instead, it is now apparent that disparate rules governing the confinement of MDOs are permissible.53 In so concluding, courts have asserted that the need to protect the interests of the community is paramount to the liberty interests of the MDO. They have tended to focus either on the dangerousness posed by such individuals, the fact that they initiated the process by entering a plea that asserted their MDO status, or that they received a hearing establishing that they were indeed an MDO.54

52. See discussion supra part II.B.1.

53. See, e.g., Jones v. United States, 463 U.S. 354 (1983) (holding that insanity acquittee could be committed to a mental institution beyond the length of the acquittee's hypothetical criminal sentence under lesser standards than required for civil commitment; proof of insanity could be based on preponderance of evidence, whereas civil commitment required proof meeting more stringent clear and convincing standard); United States v. Roberts, 915 F.2d 889 (4th Cir. 1990) (holding there is a rational basis for distinguishing between defendants found incompetent to stand trial, persons found to be suffering from a mental disease prior to sentencing, and inmates found to be mentally ill while serving their sentences in establishing maximum term of commitment), cert. denied, 498 U.S. 1122 (1991); Glatz v. Kort, 807 F.2d 1514 (10th Cir. 1986) (rejecting challenge to statute permitting automatic commitment of insanity acquittee without a pre-commitment hearing and different burden and standard of proof for release); United States v. Ecker, 543 F.2d 178 (D.C. Cir. 1976) (upholding procedures and standards used to review proposed conditional release into community of insanity acquittee; proposed equation of commitment and release procedures for insanity acquittees and individuals found incompetent to stand trial or civil patients rejected), cert. denied, 429 U.S. 1063 (1977); State v. Foucha, 563 So. 2d 1138 (La. 1990), rev'd, 112 S. Ct. 1780, (1992) (justifiable distinction between civil committees and NGRI acquittees) State v. Hungerford, 267 N.W.2d 258 (Wis. 1978) (holding that it is not a denial of equal protection to apply different standard of dangerousness in committing individual under the Wisconsin Sex Crimes Act than for individual civilly committed).

54. See, e.g., Ecker, 543 F.2d at 196 ("Previously this Court has concluded that the dangerousness demonstrated by prior criminal conduct does provide a rational basis for some disparities in the statutory provisions governing commitment and release"); insanity acquittal reflected a judicial determination that defendant did the act of which accused and, based on this, Congress could appropriately determine that these individuals pose significant risk to community and public entitled to additional procedural and substantive protections to insure against premature release; see also Jones, 463 U.S. at 367, 370. (The Court rejected an insanity acquittee's request for a civil commitment standard after being placed in a psychiatric hospital for a period of time longer than the maximum prison sentence of the underlying crime. "In equating these situations," the Court stated "[Jones] ignores important differences between the class of potential civil-commitment candidates and the class of insanity acquittees that justify differing standards of proof." The higher standard for civil commitments was approved because of the danger of inappropriate commitment for what some perceive as abnormal behavior but which, in fact, is within the range of conduct generally acceptable, and in such circumstances both society and the individual must share risk of error. However, for an insanity acquittee, there is less risk of error since it was the acquittee who raised insanity as a defense and proved the criminal act was a product of his mental illness. More importantly, the proof that he committed a criminal act as a result of mental illness eliminates the risk that he is being committed for mere "idiosyncratic behavior", and the danger of stigmatization from commitment is not present since the individual is already stigmatized by insanity verdict that the individual himself sought. "This holding accords with the widely and reasonably held view that insanity acquittees constitute a special class that should be treated differently from other candidates for
However, while courts have been more willing to allow differences between the commitment and release of MDOs and civilly committed patients, allowable differences between the two groups have been reduced when evaluating the appropriate level of treatment provided. Nevertheless, where a direct link can be established between the treatment provided and the security needs of the community, some disparity tends to be tolerated (e.g., in the conditions of confinement within a maximum security psychiatric facility).

2. Expansion of “Dangerousness”

The courts have almost always taken dangerousness into account in their determinations regarding the MDO, regardless of the era. However, whereas dangerousness had a relatively narrow definition during the 1960s and 1970s, in the 1980s and 1990s the tendency has been to expand its reach. Courts have defined dangerousness to allow con-commitment.”); see also Glatz, 807 F.2d at 1522 (“Insanity acquittees and involuntary civil committees are not similarly situated groups for equal protection purposes.... [t]he insanity acquittee has confessed to committing a criminal act earlier and the grand jury or the court has found probable cause to believe that he did in fact commit the act. (citation omitted) It is not unreasonable to conclude that an insanity acquittal supports an inference of continuing mental illness.”); Tulloch v. State, 465 N.W.2d 448 (Neb. 1991) (past history of dangerous criminal behavior provides rational basis for classification; purpose of NGRI statute is to protect the public); Hungerford, 267 N.W.2d at 258 (equal protection argument rejected because criminal conviction considered reasonable justification for disparity, and legislature's primary and distinguishing aim under Sex Crimes Act was to protect public by avoiding release into open society of those who might commit additional sex crimes because of un cured mental disorder).

55. See infra part III.B.

56. See, e.g., Doe v. Gaughan, 808 F.2d 871, 881 (1st Cir. 1986). When evaluating conditions of confinement within a maximum security psychiatric facility, the court refused to distinguish between (1) civilly committed patients transferred in because of dangerousness and unmanageability, (2) sentenced criminals transferred in because of the need for mental health treatment, and (3) persons charged with a crime and committed for period of court-ordered observation. Since the State has a legitimate interest in confining a violent mentally ill person to prevent harm to others, and since all these patients meet this criteria, the court held it permissible to place all three groups together in a secure setting and treat them similarly. The court stated, “Given the fact that persons sent to Bridgewater are not just mentally ill, but fall within a special class of persons who are both mentally ill and violent and in fact have behavioral problems beyond the capacity of other institutions to handle, the decision to place them in this special facility designed to contain their violence, and yet also staffed to deal with their mental illnesses, does not violate equal protection principles.” The court listed security reasons, their tendency to be more seriously ill and more dangerous, and their different therapeutic needs as justification for curtailing or limiting their personal rights as compared to civil patients in general. Id.

57. See, e.g., Glatz, 807 F.2d at 1514 (to be released from treatment facility, NGRI acquit tee must show he would not be dangerous in reasonably foreseeable future); Ecker, 543 F.2d at 188 (before releasing NGRI acquittees, determinations required of future dangerousness must be more specific than those used for assessing release of patients civilly committed; not sufficient to merely find likelihood of absence of future dangerousness (as for civil patients), but rather must make “affirmative finding that it is at least more probable than not that [the insanity acquittee] will not be violently dangerous in the future”).
sideration of a wide range of evidence to establish its presence, including the criminal charge or conviction that initiated the MDO process and the likelihood of psychological danger, placing the burden on the MDO to show an absence of dangerousness. Trial courts have been afforded considerable discretion in determining whether an MDO is dangerous, including the ability to disregard expert testimony as well as assertions regarding the difficulty of pre-

58. See, e.g., In re Brown, 414 N.W.2d 800 (Minn. Ct. App. 1987). In affirming commitment, the court placed great weight on Brown's lengthy history of incarceration and institution, in particular four incidents of sexually inappropriate behavior over ten-year span; four experts split on whether Brown met statutory dangerousness criteria (including overt act) for commitment; however, the court concluded Brown's concurrent incarceration for fourth degree sexual misconduct occurring ten months earlier was sufficient to meet statutory criteria when considered with numerous other instances of assault.

A similar evolution has occurred with regard to civil commitments. See, e.g., Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983) (Constitution does not require an affirmative showing that some recent "overt" conduct took place demonstrating substantial and present risk of serious physical harm; such a requirement would inappropriately superimpose criminal concepts on civil commitment scheme where the two have very different purposes and effects, and would not necessarily improve hotly debated medical profession's ability to predict dangerousness); Naidu v. Laird, 539 A.2d 1064 (Del. 1988) (permissible to use past psychiatric history to assess patient's present propensity for harm); See also Mark J. Mills, Civil Commitment of the Mentally Ill: An Overview, 484 ANNALS AM. ACAD. POL. & SOC. SCI. 28 (1986) (discussion of forces driving change).

59. See, e.g., Allen v. Illinois, 478 U.S. 364, 373 (1986) ("antecedent conduct is received not to punish past misdeeds, but primarily to show the accused's mental condition and to predict future behavior"); Jones, 463 U.S. at 364 (finding of insanity at criminal trial sufficiently probative of both mental illness and dangerousness to justify commitment; requisite level of dangerousness not solely established by certain types of crimes (e.g., violent crimes)); Hungerford, 267 N.W.2d at 258 (in extending commitment under Wisconsin Sex Crimes Act, defendant's criminal record admissible even though civil commitment proceedings required evidence of recent violent behavior or recent overt act, attempt or threat to do physical harm; distinction justified by necessity of protecting society from dangerous sex crimes; also, greater latitude of proof as to similar occurrences was permissible, including past convictions that occurred several years before, particularly where defendant confined for much of period, thereby limiting ability to commit such acts).

60. See, e.g., Hungerford, 267 N.W.2d at 264 (statutory standard for recommitment under Wisconsin Sex Crimes Act not unconstitutionally vague because its assessment of potential dangerousness allowed for analysis of impact on the community of defendant's proposed release; "the Sex Crimes Act was intended to protect the public from the danger of psychological as well as physical harm posed by the sexual deviate"); evidence admissible even though such an assessment would have been impermissible in a corresponding civil commitment proceeding).

61. See, e.g., Glatz v. Kort, 807 F.2d 1514 (10th Cir. 1986) (upholding placing burden of proof on NGRI acquittee contesting treating facility's decision not to release him to show he would not be dangerous in the reasonably foreseeable future).

62. See, e.g., Glatz, 807 F.2d at 1514 (not necessary to specify factors that guide predictions of dangerousness in determining whether NGRI acquittee should be released from treatment facility); LaDew v. Commissioner of Mental Health, 532 A.2d 1051 (Me. 1987) (in reviewing release petition by insanity acquittee, trial judge given wide discretion to disregard expert psychiatric testimony that indicated acquittee did not currently have a "mental disease or defect" and thus, technically no longer met commitment criteria; court stressed that all wi-
dicting future dangerousness. As a result, the courts appear to be willing to rely on relatively remote conduct as a substitute for present dangerousness. In addition, they appear to be less likely to require an individualized evaluation of the relative dangerousness of the MDO and, instead, accept a decision-making scheme that makes broad-ranging assumptions about MDOs as a class. Allowing an expansive consideration of the possible presence of dangerousness results in the increased likelihood that MDOs will be found appropriate for commitment to a psychiatric facility and less likely to be released subsequent to treatment. Where the safety of the community is most at

nesses agreed that if acquittee released he would pose a threat to the safety of himself and others, that there was no change in his mental condition since committed 16 months earlier, and that he had an antisocial personality disorder manifested in repeated antisocial acts); United States v. Ecker, 543 F.2d 178, 191 (D.C. Cir. 1976) (permissible to disregard both recommendation of superintendent of the psychiatric hospital where NGRI acquittee placed and four expert witnesses (three called by defendant and one by the government), that NGRI acquittee be conditionally released; heavy emphasis on "undeniable fact that this patient has been thought by the medical experts to be ready for a return to community life before, and that the experts have been proved tragically wrong").

63. See, e.g., Jones, 463 U.S. at 364 n.13 (rejecting argument that legislature's mandate of automatic commitment for mental health treatment upon insanity acquittal should be overturned because there was "[no] empirical evidence indicating that mentally ill persons who have committed a criminal act are likely to commit additional dangerous acts in the future" or because "available research fails to support the predictive value of prior dangerous acts"; uncertainty of diagnosis and tentativeness of professional judgment, rather than limiting legislature's discretion, merely meant "that courts should pay particular deference to reasonable legislative judgments"); Glatz, 807 F.2d at 1514 (reviewing release of NGRI acquittees from treatment facilities, court rejected acquittee's argument that it is virtually impossible to predict future dangerousness; mere difficulty of the determination did not mean it could not be made; prediction of future criminal conduct is an essential element of many decisions rendered by the criminal justice system); People v. Colvin, 171 Cal. Rptr. 32 (Cal. Ct. App. 1981) (rejecting assertion that MDOs' commitments should be overturned because resulted in arbitrary commitments since psychiatric studies showed no reliable method for predicting dangerousness and thus risk of over-prediction; recent empirical data suggested that psychiatrists could indeed identify disturbed individuals who display dangerous tendencies and successfully treat them).

64. See, e.g., Jones v. United States, 463 U.S. 354 (1983) (accepting legislative scheme that concluded that all insanity acquittees possessed at least the minimum level of dangerousness necessary to meet commitment criteria; reasons included: (1) because hearing reviewing basis for commitment guaranteed within short amount of time (30 days), acquittee would not have to wait unreasonable amount of time to challenge the legislative presumption; (2) separate commitment hearing at time of commitment would raise many of same issues litigated at the criminal trial resulting in waste of government resources; and (3) approach necessary for "protection of society").

65. See, e.g., People v. Villanueva, 528 N.Y.S.2d 506 (N.Y. Sup. Ct. 1988) (finding of current dangerousness not required to commit individual found incompetent to stand trial; "although defendant did not present a current substantial risk of physical harm to himself or others, he did require involuntary psychiatric hospitalization because he had a mental illness for which care and treatment as the inpatient of a hospital were essential to his welfare . . . placement in a less restrictive setting in which he could be cared for and treated appropriately . . . was not then available and . . . as a result of his mental illness he was unable to appreciate the need for such care and treatment").
risk, the courts seem to give less weight to the interests of the MDO.\(^6\)

Nevertheless, the courts' adoption of this premise has also been largely limited to commitment and release decisions. When evaluating the treatment provided, courts have tended not to focus on the relative dangerousness of the MDO. This appears to be due to an implicit assumption that within the therapeutic environment public safety is not endangered and it is the individual's mental disability, rather than the MDO's dangerousness, that guides the course of treatment.\(^7\)

3. **Reduced Judicial Scrutiny and Informal, Non-Adversarial Proceedings**

In the preceding era, courts tended to adopt criminal justice procedures to protect the rights of the MDO. As a result, a formal, judicially supervised, adversarial confrontation between the State and the MDO was often required to resolve contested commitment and retention decisions.\(^6\) Decision-making power tended to be placed in the hands of the judiciary.\(^69\)

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\(^6\) See, e.g., Jones, 463 U.S. at 354 (automatic commitment scheme for NGRI acquitees necessary for "protection of society"); Glatz, 807 F.2d at 1520 (reviewing basis for releasing NGRI acquitee, noted that State has substantial interest in avoiding premature release, because "releasing an individual whose conduct was previously dangerous to society, when it has not been established that he is no longer dangerous, poses a real threat to society"); LaDew, 532 A.2d at 1051 (State Forensic Service created to provide additional review of mental condition of insanity acquitees seeking release because of public concern that acquitees were too quickly being released); Hungerford, 267 N.W.2d at 258.

\(^7\) See, e.g., Allen v. Illinois, 478 U.S. 364, 373 (1986) (permissible to house together in maximum security facility individuals committed as sexually dangerous persons with sentenced prisoners when placement provides treatment rather than punishment; state entitled to take "measures to protect the welfare and safety of other citizens"); however, state could not impose a regimen essentially identical to that imposed on felons with no need for psychiatric care); Doe by Roe v. Gaughan, 617 F. Supp. 1477, 1479-80 (D.C. Mass. 1985), aff'd, 808 F.2d 871 (1st Cir. 1986) (holding it is permissible to house together criminal and civil patients in maximum security facility; in contrast to widely held assumptions, "[c]ivil patients are more likely to be dangerous and unmanageable than those serving criminal sentences"); facility provided "remarkably safe environment given the character of the patients"); County of Hennepin v. Levine, 345 N.W.2d 217 (Minn. 1984) (upholding pass program for "mentally ill and dangerous" patients that, unlike release or discharge decisions, did not have to be reviewed by special review board or receive prior court approval; part of patients' treatment program, and as such had to be applied in least restrictive fashion; important to maintain discretion of treating physician, even if such decisions entail certain degree of trial and error the cost of which public must bear; dangerousness of patients closely scrutinized at entrance and exit to mental health system, but within treatment facility itself the courts largely refrain from interfering in evaluations of dangerousness, particularly since further refinements in predicting dangerousness likely to result in "exercise in futility").

\(^6\) See, e.g., Specht v. Patterson, 386 U.S. 605 (1967) (persons subject to MDO proceedings are entitled to certain procedural rights beyond those constitutionally required for non-capital sentencing proceedings which may be quite informal; includes right to be present with counsel, opportunity to be heard, right to confront and cross-examine witnesses, and right to offer evidence).

\(^69\) See supra part II.B.3.
In the 1980s and 1990s, however, many courts began to issue rulings that restored the primary locus of decision making to mental health professionals (particularly in routine commitment and release decisions)\textsuperscript{70} and reserved for the judiciary a more residual function as

\textsuperscript{70} See, e.g., United States v. LaFromboise, 836 F.2d 1149 (8th Cir. 1988) (upholding provisions of federal 1984 Insanity Defense Reform Act that assigned responsibility for mandated periodic review of basis for continued commitment of insanity acquittee solely to director of hospital where acquittee committed); Glatz, 807 F.2d at 1514 (upholding statute that assigned primary weight in release decision to chief officer and staff at treatment facility where NGRI acquittee committed); Williams v. Wallis, 734 F.2d 1434 (11th Cir. 1984) (acceptable decision that officer made a mental health facility was usually initiated by acquittee's treatment team, with final decision made by administrator within the facility); Hickey v. Morris, 722 F.2d 543 (9th Cir. 1983) (decisions regarding confinement and release of insanity acquittees did not require automatic, periodic judicial review; liberty interest sufficiently protected by statute's requirement that independent health professionals provide regular examinations of insanity acquittees; furthermore, if free to conduct the evaluation independently, evaluation can be conducted by staff physician within the hospital where being confined); United States v. Ecker, 543 F.2d 178, 193 (in discussing proper procedures for proposed conditional release of insanity acquittee, "[t]he district court, the hospital, the patient, and the government share an obligation to elucidate and explore all the relevant facts"); Osgood v. District of Columbia, 567 F. Supp. 1026, 1036 (D.D.C. 1983) (discussing inmate's right to refuse injection of psychotropic drug against her will; noted "[i]n resolving these issues some deference must be afforded to the findings of the professionals involved"); Levine, 345 N.W.2d at 217 (upholding pass program allowing for issuance of passes by head of treatment facility without prior approval of special review board); Kort v. Carlson, 723 P.2d 143 (Colo. 1986) (trial court erred when it incorporated extensive treatment recommendations in its commitment order for defendant committed as incompetent to stand trial); State v. Gee, 695 P.2d 376 (Idaho 1985) (upholding provision requiring person serving sentence for any of a series of sex-related crimes to be examined by psychiatrist prior to release or parole, and requiring state parole board to consider psychiatrist's recommendation in making decision); People v. Colvin, 171 Cal. Rptr. 32 (Cal. Ct. App. 1981) (trial court not required to state its own reasons for choice of placement alternative for a mentally disordered sex offender; allowed to merely read into record a recommendation from a county health director).

Even in cases dealing with individuals who are not MDOs, where arguably the opportunity for an erroneous deprivation of liberty is greater since there has been no prior consideration of relevant issues such as dangerousness, there have been rulings permitting mental health professionals to assume decision-making roles that might otherwise be assigned to a judge or judicial officer. See, e.g., Woe v. Cuomo, 729 F.2d 96, 105 (2d Cir.) (discussion of constitutionality of care received by involuntarily committed civil patients; "[t]he question . . . is not what treatment was actually provided, but whether the treatment decision was professionally made and falls within the scope of professional acceptability"), cert. denied, 469 U.S. 936 (1984); Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983) (whether individual entitled to judicial hearing prior to or shortly following involuntary commitment); Doe v. Gallinot, 657 F.2d 113 (9th Cir. 1981); Doe by Roe, 617 F. Supp. at 1486 (in reviewing quality of conditions and level of treatment provided involuntarily civilly committed mental patients, "[e]courts are to adopt a deferential standard in reviewing restraint and treatment decisions", with challenged practices upheld absent showing they reflect substantial departure from professional standards); Sabo v. O'Bannon, 586 F. Supp. 1132, 1139 (E.D. Pa. 1984) (discussing Fourteenth Amendment right to minimally adequate treatment of mentally retarded individual involuntarily committed to a state hospital; adopted a "deferential standard [that] recognizes the course of treatment chosen by the professional decision-maker is presumptively correct").
the reviewing body of last resort. The reviewing body of last resort.71 Furthermore, courts tended to approve more informal nonadversarial proceedings and thereby limited the application of some of the requirements accompanying a criminal trial.72 The rationale often given by the courts was that it was permissible to allow less formal procedures because these proceedings were designed to help MDOs, not to punish them (i.e., they were more civil than criminal in nature).73 Other reasons frequently raised were that courts have a limited ability to make the necessary diagnoses and prognoses,74 that mental health professionals are ade-

71. See, e.g., LaFromboise, 836 F.2d at 1149 (annual report describing basis for continued commitment of an insanity acquittee submitted to district court, but up to acquittee to independently request judicial hearing); Williams, 734 F.2d at 1434 (decision to release insanity acquitees assigned to treating mental health professionals, but acquittee able to independently petition judiciary for writ of habeas corpus); Hickey, 722 F.2d at 543 (in not requiring automatic periodic judicial review of determinations regarding confinement and release of insanity acquittees, noted that judiciary retains discretionary power to review the exceptional case and insanity acquittee could independently file habeas corpus petition seeking review).

72. See, e.g., Williams, 734 F.2d at 1434 (due process does not require that periodic release procedures for insanity acquittees be adversarial); Hickey, 722 F.2d at 549 (upholding procedures for confinement and release of insanity acquittees, rejecting plaintiff's argument that lack of automatic periodic judicial review of confinement violated due process; "Due Process does not always require an adversarial hearing"); Ecker, 543 F.2d at 192 (in ruling there was no assignable burden of proof in conditional release proceeding, court adopted a "nonadversarial view of the burden of producing evidence in 'proceedings involving the care and treatment of the mentally ill'.")

73. See, e.g., Allen, 478 U.S. at 364 (holding the Fifth Amendment's guarantee against compulsory self-incrimination is not applicable to proceeding under Illinois Sexually Dangerous Persons Act); Ecker, 543 F.2d at 193 ("We hold that in a hospital-initiated conditional release proceeding there is no assignable burden of proof as we would know it in a criminal or civil case. These are truly investigatory proceedings in which traditional notions of proof are simply inapplicable."); People v. Catron, 246 Cal. Rptr. 303 (Cal. Ct. App. 1988) (holding procedural changes in statute governing commitment of NGRIs not an ex post facto law, and thus not prohibited as it would be under criminal law).

74. See, e.g., Allen, 478 U.S. at 364 (privilege against self-incrimination not available in proceedings pursuant to Illinois' Sexually Dangerous Persons Act because essentially civil rather than criminal in nature; State obligated to provide care and treatment and to release at any time patient found no longer dangerous; since no attempt to punish, procedures not criminal in nature and constitutional protections guaranteed criminal defendants did not apply); Williams, 734 F.2d at 1434; Hungerford, 267 N.W.2d at 258 (greater latitude of proof regarding admission of defendant's criminal record for Sex Crimes Act recommitment than at criminal trial); Catron, 246 Cal. Rptr. at 303.

75. See, e.g., Williams, 734 F.2d at 1439

To impose an adversarial atmosphere upon the medical decisionmaking process would have a natural tendency to undermine the beneficial institutional goal of finding the least restrictive environment including eventual release. Instead of an additional safeguard, the adversarial intrusion might very probably prove counterproductive to the interests of acquittees. Moreover, "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments."

Kort v. Carlson, 723 P.2d 143, 148 (Colo. 1986) (refusing to intervene in treatment provided
quately or better equipped to make these determinations, and that assigning the decision-making responsibility primarily to mental health professionals will be more likely to insure the safety of the community. In addition, the courts have asserted that increasing procedural requirements will do little to increase the accuracy of the determinations being made, will impose an undue financial burden on the State, and that the courts will be there to correct any flagrant abuses.

individual committed as incompetent to stand trial, noted, "[o]ther courts, addressing the question, start with the assumption that judges are not well suited to determine appropriate modes of psychiatric treatment").

76. See, e.g., United States v. LaFromboise, 836 F.2d 1149 (8th Cir. 1988) (as long as hospital director acts independently in assessment of mental condition of insanity acquittees, due process does not require periodic adversary hearing regarding basis for continued commitment); Glatz v. Kort, 807 F.2d 1514, 1520 (10th Cir. 1986) (upholding statute assigning primary weight in release decisions to treating mental health staff, "We cannot say it is constitutionally unreasonable to attach such significance to the . . . decision made by those who have had the most recent contact with the insanity acquittee and who have observed him over a period of time"); Williams v. Wallis, 734 F.2d 1434, 1438 (11th Cir. 1984). The court was not concerned that assigning decision-making responsibility for release decisions to treating mental health professionals would create undue risk of erroneous deprivation of acquittees' liberty interest because hospitals and their medical professionals certainly have no bias against the patient or against release. Therefore, we can safely assume they are disinterested decision-makers. In fact, the mental health system's institutional goal—i.e., transfer to a less restrictive environment and eventual release—favors release. Other factors also favor release . . . which militates against any motivation to unnecessarily prolong hospitalization, and including the medical professional's pride in his own treatment.

Id.; County of Hennepin v. Levine, 345 N.W.2d 217, 223 (Minn. 1984) ("To require special review board approval of issuance of passes would 'tie the hands' of the treating physician and eviscerate the physician's discretion necessary for treatment."); Kort, 723 P.2d at 149 (stating that "decisions about the appropriate treatment for the defendant are within the discretion of the [treatment] staff," ruled that trial court erred when it incorporated extensive treatment recommendations in its commitment order); Colvin, 171 Cal. Rptr. at 32 (stating that recent empirical data suggests that psychiatrists could indeed identify disturbed individuals who display dangerous tendencies, and successfully treat them).

77. See, e.g., Williams, 734 F.2d at 1434 (deformalized, medical decision-making process superior to adversarial proceeding for determining whether to release insanity acquittee and will protect state interest in preventing premature release of dangerous individuals); Levine, 345 N.W.2d at 223 (permissible to allow treatment staff to issue passes because, "public's safety is protected through the actual commitment and discharge process").

78. See, e.g., Williams, 734 F.2d at 1434 (adversarial release procedures for insanity acquittees would contribute little to necessary release determination); Levine, 345 N.W.2d at 223 (allowing treatment staff to issue passes without further review, court stated, "Further attempts to predict dangerousness result in an exercise in futility").

79. See, e.g., Williams, 734 F.2d at 1434 (adversarial hearings would impose severe financial burden on State).

80. See, e.g., Williams, 734 F.2d at 1434 (availability of writ of habeas corpus means dissatisfied acquittee has recourse to judicially-monitored adversarial review); Hickey v. Morris, 722 F.2d 543 (9th Cir. 1984) (judiciary retains discretionary power to review the exceptional case).
Nevertheless, some exceptions have been noted to the general rule that procedures involving the MDO should be informal, non-adversarial confrontations with the bulk of the decision making left to the treating mental health professional. Where courts have concluded that such proceedings do not provide adequate protection for the community and lead to premature releases, they tend not to be swayed by the recommendations of mental health professionals and reserve the ultimate decision for the judiciary. Alternatively, additional protections and a greater role for the judiciary have been required where the courts determine that the public safety is not endangered and either the MDO is at a distinct disadvantage in the proceedings or the treatment of the MDO is in question.

4. Impact

During this era, the balance between the individual rights of the MDO and the security interests of the community has tended to shift

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81. See, e.g., United States v. Ecker, 543 F.2d 178, 183-84. Rejecting a standard of review that would have greatly limited involvement of court in decisions to release NGRI acquittees, the court stressed that the “court must decide whether the hospital's proposal provide[s] treatment and cure for the individual in manner which affords reasonable assurance for the public safety.” Id. Under such circumstances, the court's role is active, rather than passive, with greater responsibilities, and the court, not just the hospital, “must conclude that the patient has sufficiently recovered so that under the specified conditions he will not in the reasonable future endanger himself or others.” Id. Senior v. State, 369 S.E.2d 49 (Ga. Ct. App. 1988) (upholding refusal to grant NGRI acquittee's request for off-campus privileges as part of gradual release program even though recommended by treating mental health professionals; as with a petition seeking outright release of insanity acquittee, committing court entirely free to reject recommendation of institutional staff).

82. See, e.g., Waldrop v. Evans, 681 F. Supp. 840 (M.D. Ga. 1988), aff'd, 871 F.2d 1030 (11th Cir. 1989) (recognizing that when individual is found guilty but mentally ill there is great danger that severely mentally disturbed people will be sent to prison system immediately upon sentencing where authorities are generally ill-equipped to deal with them; such individuals should first be sent to hospital of some sort for a period long enough for a proper evaluation to be made and then to prison with sufficient mental health safeguards to prevent subsequent tragedies stemming from mental illness); Ward v. Kort, 762 F.2d 856 (10th Cir. 1985) (insanity acquittees placed in forensic ward of state psychiatric hospital must be provided either reasonable access to law library or assistance of counsel in filing civil rights complaints; such individuals otherwise not able to assert and pursue constitutional rights and protect themselves from inadequate treatment); Hockensmith v. State, 524 So. 2d 462 (Fla. 2d DCA 1988) (finding that NGRI acquittee continued to meet criteria for involuntary commitment did not justify his absence at hearing making that determination when he desired to be present, absent showing “compelling circumstance”); People v. Colvin, 171 Cal. Rptr. 32 (Cal. Ct. App. 1981) (in a commitment hearing, not sufficient for trial court to rely on relatively obscure written statements given defendant explaining various statutory rights, nor could defendant implicitly waive rights by remaining silent; implicitly recognizing potential legal naivete and limited capacity of such individuals, court held these procedural rights must be explained orally and directly to defendant by presiding judge, and only if expressly waived could they be suspended).

83. See infra part III.B.
back towards the latter with regard to commitment and release decisions. Yet, this shift has been accompanied by a greater willingness of the judiciary to scrutinize the nature of the treatment provided the MDO. The courts have paid specific attention to three aspects of treatment decisions regarding the MDO, namely, the general right of the MDO to treatment, the ability of the MDO to resist treatment over objection, and the acceptable parameters of the treatment programs provided the MDO. As a result, mental health professionals may perceive that their treatment prerogatives are increasingly challenged, that their traditional discretion in making treatment decisions has been circumscribed, and that there is greater uncertainty over what constitutes an appropriate treatment for the MDO.

III. **LEGAL IMPACT OF CHANGES IN UNDERLYING PREMISES**

The evolution of these underlying premises has resulted in subtle, but significant, changes in the law pertaining to the treatment of the MDO. The remainder of this Article discusses those changes.\(^8\)

**A. Procedural Aspects Associated with the Retention of the MDO**

1. **Burden of Proof Placed on MDO**

One aspect of the law that has changed considerably is the assignment of the burden of proof in proceedings determining the freedom of the MDO. In lawsuits in general, the party assigned the burden of proof has the responsibility to establish his or her position, and if the judge concludes that the evidence presented by that party is not more persuasive than that presented by the opposing party, then the party with the burden of proof loses.\(^5\) In a criminal case, the State, through its prosecuting attorney, is constitutionally bound to prove the criminal defendant committed all elements of the alleged crime.\(^6\) In the 1960s and 1970s, courts frequently concluded that because the State was attempting to restrict the freedom of the MDO, the State should have the burden of proof at proceedings to determine the lib-

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\(^8\) For earlier discussions of the law pertaining to MDOs, see John Monahan & Henry J. Steadman, **Mentally Disordered Offenders: Perspectives from Law and Social Science** (1983); Perlin, supra note 2; Barbara A. Weiner, **Legal Issues Raised in Treating Sex Offenders**, 3(4) Behav. Sci. & L. 325 (1985).

\(^5\) See Black's Law Dictionary 178 (5th ed. 1979) ("In the law of evidence, the necessity or duty of affirmatively proving a fact or facts in dispute on an issue raised between the parties in a cause.").

In recent years, however, this burden has shifted to the MDO in a number of contexts.

For example, many states and the federal government revamped their laws pertaining to the insanity defense, frequently in direct response to the John Hinckley trial, so that alleged insanity at the time of the crime became an affirmative defense that had to be raised and proven by the criminal defendant at trial. Typical prior practice had been to force the State to prove the defendant was sane at the time of the crime. Courts reviewing this change have generally upheld it. Among the reasons given for these holdings is that although an intent to commit a crime may be an element the State must establish in order to obtain a criminal conviction, insanity at the time of the crime is not linked to intent because an insane person can premeditate, or think beforehand, about an act even though that thinking may be confused or irrational. Also, assigning the burden of

87. For an opinion displaying the earlier train of thought of the 1960s and 1970s regarding the burden of proof for MDOs, both at the initial criminal trial and at a subsequent release proceeding, see Dorsey v. Solomon, 604 F.2d 271 (4th Cir. 1979).

88. John Hinckley successfully asserted an insanity defense in response to criminal charges brought against him following an assassination attempt aimed at former President Ronald Reagan.

89. See State v. Box, 745 P.2d 23 (Wash. 1987) (citing 1985 law review article claiming that more than half the states in the nation had a provision that required the defendant to prove insanity by a preponderance of the evidence).

90. See Dorsey, 604 F.2d at 271.

91. See, e.g., United States v. Byrd, 834 F.2d 145 (8th Cir. 1987) (holding Federal Insanity Defense Reform Act of 1984 did not violate fifth amendment due process clause when it required defendant to establish defense of insanity by clear and convincing evidence; rejecting defendant’s argument that it inappropriately relieved State’s responsibility to prove all elements of crime; insanity not an element of crime charged, but independent concept that could be properly assigned to defendant to raise and establish).

Numerous state courts have reached similar holdings. For one of the more expansive discussions of the issues raised, see Box, 745 P.2d at 23 (state statute did not violate either state or federal due process by requiring defendant to prove insanity by preponderance of the evidence); see also People v. Bouchard, 535 N.E.2d 1001 (Ill. App. Ct. 1989); State v. Marley, 364 S.E.2d 133 (N.C. 1988); People v. Kohl, 527 N.E.2d 1182 (N.Y. 1988); State v. Moorman, 744 P.2d 679 (Ariz. 1987); Treece v. State, 532 A.2d 175 (Md. Ct. Spec. App. 1987); State v. Davis, 361 S.E.2d 724 (N.C. 1987).

For examples of the lengths courts will go to avoid issuing an NGRI finding or to allow a claim of a mental disorder to prevent imposition of a prison sentence, see United States v. Crews, 781 F.2d 826 (10th Cir. 1986) (NGRI acquittal refused); State v. Anderson, 468 N.W.2d 617 (1991) (prison sentence imposed after finding that disorder or mentally disordered sex offender is untreatable); State v. Anderson, 789 P.2d 27 (Utah 1990) (sentence to state prison rather than to state hospital upheld despite finding that defendant mildly to moderately mentally retarded and suffered from several personality disorders); Moorman, 744 P.2d at 679 (NGRI acquittal refused); State v. Lane, 532 A.2d 144 (Me. 1987) (NGRI acquittal refused); Daniels v. State, 418 So.2d 185 (Ala. Crim. App.) (NGRI acquittal refused), cert. denied, 459 U.S. 1073, (1982).

92. See Box, 745 P.2d at 23.
proof to the defendant avoids the anomaly of having the State argue at the criminal trial that the defendant was sane in order to obtain a conviction, then having to argue at a subsequent commitment hearing that the defendant was insane in order to prevent the MDO's release.\textsuperscript{93} Finally, being criminally responsible is an exculpatory fact relating to punishment and not an element of the crime.\textsuperscript{94} Courts have also upheld the practice of placing the burden on the defendant to show incompetence to stand trial and to overcome a presumption of competency.\textsuperscript{95}

The assigned burden of proof at hearings to contest the State's continued retention of an MDO for mental health treatment has also been shifted from the State to the MDO. Courts have tended to uphold these changes.\textsuperscript{96} For example, in upholding the placing of the burden of proof on an insanity acquittee seeking release at a subsequent hearing following commitment,\textsuperscript{97} courts have found justification in: the government's interest in preventing the premature release of persons who have already proven their dangerousness to society by committing a criminal act and being insane at the time;\textsuperscript{98} the benefit the MDO will receive from treatment during continued retention;\textsuperscript{99} the acquittee's continuing eligibility for discharge if treatment staff

\textsuperscript{93} See Treece, 532 A.2d at 175.

\textsuperscript{94} Id.


\textsuperscript{96} See, e.g., United States v. Wallace, 845 F.2d 1471, 1474 (8th Cir.), cert. denied, 488 U.S. 845 (1988) (federal statute placing burden of proof on insanity acquittee seeking release following commitment did not violate due process clause of fifth amendment); Glatz v. Kort, 807 F.2d 1514 (10th Cir. 1986) (constitutionally permissible for statute to require insanity acquittee to prove by preponderance of evidence that meets release criteria when chief medical officer at facility where committed disagrees); Williams v. Wallis, 734 F.2d 1434 (11th Cir. 1984) (procedure placing burden of proof on insanity acquittee in habeas corpus proceeding to prove by preponderance of evidence that no longer mentally ill or dangerous and thus fit for release upheld) Hickey v. Morris, 722 F.2d 543 (9th Cir. 1983) (upholding provision placing burden on insanity acquittee to prove fitness for release at jury hearing by preponderance of evidence). See generally infra part III.C.

\textsuperscript{97} For a discussion of the commitment of an insanity acquittee, see infra part II.A.2.

\textsuperscript{98} See, e.g., Wallace, 845 F.2d at 1471; Glatz, 807 F.2d at 1514; Williams, 734 F.2d at 1434; Hickey, 722 F.2d at 543.

\textsuperscript{99} See, e.g., Wallace, 845 F.2d at 1471; Williams, 734 F.2d at 1434.
conclude discharge is appropriate; the tendency of the mental health system to favor release; and important differences between civil committees and insanity acquittees that warrant placing the burden on the latter and not the former, including the facts that since the acquittee raised the insanity issue, the likelihood of error is diminished, and because the commission of a criminal act has been proven, concern that the acquittee will be committed for mere "idiosyncratic behavior is eliminated.

However, cases placing the burden of proof on the MDO primarily center on proceedings that determine the subsequent placement and eventual release of the MDO. Where the disposition of the MDO is not at stake and the protection of society is not an issue (e.g., where an objection to the treatment received has been raised), courts are more likely to recognize the liberty interests of the MDO and place the burden of proof on the State.

2. Automatic Commitment and Retention

A number of courts have recently upheld statutory schemes that provide for immediate involuntary commitment subsequent to a successful assertion of an insanity defense by a criminal defendant. A hearing to review the commitment status within forty to sixty days is typically mandated. Prior to that hearing, however, the acquittee is forced to undergo hospitalization based solely on a verdict that the defendant was insane at the time of the criminal act. Even though there has been no finding that the defendant is currently mentally ill and dangerous as otherwise required for the imposition of civil commitment, this verdict serves as the basis for the acquittee's civil commitment regardless that a considerable period of time may have

100. See, e.g., Wallace, 845 F.2d at 1471, 1473; Williams, 734 F.2d at 1434.
101. See, e.g., Williams 734 F.2d at 1440 ("the mental health system's institutional goal of transfer to a less restrictive environment and eventual release has a logical tendency to favor release").
102. See, e.g., Wallace, 845 F.2d at 1471; Glatz, 807 F.2d at 1514.
103. See infra part III.B.2.
104. Although this section focuses on NGRI acquittees, an involuntary period of evaluation for individuals found incompetent to stand trial has also been upheld. See, e.g., 18 U.S.C. § 4241(d) (1988) (defendant judged incompetent to stand trial can be confined for treatment for a reasonable period not to exceed four months, which can be extended for an additional reasonable period based on court's conclusion that with additional confinement defendant will likely attain capacity to stand trial); United States v. Shawar, 865 F.2d 856 (7th Cir. 1989) (mandatory commitment of defendant found incompetent to stand trial does not violate due process; finding of dangerousness or likelihood of recovery not required; approach recognizes limitations on federal courts in field of mental health and benefit to defendant of opportunity for in-depth examination and proper mental health care); United States v. Waddell, 687 F. Supp. 208, 209 (M.D.N.C. 1988).
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passed since the criminal act. Nevertheless, in contrast to earlier rulings that rejected automatic commitment, courts now generally find permissible statutory schemes that allow commitment (albeit for a limited period of time prior to mandatory review) based solely on an individual’s acquittal of a criminal defense by reason of insanity.

In upholding this approach, the courts have relied on rationale similar to that used to support placing the burden of proof on MDOs. For example, courts argue that the need to protect the public safety justifies the temporary deprivation of the individual’s liberty. This approach is considered necessary in order to give mental health professionals an opportunity to more fully explore the mental health status of the acquittee to better predict the future behavior of the

105. A period of months, even years, may pass between the commission of a criminal act, arrest, and subsequent conviction.

106. See, e.g., Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968); Cameron v. Mullen, 387 F.2d 193 (D.C. Cir. 1967); People v. Lally, 224 N.E.2d 87 (N.Y. 1966).

107. See, e.g., Jones v. United States, 463 U.S. 354, 369-70 (1983) (permissible to commit insanity acquittee, regardless of nature of crime, to mental hospital for up to 50 days without a hearing; contemporaneous survey cited that showed 14 jurisdictions provided for automatic commitment of at least some insanity acquittees); Glatz v. Kort, 807 F.2d 1514 (10th Cir. 1986) (statute upheld that automatically committed NGRI acquittee for 180 days with no absolute right to release hearing during period); State v. Huieett, 394 S.E.2d 486 (S.C. 1990) (changes making commitment easier can be applied retroactively). People v. Catron, 246 Cal. Rptr. 303, 307 (1988) (State can hold NGRI acquittee for 180 days without hearing on issue of restoration of sanity and release to society); In re Martin B., 525 N.Y.S.2d 469 (1987).

One opinion recommended automatic commitment where the legislature had not instituted such a procedure. See Waldrop v. Evans, 681 F. Supp. 840, 862 (M.D. Ga. 1988), aff'd, 871 F.2d 1030 (11th Cir. 1989) (concerned about the negative impact from sending individuals found guilty but mentally ill directly to a prison system poorly equipped to deal with them, court found such individuals “should be sent first to a hospital of some sort for a period long enough for a proper evaluation to be made and then sent to the prison system with adequate safeguards to prevent the type of tragedies that happened in the instant case”). But cf. Schuttemeyer v. Commonwealth, 793 S.W.2d 124 (Ky. Ct. App. 1990) (at hearing held following 21-day examination, trial court order requiring continued involuntary hospitalization of insanity acquittee remanded, in part due to lack of proof that hospitalization was the least restrictive mode of treatment).

108. See, e.g., Jones, 463 U.S. at 364-66 (insanity acquittal sufficiently probative of both mental illness and dangerousness to justify automatic commitment). As for dangerousness aspect, the court stated “[t]he fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness . . . [i]ndeed, this concrete evidence generally may be at least as persuasive as any predictions about dangerousness that might be made in a civil-commitment proceeding.” Id. NGRI acquittal of nonviolent crime against property sufficient basis for commitment, as “This Court never has held that ‘violence,’ however that term might be defined, is a prerequisite for a constitutional commitment”; as for mental illness aspect, “Nor can we say that it was unreasonable for Congress to determine that an insanity acquittal supports an inference of continuing mental illness. It comports with common sense to conclude that someone whose mental illness was sufficient to lead him to commit a criminal act is likely to remain ill and in need of treatment.” Id. Glatz, 807 F.2d at 1514 (NGRI determination established both dangerousness and mental illness).
individual and prevent future dangerousness. In this area as well, courts have distinguished MDOs from individuals who were previously similarly situated, namely individuals subjected to civil commitment proceedings. Some have asserted that because this automatic commitment only occurred after the acquittee advanced insanity as a defense, there was good reason for diminished concern for the risk of an inappropriate commitment, and the presence of a criminal act eliminated the possibility that the individual was being committed for "idiosyncratic behavior." This resulted in negating two of the primary reasons for mandating procedural protections associated with civil commitment in general. Finally, the courts have also noted the need to promote governmental efficiency in proceedings as a further justification.

3. Extended or Indefinite Commitment

In contrast to the finite time limits placed during the 1960s and 1970s on the commitment of the MDO, with the 1980s and 1990s came societal pressures to extend the commitment of the MDO. Legislatures and courts generally acceded to these pressures. Earlier cases typically ruled that an MDO could be held for mental health treatment only while the individual was being actively treated. De facto preventive detention to protect society from the potential harm that might be perpetrated by such individuals upon release was not considered permissible. In the 1980s and 1990s, however, courts began to expand the bases for retention and to extend maximum lengths of time individuals could be confined for treatment.

For example, upon the expiration of their prison sentences, prisoners with a history of psychiatric treatment during the course of their incarceration are routinely referred for psychiatric evaluation prior to release or parole. If they are found to meet the requisite civil commit-

109. See, e.g., Jones, 463 U.S. at 366 ("critical question" identified as being whether acquittee had recovered); Glatz, 807 F.2d at 1514 (automatic commitment gave State opportunity to assess insanity acquittee's mental status and determine whether likely to pose danger to society or himself); Catron, 246 Cal. Rptr. at 306 ("institutional examination period" necessary to give experts opportunity to evaluate and observe acquittee to determine progress in recovering sanity) (citing In re Franklin, 496 P.2d 465 (Cal. 1972)).

110. See, e.g., Jones, 463 U.S. at 366.

111. Id. at 354.

112. Id. at 366 (to require another hearing regarding mental status of acquittee immediately upon completion of criminal trial would waste scarce government resources and require relitigating much of the criminal trial).


114. Id.

115. Id.
ment criteria, they are directly committed to a psychiatric hospital upon release. Similarly, as will be discussed, some courts have argued that MDOs involuntarily committed cannot be released simply because their psychiatric symptoms are in remission if they continue to be dangerous or have given indications that they will not adhere to their treatment plans upon release, creating a potential for relapse.116

Perhaps the clearest indication of this shift occurred in legislation that allowed courts to commit insanity acquittees indefinitely. The Supreme Court upheld such an approach117 and further ruled that the insanity acquittee could be hospitalized for a period of time longer than the individual could have been incarcerated if convicted of the crime charged.118 The Court refused to find analogous its holding from the preceding era in Jackson119 that a person found incompetent to stand trial could not be hospitalized for an indefinite period of time.120 Again the underlying theme was to protect society from the potential dangerousness of the MDO.121 The Court emphasized the fact that the MDO was being treated and not punished, thereby making the corresponding criminal sentence irrelevant. Finally, putting a different twist on a theme used during the preceding era, the Court suggested that the inability of mental health professionals to predict the course of mental illness justified an indeterminate period of commitment.122

Several states and Congress have adopted an approach that allows involuntary treatment to be continued for a period of time equal to the maximum term for which the MDO could have been convicted.123 Courts have upheld this approach,124 but have also applied it in ways

118. Id.
120. See supra notes 34-35 and accompanying text.
121. Jones, 463 U.S. at 368 ("The purpose of commitment following an insanity acquittal, like that of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness. The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous.").
122. Id. ("[B]ecause it is impossible to predict how long it will take for any given individual to recover—or indeed whether he ever will recover—Congress has chosen ... to leave the length of commitment indeterminate, subject to periodic review of the patient's suitability for release.").
123. See, e.g., 18 U.S.C. § 4244(d) (1988) (after conviction, if court determines that defendant suffers from a mental disease or defect, court may commit defendant to a suitable facility for care and treatment up to maximum term authorized for crime of which defendant is convicted).
124. See, e.g., Hickey v. Morris, 722 F.2d 543 (9th Cir. 1984) (statute upheld setting maxi-
that resulted in indeterminate or relatively lengthy periods of commitment. In their opinions, courts have emphasized that such an approach is necessary to protect society, promises to be beneficial to the MDO, holds the individual only so long as treatment is necessary, and gives mental health professionals an opportunity to effect change. Similarly, for certain MDOs the imposition of a prison sentence following successful completion of a treatment program has been upheld, as well as commitment after having served a substantial portion of a criminal sentence or in lieu of a criminal sentence.
over the MDO's objection.  

B. Treatment Decisions Regarding the MDO

Courts more recently have adopted a slightly different perspective when assessing the treatment provided MDOs during their confinement. Although still conscious of a need to protect society if the treatment program has the potential to endanger society (e.g., by placing the MDO in the community and increasing the risk of escape), generally the courts appear satisfied that commitment to a secure facility sufficiently satisfies the community's concerns. Instead, the courts have given greater weight to the other paramount interest involved, namely, the interest of the MDO. Perhaps, as discussed, because the interests of the MDO tend to receive diminished recognition in commitment and release decisions, the courts may be counter-balancing this by increasing their scrutiny of the mental health treatment provided the MDO. In so doing, the courts have incorpo-

132. See, e.g., State v. Hass, 566 A.2d 1181, 1182 (N.J. Super. Ct. Law Div. 1988) (single criminal sexual act in conjunction with subsequent sexual fantasies can serve as basis for ordering defendant to serve sentence at diagnostic and treatment center where he will receive intensive psychological treatment even though greater stigma may attach, and possible less chance for parole than if placed in general prison population; State has substantial interest in treating defendant so that upon release he will not pose a further threat to society).

133. The focus of this section is on affirmative treatment programs provided to the MDO in the course of custody. Cases discussing these treatment programs are generally distinct from cases discussing the right of the MDO to minimally adequate conditions of confinement (e.g., their right to adequate clothing, food, shelter) and the duty imposed on custodial staff to protect the MDO from harm (e.g., prevention of suicide). For examples of such cases, see Purvis v. Ponie, 929 F.2d 822 (1st Cir. 1991) (prison officials have a duty to protect prisoners from other violent prone prisoners); Brogsdale v. Barry, 926 F.2d 1184 (D.C. Cir. 1991) (prison overcrowding exacerbating mental health problems of inmates); Buffington v. Baltimore County, 913 F.2d 113 (4th Cir. 1990) (en banc), cert. denied, 499 U.S. 906 (1991) (suicide by pretrial detainee); Sawyer v. County of Creek, 908 F.2d 663 (10th Cir. 1990) (sudden death of pretrial, precommitment detainee); Burns v. City of Galveston, 905 F.2d 100 (5th Cir. 1990) (suicide of pretrial detainee); Belcher v. Oliver, 898 F.2d 32, 34-35 (4th Cir. 1990) ("The general right of pretrial detainees to receive basic medical care does not place upon jail officials the responsibility to screen every detainee for suicidal tendencies") (citing Danese v. Asman, 875 F.2d 1239, 1243-44 (6th Cir. 1989) (includes summary of opinions by six other circuits reaching same conclusion); Edwards v. Gilbert, 867 F.2d 1271 (11th Cir. 1989) (juvenile committing suicide in prison); Elliott v. Cheshire County, 750 F. Supp. 1146 (D.N.H. 1990) (suicide of pretrial detainee), aff'd in part and vacated in part, 940 F.2d 7 (1st Cir. 1991); Langley v. Coughlin, 715 F. Supp. 522 (S.D.N.Y. 1989) (discussing both failure to treat and conditions of confinement); Capodagli v. Wilson, 536 N.E.2d 135 (III. App. Ct.), appeal denied, 541 N.E.2d 1104, cert. denied, 493 U.S. 919 (1989) (prisoner's suicide); Tittle v. Mahan, 566 N.E.2d 1064 (Ind. Ct. App.) (suicide of pretrial detainee), vacated in part, 582 N.E.2d 796 (Ind. 1991); Wayne County Jail Inmates v. Chief Exec., 444 N.W.2d 549 (1989) (county jail placed in receivership partly due to serious overcrowding, unreasonable assault and suicide rates, exacerbation of mental illness attributed to jail environment and regimen, and psychiatric prisoners housed under counter-therapeutic and degrading conditions).

134. See supra part III.A.
rated many of the same general principles used in the 1960s and 1970s to address legal challenges brought on behalf of MDOs in general.

The courts have paid specific attention to three aspects of treatment decisions regarding the MDO: the general right of the MDO to treatment, the ability of the MDO to resist treatment over objection, and the acceptable parameters of the treatment programs provided the MDO. However, courts remain cautious when the MDO is in a setting of questionable security. Thus, in considering the courts’ treatment decisions, it is often necessary to distinguish non-sentenced MDOs frequently placed in a mental health facility from sentenced MDOs placed within the relatively secure confines of a prison.

1. Right to Treatment

(a) Mental Health Facilities.

Attempts to establish an involuntarily committed individual’s right to treatment are not new.135 Judicial discussion of the question dates back to 1966 when the Court of Appeals for the District of Columbia became the first court to formally recognize the right.136 Most current discussion of this asserted right, however, centers on the United States Supreme Court’s 1982 opinion in Youngberg v. Romeo, the Court’s first and only opinion directly addressing this question.137

Although the Court’s opinion addressed only the constitutional rights of an involuntarily committed individual with mental retardation (thus its emphasis on habilitation and training), courts have broadly interpreted the decision to provide the basis for a similar recognition of the treatment rights of the involuntarily committed mentally ill. These courts typically point to the Court’s simultaneous remand of two lower court opinions addressing issues regarding the mentally ill for reconsideration in light of its opinion in Youngberg.138

In Youngberg, the Court was clearly aware it was treading new ground and proceeded cautiously. The Court had no difficulty recognizing a right to safe conditions and freedom from bodily restraint for an individual who had been involuntarily committed.139 However, it professed concern over recognizing an asserted constitutional right

135. See generally Perlín, supra note 2, at 1-214; Weiner, supra note 84, at 334-40.
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40 Like other courts that have expressed difficulty in grappling with mental health concepts and terminology, the Court noted the lack of precision and consistency in the use of the term "habilitation."41 Furthermore, the Court alluded to the disagreement among mental health professionals regarding the appropriate modes of habilitation and needed types of training, and their ultimate success.42 Like other courts in the 1980s and 1990s that recognized a need to defer to the insights of mental health professionals, the Court also noted the considerable discretion that must be afforded the State in designing and delivering any such services.43 As a result, the Court refrained from explicitly recognizing a general constitutional right to habilitation/training for a person with mental retardation involuntarily committed to a state institution. Instead, the Court recast the right as a means to an end, namely that minimally adequate or reasonable training was required in order to ensure that the rights to safety and freedom from undue restraint of such individuals were not jeopardized.44 However, what was required had to be determined on a case-by-case basis that focused on the facts and circumstances of each case.

The Court additionally qualified even this very cautious position in a manner representative of courts of the 1980s and 1990s. These rights were not absolute, but had to be balanced against "the demands of an organized society,"45 as relevant State interests had to be taken into account. While not explicitly stating the particular State interests at stake, the Court did indicate the necessity for institutional care; the often unavoidable overcrowding and understaffing of institutions; the wide range and number of decisions, needs, and problems faced in the course of a typical day by the staff within these institutions; and the necessity that such staff not work with the cloud

140. Because it focused on the constitutional rights of an involuntarily committed, mentally retarded individual, the Court discussed what was referred to as a right to "habilitation" or training. Youngberg, 457 U.S. at 320. This has also been referred to as a "right to habilitative treatment." See Note, The Supreme Court: 1981 Term, 96 HARV. L. REV. 62, 82 (1982). Sometimes the phrase "right to treatment" has been reserved for involuntarily committed individuals with a mental illness. Although different types of services would be required, from a legal perspective the nature of a right to habilitation and a right to treatment for individuals who have been involuntarily committed appear to be largely synonymous, and will be considered as such here. See e.g., Rennie v. Klein, 720 F.2d 266, 269 (1983).

141. Youngberg, 457 U.S. at 320.

142. Id.

143. Id. (The Court also professed uncertainty as to whether plaintiff was actually seeking a right to habilitation.)

144. Id.

145. Id.
of a potential lawsuit influencing their every decision. Furthermore, the Court asserted, "If there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury." Instead, the Court argued that these decisions generally must be left to the professionals providing the care, explicitly adopting the wide-spread premise of the 1980s and 1990s that courts, because of their lack of expertise in such matters, should limit their intrusion.

The Court then proceeded to state the general rule of law which has guided courts reviewing treatment decisions made within mental health facilities throughout the 1980s and 1990s. The Court held:

The decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.

Despite this cautious approach by the Court, federal courts in the 1980s and 1990s, utilizing the rule in Youngberg, were increasingly willing to undertake scrutiny of the care provided by state facilities for the mentally disabled, including that provided for the mentally ill. State courts have also had a tendency to adopt a similar ap-

146. Id.
147. Id. at 321.
148. The Court stated:
In this case, the minimally adequate training required by the Constitution is such training as may be reasonable in light of respondent's liberty interests in safety and freedom from unreasonable restraints. In determining what is "reasonable"—in this and in any case presenting a claim for training by a State—we emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions.

Id. at 322-23.
149. Id. at 323.
150. For two examples of judicial opinions that viewed the right to treatment expansively, see Woe v. Cuomo, 638 F. Supp. 1506 (E.D.N.Y.), aff'd in part, 801 F.2d 627 (2d Cir. 1986) (suggests rights of a mentally ill patient include rights to humane and therapeutic environment, qualified staff in sufficient numbers, individualized treatment plan for each patient, and planned therapeutic activities and programs; doubtful facility can provide any of these if overcrowded, thus steps taken to reduce facility population by enjoining admissions); Sabo v. O'Bannon, 586 F. Supp. 1132 (E.D. Pa. 1984) (if right to safe conditions includes right to be safe from a pattern of attacks and injuries as recognized in Youngberg, it must also protect individuals from unsafe administration of drugs and assure freedom from chemical restraint; judiciary will also examine type of training to determine whether it advances individual's basic
proach.\textsuperscript{151} Generally, the critical question has remained whether professional judgment was exercised by the staff providing care.\textsuperscript{152}

For the MDO, judicial recognition of a right to treatment has followed a similar track. A series of opinions by the Court of Appeals for the District of Columbia in the 1960s and 1970s recognized a right to "reasonably suitable and adequate" treatment for persons either involuntarily committed after being found not guilty by reason of insanity (NGRI)\textsuperscript{153} or determined to be a sexual psychopath.\textsuperscript{154} The court concluded that because the respective statutory schemes allowed for indefinite commitment, such confinement could only be justified if therapeutic treatment was provided during confinement.\textsuperscript{155} Like many other courts during this era, this court based its conclusion on a determination that such individuals were indistinguishable from those who had been civilly committed and were entitled to the least restrictive alternative.\textsuperscript{156} As a result, the court was prepared to recognize a relatively expansive right to treatment.\textsuperscript{157}

Although relatively few other courts discussed the right to treatment of the MDO during this era, the Ninth Circuit Court of Appeals...
adopted a relatively similar position. That court was also willing to require individualized treatment and to actively interject itself in the treatment decision-making process, but was unwilling to recognize budgetary restraints on the ability to provide the necessary treatment.

However, recent cases appear to retreat slightly in the scope of their recognition of a right to treatment for the MDO, at least where the MDO is placed in a relatively non-secure mental health facility. Tending to emphasize that the potential dangerousness of the MDO requires a different treatment modality, these cases typically recognize the recurring need to protect public safety. Thus, courts appear willing to limit the breadth of the right to treatment of the non-sentenced MDO, give greater deference to the judgment of professional staff, place less emphasis on exploring less restrictive alternatives, and allow budgetary restraints to be taken into account when determining what is acceptable treatment.

158. See Ohlinger v. Watson, 652 F.2d 775 (9th Cir. 1980) (relying on several civil commitment cases, State cannot justify indeterminate life sentence for an individual as a "sex offender" based on mental illness without affording appropriate treatment).

159. Id. at 778 (these individuals have "a constitutional right to receive 'such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition'" (quoting Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971))).

160. See, e.g., Knight v. Mills, 836 F.2d 659 (1st Cir. 1987) (basis for commitment as sexually dangerous person not limited to need for treatment, but also to provide for State's public safety needs by providing high security environment for men with potential for doing serious harm; Plaintiff's reliance upon Fourteenth Amendment "treatment cases" pertaining to the involuntarily civilly committed misplaced); Partridge v. Two Unknown Police Officers, 791 F.2d 1182 (5th Cir. 1986) (refusal to recognize broad right to treatment for pretrial detainee who committed suicide while held in municipal jail); Woe v. Cuomo, 638 F. Supp. 1506 (E.D.N.Y.), aff'd in part, 801 F.2d 627 (2d Cir. 1986) (dismissed plaintiff's complaint that inadequate treatment was provided at state hospital primarily for "criminally insane," noting their dangerousness "inevitably affects the nature of the appropriate treatment" and distinguishes them from other involuntarily civilly committed patients); Bahrenfus v. Bachik, 806 P.2d 170 (Or. Ct. App. 1991) (rejected complaint by insanity acquittees that failure to provide treatment meant they would not qualify for early release, noting not entitled to early release; similar basis for rejecting complaint that not afforded same good time credits as prison inmates; in order to base claim on lack of treatment, plaintiffs must show likely to result in immediate, serious, ongoing health hazard to them); In re G. S., 551 N.E.2d 337 (III. App. Ct. 1990) (despite minor's obvious need for psychiatric care, permissible to commit to Department of Corrections (DOC) rather than to private hospital for psychiatric treatment where no evidence the minor would not receive psychiatric treatment through DOC; trial court had made repeated referrals to hospital resulting in premature release of minors and commitment to DOC necessary for protection of community); Commonwealth v. Davis, 551 N.E.2d 39 (Mass. 1990) (even though most of the experts agreed treatment center not the best place for defendant and trial judge found out-of-state placements "more beneficial," not required to provide optimal or better treatment or alternative that provides less restrictive environment); State v. Gilliland, 769 P.2d 477, 483 (Colo. 1989) (day-to-day treatment decisions for hospitalized insanity acquittees best left to those responsible for treatment; standard not whether very best treatment deci-
MENTALLY DISORDERED OFFENDERS

The First Circuit Court of Appeals issued an opinion expressing particularly strong reservations on a right to treatment for the MDO. The court found that, "there is no constitutional requirement . . . that all mental patients in state-run hospitals receive the same rights or care." Thus, the court upheld distinctions in the privileges afforded various groups of patients where those differentiations were "related to the severity of their illness, their violent propensities, and the type of treatment they are believed to need." Included among these distinctions were the placing of limitations on mailing privileges, visitations, freedoms in personal grooming, handling of patient moneys, and storage of patient property. In discussing the level of treatment required, the court stated:

Given that security and control, in addition to patient therapy, is the appropriate primary focus in the case of persons committed to [this facility], while returning patients to the community is the primary focus at mental health facilities, it is not irrational for the state to expend more of its limited resources on stabilizing and controlling these violent patients, and perhaps somewhat less of its resources on the usual psychiatric approaches. The state might believe that if, in addition to the cost of the high security that [this facility's] patients require, it must also guarantee to provide "the highest practicable professional standards" (which patients who do not need high security are statutorily mandated to receive), the cost of treating [this facility's] patients would become prohibitive.

However, the court noted that the need for greater security could not be a basis for totally denying psychiatric care and adopted the

161. Doe v. Gaughan, 808 F.2d 871 (1st Cir. 1986). Although focusing on the right to treatment of mentally ill patients committed to a maximum security facility, the language of this opinion appears to clearly apply as well to the sentenced and non-sentenced MDOs with whom they were housed. Id.

162. Id. at 881.

163. Id. at 882 ("Many of the privileges provided to the less violent patients in Department of Mental Health facilities may rationally be found to be inappropriate for patients who exhibit the need for strict security.").

164. Id. at 883.
Youngberg professional judgment standard for assessing the conditions of confinement. Like other courts, the First Circuit stressed that this standard would appropriately minimize the federal judiciary's interference with the internal operations of state institutions.

In ruling that conditions at this facility passed constitutional muster, the court focused on many aspects, including: the lack of murders and the minimal number of suicides in the past eight years while housing a dangerous and unmanageable population; the procedures that minimized, limited, and reviewed the use of restraints and isolated incidents of abuse by staff; the fact that both standard and innovative modalities of treatment were used; evidence that despite overcrowding, staff members had still been able to exercise professional judgment and provide adequate treatment; and the plaintiff's failure to show that the treatment program or a lack thereof had caused the loss of pre-existing self-care skills.

Courts in general have been hesitant to recognize an expansive right to treatment for MDOs placed in a mental health facility. Ironically, pressure for increased scrutiny of the proffered treatment may come from a set of cases that traditionally were very restrictive in recognizing individual rights, namely, cases addressing the rights of inmates (and MDOs) in a prison setting.

(b) Prisons.

The recognition of a right to treatment for MDOs who have been convicted and sentenced for the commission of a crime has followed a different legal track than those involuntarily committed to a mental

165. Id. at 884-86.

166. The lower court opinion, which Doe v. Gaughan, 808 F.2d 871 (1st Cir. 1986), affirmed, expressed similar views. See Doe v. Gaughan, 617 F. Supp. 1477 (D.C. Mass. 1985) (even though an individual might be restrained, more than the norm for a state hospital patient, it is not impermissible—absent showing done arbitrarily for convenience of staff; restraint and seclusion in this setting necessary to protect staff or patients from violence, preserve institutional environment, and shape behavior of individual restrained).


168. Id. at 1487-88 (Although overcrowding and understaffing forced at least one patient to spend an undue amount of time in his room, this was "a result of his most unfortunate and devastating mental illness as much as it is a shortcoming of the facility. The constitution does not require a state to provide an ideal environment for each person in its mental institution. Rather, it must provide an environment in which professional judgment may be exercised.").

169. Id. at 1483 (refusing to order a specific treatment modality requested for one patient that was noted unsuccessful at earlier stages of illness and less likely to be successful at this later stage; availability of other approaches merely reflected differences in professional opinion and failed to show realistic likelihood that they would meaningfully improve quality of patient's life).
health facility.\textsuperscript{170} Convicted MDOs' rights are typically based upon those of prison inmates in general, with the Eighth Amendment right to be free from cruel and unusual punishment providing the standard for assessing the treatment provided.\textsuperscript{171}

In contrast, for non-sentenced MDOs, including pretrial detainees, the right to treatment is derived (as for civil patients) from the Fourteenth Amendment right not to be deprived of life, liberty, or property without due process.\textsuperscript{172} This includes a right to be free from punishment altogether - a right not accorded to prison inmates.\textsuperscript{173} However, the Eighth Amendment has increasingly also been found to assure a given level of treatment to inmates in general, and sentenced MDOs in particular.

The Eighth Amendment line of cases suggesting a right to psychiatric treatment for prison inmates begins with the United States Supreme Court's 1976 opinion in \textit{Estelle v. Gamble}.\textsuperscript{174} \textit{Estelle} established that the critical issue in treatment cases is whether there has been deliberate indifference to a prisoner's serious medical needs.\textsuperscript{175} It should be noted that \textit{Estelle} focused on the response of prison officials to an inmate's back problems, and the Court did not, and has not to date, specifically rule that "serious medical needs" included psychiatric needs. At first, courts were reluctant to reach such a conclusion; however, numerous courts have since been willing to make this extension.

\textsuperscript{170} Included in this discussion are individuals who receive a prison sentence in conjunction with a finding of a mental disability (e.g., individuals sentenced as mentally disordered sexual offenders, guilty but mentally ill) or individuals for whom mental disorder was not a factor at conviction or sentencing but who exhibit symptoms of a mental disorder requiring treatment during the course of incarceration.

\textsuperscript{171} Although less discussed and developed, an inmate may possess a right to mental health treatment under state law. See, e.g., Lewis v. Griffin, 376 S.E.2d 364 (Ga. 1989) (relying on Georgia Mental Health Act). \textit{But see} Melville v. State, 793 P.2d 952 (Wash. 1990) (neither Washington statutes nor administrative rules created duty to provide mental health treatment to a prison inmate).

\textsuperscript{172} \textit{See} Bell v. Wolffish, 441 U.S. 520 (1979).

\textsuperscript{173} Some courts have used an Eighth Amendment standard to assess the treatment given to pre-trial detainees, but these courts have indicated that this was a minimal standard, and such detainees may be entitled to more. \textit{See}, e.g., City of Revere v. Mass. General Hosp., 463 U.S. 239 (1983) (reserved question of whether pretrial detainees might enjoy more extensive rights under Fourteenth Amendment than prisoners under Eighth Amendment; acknowledged they enjoy rights at least as great); Partridge v. Two Unknown Police Officers, 791 F.2d 1182 (5th Cir. 1986); Elliott, v. Cheshire County 750 F. Supp. 1146 (D.N.H. 1990); Tittle v. Mahan, 566 N.E.2d 1064 (Ind. Ct. App. 1991). In contrast, courts generally have refrained from using the Fourteenth Amendment as a guide for assessing the psychiatric care given an inmate, largely holding that line of cases inapplicable to their analyses.


\textsuperscript{175} \textit{Id}.\textsuperscript{176}
Early opinions addressing the right to mental health treatment of prison inmates tended to address the very basic parameters of the right. In one of the first opinions recognizing the right, the Fourth Circuit Court of Appeals found no underlying distinction between the right to medical care for physical ills and mental health needs. The court held that under the Eighth Amendment, prison inmates suffering from a mental illness are entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.

The court qualified this by limiting treatment to what could be provided on a reasonable cost and time basis and to what was a medical necessity (i.e., not simply desirable). Furthermore, the court stated a desire to limit judicial review of treatment decisions by adopting the professional judgment rule and requiring a showing of deliberate indifference by staff to the treatment needs of the inmate. The court appeared uncomfortable in attempting to make clinical judgements, yet appeared to believe it was compelled to respond to egregious circumstances, at least to the extent of requiring that some type of treatment be provided.

Succeeding courts addressing these issues have generally followed the basic analytical model set out by the Fourth Circuit. Yet, immediately after the Fourth Circuit opinion, courts typically adopted those portions of the opinion that were relatively conservative in nature. These cases focused on the basic presence or absence of mental health treatment. Furthermore, courts initially expressed a reluctance to

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177. Id. at 47.
178. Id.
179. Id. at 48 ("In so holding, we disavow any attempt to second-guess the propriety or adequacy of a particular course of treatment. Along with all other aspects of health care, this remains a question of sound professional judgment. The courts will not intervene upon allegations of mere negligence, mistake or difference of opinion.... [T]he complainant must allege deliberate indifference to his continued health and well-being."). (citing Developments in the Law Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1335 nn.84-85 (1974)).
180. Id. at 48 n.3 ("[D]iagnosis remains 'an extremely subjective art'... [P]sychiatrists themselves differ on the underlying theories (hence methodologies) of treatment.").
181. Id. ("Although courts are ill-equipped to prescribe the techniques of treatment, this does not alter the fact that in many cases treatment is obviously called for and is available in some form.").
182. See, e.g., Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983) (dismayed by fact posi-
grant the same right to treatment to sentenced MDOs that is recognized for non-sentenced MDOs.\textsuperscript{183}

There is an indication, however, that an increasing number of courts are recognizing the right to treatment of mentally ill inmates, broadening the scope of the right, and more closely scrutinizing the nature of this treatment. As a result, the nature of this right may soon equal that granted to non-sentenced MDOs and potentially civilly committed individuals in general.\textsuperscript{184}

For example, courts have exhibited a general willingness to engage in a closer, more detailed examination of the treatment provided, in-

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\item [\textsuperscript{183}] See, e.g., Youngberg v. Romero, 457 U.S. 307, 321-22 (1982) ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish"); Doe v. District of Columbia, 697 F.2d 1115, 1123 (D.C. Cir. 1983) ("we must remember that we are dealing with prisoners, who in most instances are persons who have been convicted of committing serious crimes,") and just because these prisoners have retained certain constitutional rights following incarceration, does not mean these rights are not subject to limitations); Hoptowit, 682 F.2d at 1255 n.8 ("[T]hose serving criminal sentences have no constitutional right to rehabilitation..."). Incarceration for criminal offenses 'is primarily for punitive purposes. Although rehabilitation may be desirable, it is not necessarily the primary function of such incarceration.'" (quoting Ohlinger v. Watson, 652 F.2d 775, 778-79 (9th Cir. 1981)); Woe v. Cuomo, 638 F. Supp. 1506, 1517 (E.D.N.Y.) aff'd in part, 801 F.2d 627 (2d Cir. 1986) ("the Court [of Appeals for the Second Circuit] infers that the mentally ill patient has rights greater than a prisoner’s, or more accurately, different than a prisoner’s"); State v. Christopher, 652 P.2d 1031, 1034 (Ariz. 1982) ("the Youngberg Court expressly held that involuntarily committed patients are entitled to a higher level of treatment and conditions than are convicted criminals").

There was also an initial reluctance to grant sizeable monetary awards in such cases. See, e.g., Doe, 697 F.2d at 1115.

\item [\textsuperscript{184}] See, e.g., Langley v. Coughlin, 715 F. Supp. 537 (S.D.N.Y. 1989) ("Although it could be argued that the due process clausepermits a more searching review of the alleged misdeeds of prison employees and officials than does the Eighth Amendment, ... the Supreme Court and Second Circuit have made no such distinction in recent decisions."). Compare Fox v. Zenon, 806 P.2d 166 (Or. Ct. App. 1991) (prisoner allowed to file habeas complaint of denial of treatment) with Bahrenfus v. Bachik, 806 P.2d 170 (Or. Ct. App. 1991) (insanity acquitees not entitled to habeas writ for failure to provide treatment).
\end{itemize}
cluding a detailed chronological evaluation of the day-by-day treatment afforded, a review of the inmate's prior treatment (for comparative purposes), and an examination of the inmate's medical records. Similarly, courts have been willing to take a far more extensive look at the specific types of services provided the mentally ill inmate and to require that those services be individualized. Courts have also expanded the means by which deliberate indifference can be established.

At the same time, there has been a gradual increase in the services required. Recently, courts have not been content to merely base rulings on the presence or absence of services, but have examined how well the treatment provided matches the needs of the individual MDO/inmate. Among the expansions in required services that have occurred are: mandating on-site mental health staff and a range of staff expertise; increased staff training; heightening the required

185. See, e.g., Torraco v. Maloney, 923 F.2d 231 (1st Cir. 1991) (in finding no liability, noted that two times inmate expressed need for mental health attention, prison officials accommodated the inmate); Greason v. Kemp, 891 F.2d 829 (11th Cir. 1990) (concerned that anti-depression medication discontinued abruptly after brief initial visit and without conducting a mental status examination or without reviewing inmate's clinical file which would have established danger of withdrawing medication); Meriwether v. Faulkner, 821 F.2d 408 (7th Cir.), cert. denied, 484 U.S. 935 (1987) (right to treatment for transsexual inmate); Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986); Tillery v. Owens, 719 F. Supp. 1256 (W.D. Pa. 1989), aff'd, 907 F.2d 418 (3d Cir. 1990); Waldrop v. Evans, 681 F. Supp. 840 (M.D. Ga. 1988), aff'd, 871 F.2d 1030 (11th Cir. 1989); Gusliblomini v. Alexander, 583 F. Supp. 821 (D.C. Conn. 1984).

186. See, e.g., Smith v. Jenkins, 919 F.2d 90 (8th Cir. 1990).

187. Id.

188. See, e.g., Greason, 891 F.2d at 829 (addressing lack of recreation time outside of cell; require mental health treatment plans; require policies and procedures to help staff prevent suicide); Tillery, 719 F. Supp. at 1256 (concern over significant delays between requests for psychiatric consultations and actual interviews; inadequate record keeping; require extensive overhaul of care provided in psychiatric observation cells); Waldrop, 681 F. Supp. at 861 ("There needs to be some better plan for recognizing severe mental disorders upon sentencing. The prisoner then should be provided with adequate treatment consistent with his needs.").

189. See, e.g., Smith, 919 F.2d at 90 (doctor's decision to employ easier and less efficacious course of treatment); Greason, 891 F.2d at 829 (awareness by supervisory official of similar incident one year prior to inmate's suicide separates this case from those involving only single errant official and single incident of errant behavior); Ramos, 639 F.2d at 559 (standard expanded from proving repeated examples of negligent acts disclosing a pattern of conduct by staff to simply proving systemic and gross deficiencies in staffing, facilities, equipment, or procedures); Langley, 715 F. Supp. at 522 (not necessary to show all members of class received inadequate treatment; sufficient to show occurs in a sample of); Waldrop, 681 F. Supp. at 840 (one episode of gross misconduct can outweigh overall pattern of general attentiveness).

190. See, e.g., Greason v. Kemp, 891 F.2d 829 (11th Cir. 1990) (severe lack of staff members capable of providing adequate time and psychiatric care to inmates); Tillery v. Owens, 719 F. Supp. 1256 (W.D. Pa. 1989) (need for active therapy).

191. See, e.g., Greason, 891 F.2d at 829 (need for institutionalized mental health unit for inmates with severe emotional problems; where approximately 70-75 inmates required mental health care, insufficient that psychiatrist visited facility only once a week); Ramos, 639 F.2d at
credentials of staff, including specialized staff training in the mental health field;193 closer monitoring of the need for mental health services;194 insisting on an environment conducive to the treatment of serious mental illness;195 segregating mentally ill inmates from the general population;196 and extending services to inmates placed in special housing units (cells often used for inmates who have violated the disciplinary code of the institution).197 In reaching these decisions, the courts have not been swayed by a lack of available funding or good faith efforts to obtain needed treatment resources.198 Courts have shown less deference to prison officials199 and have not been con-
strained by expert testimony to the contrary.\textsuperscript{200} Courts have also expanded the liability of supervising officials\textsuperscript{201} and have been less receptive to arguments asserting a need to maintain prison security.\textsuperscript{202}

As an example of a specific ruling adopting this approach, a Georgia federal district court held that a consulting psychiatrist's decision to abruptly take a prison inmate off his antipsychotic medication when the inmate shortly thereafter engaged in self-mutilation raised the possibility that the psychiatrist could be found liable for deliberate indifference to the inmate's medical needs.\textsuperscript{203} The court noted there had been no acts of self-mutilation for several preceding months while the inmate had been on powerful antipsychotic medication.\textsuperscript{204} However, after undertaking a detailed review of the psychiatrist's contacts with the inmate during the relevant time period, the court determined that a jury could find that there had been "storm warnings," including one earlier serious act of self-mutilation, that the psychiatrist had ignored.\textsuperscript{205} Similarly, the court ruled that a jury might find the prison doctor liable for failing to contact the psychiatrist after he learned of the inmate's depression and attempts to cut his arm.\textsuperscript{206} The court also provided a detailed description of this doctor's contacts, or lack of them, with the inmate over this time period.\textsuperscript{207}

The key facet of this opinion is the extreme detail the court entered into when discussing the treatment provided by a wide range of men-

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\textsuperscript{200} See, e.g., Greason, 891 F.2d at 835; Waldrop, 681 F. Supp. at 854.

\textsuperscript{201} See, e.g., Greason, 891 F.2d at 836 ("[a] supervisor can be held liable under section 1983 when a reasonable person in the supervisor's position would have known that his conduct infringed the constitutional rights of the plaintiff, and his conduct was causally related to the constitutional violation committed by his subordinate." (citations omitted)); Waldrop, 681 F. Supp. at 840. Although supervisory officials ordinarily cannot be held liable for a constitutional violation, this rule is superseded where the supervisor directly participated in acts in violation of constitution or the supervisor's actions are causally connected to constitutional violation. Id. at 848. Causal connection can be established either by the supervisor's failure to carry out a duty imposed by state law or if the supervisor implemented "haphazard and ill-conceived procedures" where numerous inmates suffered as result, including failing to insure prison adequately staffed and sufficient services provided to meet inmates' medical needs. Id. at 849-50. Supervisors may also be held liable if they knew subordinates failing to carry out medical duties in competent manner and did nothing about it. Id. at 851.

\textsuperscript{202} See, e.g., Hoptowit, 682 F.2d at 1237.

\textsuperscript{203} Waldrop, 681 F. Supp. at 860 (psychiatrist's liability issue for jury to decide).

\textsuperscript{204} Id. at 853.

\textsuperscript{205} Id. at 856.

\textsuperscript{206} Id. at 854.

\textsuperscript{207} Id. at 840.
tional health professionals, including non-psychiatric staff. Ultimately, the court embarked on an extensive critique of both the criminal justice system for placing severely mentally disturbed people in the prison system and the prison system for its failure to adequately treat such individuals.\textsuperscript{208} The court indicated concern over the often fine distinctions pursued by the criminal justice system in determining when it is appropriate to impose criminal sentences upon MDOs.\textsuperscript{209} Furthermore, regardless of how the distinction is made, the court believed that the agency housing MDOs cannot ignore the MDOs' mental health needs.\textsuperscript{210} This court, like others, indicated that where severe restrictions are placed on the freedom of the MDO by the imposition of a prison sentence, they must be counterbalanced by increasing the level of treatment provided during incarceration.

The First Circuit District Court of Appeals also engaged in an extensive evaluation of the specifics of the treatment provided a mentally ill inmate.\textsuperscript{211} Within a few months of his transfer to an overcrowded jail, the inmate "was found dead, his body dismembered."\textsuperscript{212} The court closely scrutinized, not only the acts of treating personnel, but supervisory personnel as well, including those without mental health backgrounds, and found them liable. The court carefully noted that each had the ability to prevent the tragedy without

\textsuperscript{208} Id. at 861.

\textsuperscript{209} Id.

\textsuperscript{210} Id. at 861-62.

The court feels certain that when the State of Georgia adopted the offense of guilty but mentally ill, its purpose was to take into consideration that many accused persons are mentally ill but unable to sustain an insanity defense. The rule seemed logical and was generally applauded. . . . It appears, however, that the result has been to send some severely mentally disturbed people to the prison system immediately upon sentencing, where the authorities are generally ill-equipped to deal with them. . . . [A]ny change in the criminal law to prevent the abuses of the insanity defense must be carried out in such a manner as to protect the genuinely mentally ill person from harming another or, as in this case, himself.eb;

\textsuperscript{211} Cortes-Quinones v. Jimenez-Nettleship, 842 F.2d 556 (1st Cir.), cert. denied, 488 U.S. 823 (1988).

\textsuperscript{212} Id. at 558.
relying on the psychiatric judgment of another.\textsuperscript{213} The court also went through a detailed chronology of the psychiatric history of the inmate, the decisions made, and the care, or lack of care, provided.\textsuperscript{214} Among the specific requirements imposed were an obligation to read an inmate’s records carefully, to make certain the inmate’s files contained past psychiatric records, to review these records within a few days of transfer, and to have procedures in place that would screen out psychologically disturbed prisoners.\textsuperscript{215} The court rejected the defendants’ protestations that they had no control over appropriation decisions.\textsuperscript{216} Furthermore, the court specifically addressed the placement of the mentally ill prisoner within the prison. Typically, courts have ruled that a prisoner does not have the right to be placed in a particular setting as long as the prisoner’s mental health needs are adequately addressed in the setting where he or she is placed.\textsuperscript{217} The First Circuit, however, found that a constitutional violation arises when prison officials intentionally place a mentally ill prisoner in a dangerous surrounding and fail to identify the prisoner’s need for psychiatric hospitalization.\textsuperscript{218}

Where sexual offenders are involved, courts have been hesitant to expand treatment rights of inmates. Generally, courts refuse to scrutinize the particularities of the treatment provided to the inmates, even though the effect may be to delay the inmates’ ability to qualify for early release through parole.\textsuperscript{219} The courts apparently do not object to delaying the return to the community of this treatment-resistant population that the public widely views as particularly dangerous.

\begin{itemize}
\item \textsuperscript{213} \textit{Id.}
\item \textsuperscript{214} \textit{Id.} at 559-60.
\item \textsuperscript{215} \textit{Id.} at 562.
\item \textsuperscript{216} \textit{Id.} at 560-61.
\item \textsuperscript{217} \textit{See, e.g.}, Jackson v. Fair, 846 F.2d 811, 817 (1st Cir. 1988).
\item \textsuperscript{218} It appears that the driving force behind the court’s position in \textit{Cortes-Quinones}, 842 F.2d at 556, was that the inmate was placed in an area described as chaotic and violent, with “terrible health and security problems,” and received no treatment at all for his psychiatric problems. \textit{Id.} at 560.
\item \textsuperscript{219} \textit{See, e.g.}, Langton v. Johnston, 928 F.2d 1206 (1st Cir. 1991) (rejecting complaint by class of inmates found to be sexually dangerous persons that State officials violated federal Constitution and two prior consent decrees designed to improve their institutional care; court emphasized that progress, not perfection was required); Balla v. Idaho State Bd. of Corrections, 869 F.2d 461 (9th Cir. 1989) (Idaho not required to create special psychological treatment program for sex offenders, even though these offenders were required to submit to a psychological examination before being considered for parole); Patterson v. Webster, 760 F. Supp. 150 (E.D. Mo. 1991) (plaintiffs failed to state civil rights claim when they asserted that the sexual offender program they were required to complete before early release was not sufficiently funded or staffed to assure all plaintiffs an opportunity to complete the program in timely fashion); Russell v. Eaves, 722 F. Supp. 558 (E.D. Mo. 1989) (permissible to require sex offenders to complete sexual offender program to become eligible for parole since treating prisoners differently based upon nature of crime not prohibited).
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Ironically, although most courts have been slow to expansively define the right to treatment of non-sentenced MDOs, impetus for greater attention to their treatment rights may come from the increased recognition of a right to mental health treatment for sentenced MDOs. As non-sentenced MDOs are generally perceived as entitled to no less treatment than that afforded prison inmates, they may benefit from the "evolving standards of decency" associated with the Eighth Amendment.

Although the source of the right to treatment for the two populations differs (Fourteenth verus Eighth Amendment), as well as the standard used for assessing whether the treatment provided meets minimum constitutional requirements (substantial departure from accepted professional judgment versus deliberate indifference to serious medical needs), the analytical approach used for the two populations appears to be converging. Indeed, judges presiding over prison cases have shown a tendency to discuss whether the treatment provided represented a substantial departure from the professional judgment that could be expected to be exercised within that setting.

Based on a review of the case law, recent opinions more often address the care provided sentenced, rather than non-sentenced MDOs, which in turn may reflect a relatively greater number of challenges to the care provided sentenced MDOs. Until fifteen years ago, such
cases were rare, but not now. Indeed, the flood of litigation initiated by *pro se* prison inmates has become a major concern of the courts. Perhaps a more limited judicially recognized right to treatment for non-sentenced MDOs may be a function of the fewer number of judicial opinions addressing the issue. Also, the explicit "evolving" nature of the Eighth Amendment right to treatment may be viewed by the courts as specifically granting them the latitude to readily expand the right to treatment of sentenced MDOs. The recognition of a distinct disparity in treatment rights for the two populations in the future, however, remains unlikely, as the professional judgment standard associated with the Fourteenth Amendment is also a relatively flexible and potentially evolving standard. Instead, the greater attention given the treatment rights of sentenced MDOs may increase the likelihood of breakthroughs in the treatment required for non-sentenced MDOs.

At the same time, to the extent that affording non-sentenced MDOs an expansive right to treatment potentially places society at risk, courts may be hesitant to equate non-sentenced MDOs' rights fully with those of sentenced MDOs. For example, if mental health agencies routinely adopt a therapeutic approach for non-sentenced MDOs (as they have for civil patients) that provides the MDO with ready access to the community (e.g., by emphasizing the wide-spread use of non-institutional environments, passes, and off-grounds privileges, or least restrictive treatment alternatives), courts may be reluctant to recognize the same expansive right to treatment for non-sentenced MDOs even though this approach may be considered crucial to the successful treatment of such individuals.225

Greater restrictions on pursuing insanity or incompetency at trial, causing such alternatives to become less attractive for criminal defendants, or elimination of diversionary programs, may have resulted in convicted inmates entering the prison system with greater psychiatric needs. Similarly, it is possible that inmate symptomaticity is being exacerbated by more extensive histories of drug and alcohol abuse, prison overcrowding, or other factors intrinsic to the prison system.

Finally, as separate psychiatric units for inmates are established either on prison grounds or in facilities removed from the prison complex, inmates may find such units sufficiently attractive vis-a-vis the typical prison setting that prior reluctance to acknowledge psychological problems is being overcome. Similarly, the attractiveness of this alternative setting may be sufficient to motivate the inmate to feign symptoms where none exist. 225. Courts may justify a distinction in treatment modalities where it is established that the confinement of the MDO has a different purpose from that for an individual involuntarily civilly committed or a sentenced MDO. For example, commitment of an individual found incompetent to stand trial, under *Jackson v. Indiana*, 406 U.S. 715 (1972), must be designed to restore that individual to competency so that the individual can indeed stand trial. The courts may perceive this purpose as entitling the State to attach more security conditions to the treatment program of the MDO to insure that the MDO appears as scheduled for trial. See, e.g., *State v. Otero*, 570 A.2d 503 (N.J. Super. Ct. Law Div. 1989) (court can order defendant to
There has also been a large number of cases concerning the treatment of inmates who have AIDS or who have tested HIV-positive. Although not generally addressing mental health issues, court rulings on the status of these inmates and judicial reviews of prison plans for providing them care may follow a similar course as set out in the right to treatment cases, with the two lines of cases providing precedents for each other.

Another aspect of prison care that may have a significant impact upon the evolution of the right to treatment in general involves inmates on death row. Recent rulings by the Supreme Court indicate that persons with a mental retardation are not automatically precluded from being executed following conviction for a capital offense, while at the same time a prisoner who is incompetent (including one who is insane) cannot be executed as long as the individual remains incompetent. Thus, mental health professionals may encounter an expansive range of relatively unique mental health problems when providing services to inmates on death row, including a potential ethical dilemma as their ability to provide effective treatment may serve as the basis for the execution of the inmate.
Opinions establishing a right to mental health treatment for both sentenced and non-sentenced MDOs have been almost exclusively issued by federal rather than state courts. As will be discussed, this stands in contrast to decisions discussing a constitutional right to refuse treatment. One possible explanation is that for both issues, federal courts were the initial choice for plaintiffs asserting these rights. However, unlike federal cases addressing the right to refuse treatment, federal courts have continued to be amenable to claims of a right to treatment, indeed expanding the right and scope of review, and therefore remain the venue of choice for plaintiffs challenging the care provided. Nevertheless, the possibility remains that in the future, should advocates of an increased right to treatment for sentenced or non-sentenced MDOs become dissatisfied with the recognition provided by the federal courts, they may turn to state courts as an alternative venue.  

2. Treatment Refusals

Unlike the right to treatment cases, the federal courts have not only indicated a reluctance to recognize for MDOs a broad right to refuse treatment, but have carefully circumscribed it. They tend to con-

defendant competent to be executed; "Perhaps the most awkward procedural question . . . is what to do if the defendant is found incompetent to be executed. Unless treatment is provided either in prison or in a state hospital, the problems which make a defendant unable to assist counsel (or otherwise incompetent to be executed) will likely never be corrected.").  

230. See infra part III.B.2.

231. Although not extensively developed, there is some indication that as courts become more sophisticated in addressing questions involving an alleged lack of adequate institutional treatment for the MDO, they may begin to apply the tort law concept of causation to such cases. In traditional tort law it is necessary to establish that the breach of the owed duty was both the actual and proximate cause of the harm that occurred. Generally speaking, an actual cause is established when it is shown that event A directly led to the alleged harm, while proximate cause is shown when it is established that events B, C, D, and E were not intervening causes, i.e., replaced event A as the actual cause of the harm. Thus, for example, in a prison setting, if it can be shown that the cause of an inmate's sudden psychological deterioration was not a specific act of inappropriate psychiatric care, but rather news that the inmate's wife was in the process of divorcing him, under tort law this could prevent the inmate from recovering damages from his primary therapist. For discussions of these issues, see Daniels v. Williams, 474 U.S. 327 (1986) (Constitution does not supplant traditional tort law in regulating liability for injury); Doe v. Gaughan, 808 F.2d 871 (1st Cir. 1986) (non-sentenced MDOs); District of Columbia v. Peters, 527 A.2d 1269 (D.C. 1987).

232. See supra note 51 and accompanying text.

233. This section addresses treatment refusals of individuals for whom an initial criminal proceeding has been completed and custody for purposes of treatment imposed. It does not address the right of pretrial detainees to refuse treatment, e.g., a criminal defendant forcibly given antipsychotic drugs to ensure that the defendant will be competent to stand trial. However, the Supreme Court, in Riggins v. Nevada, 112 S. Ct. 1810 (1992), has ruled that such individuals are entitled to at least as much protection as a convicted prisoner and thus have a
clude that the State's interests in overriding a treatment refusal can outweigh the individual's interests. Yet, in recent years, state courts have been willing to independently establish such a right, recognizing the individual's interests as paramount. Thus, two increasingly divergent lines of cases have emerged in the federal and state systems.

These cases typically do not address whether the MDO has the power to voice an objection and have it heard, as this fact has been widely recognized and accepted. Even the federal courts tend not to give the treatment provider carte blanche in overriding the MDO's objection. Instead, the issue has centered on who is empowered to override the MDO's objection, under what circumstances, and by what procedure. The federal courts have tended to favor review systems internal to the treating facility that do not require a judge to make the final decision. State courts, on the other hand, tend to leave the ultimate decision in the hands of a judge.

Because the federal courts have not ruled that this issue must be decided solely according to federal law, divergent state and federal court positions have been issued in several states. Furthermore, as the federal rulings based on federal law establish only the minimal requirements with which one must comply, state courts have added additional more stringent requirements with which mental health professionals must abide.\(^{234}\)

It should also be noted that opinions recognizing a right to refuse treatment and to have a judge serve as the final arbiter typically extend only to antipsychotic medication, ECT, and psychosurgery.\(^{235}\) These heightened procedural requirements have generally not been applied to forms of mental health treatment that are not intrusive, onerous, or non-reversible.\(^{236}\)

\(^{234}\) See Mills v. Rogers, 457 U.S. 291 (1982) (State may create liberty interests and procedural rights broader than those protected by federal Constitution).

\(^{235}\) See, e.g., In re Salisbury, 524 N.Y.S.2d 352 (N.Y. Sup. Ct. 1988) (administration of antibiotic to committee does not require judicial approval).

\(^{236}\) Although not often discussed in the context of MDOs, an issue just beginning to be addressed by the courts and potentially applicable to the MDO is the so-called "right-to-die."
Finally, as in the right to treatment cases, courts have tended to make distinctions in their analyses regarding the right to refuse treatment depending on whether the MDO is a non-sentenced offender typically placed in a mental health facility or a sentenced offender placed within a relatively secure prison environment.

(a) Mental Health Facilities.

State courts have tended to recognize an expansive right of the non-sentenced MDO to refuse treatment. One of the more striking aspects of these rulings is the lack of weight they give to the concepts that have driven recent decisions regarding the retention of the MDO and that have at least influenced and modified the right to treatment decisions (i.e., that all patients are not equal, that "dangerousness" should be defined expansively, and that there should be reduced judicial scrutiny and greater use of informal, non-adversarial proceedings). In contrast, the federal courts continue to give considerable weight to these concepts.

A decision of the Supreme Court of Wisconsin, *State ex rel. Jones v. Gehardstein*, typifies the various state court opinions that have in effect "overruled" their federal counterparts.237 A 1985 Wisconsin


The "right-to-die" may become an increasingly important issue for mental health professionals treating sentenced and non-sentenced MDOs. For example, as the number of MDOs suffering from AIDS increases, the question may be raised whether an MDO in the custody of the State has the same right to forgo life-sustaining medical treatment. Similarly, the question of what constitutes qualified consent to forgo life-prolonging medical treatment may be particularly complicated when raised in an institutional context. See *infra* part III.B.3.d.

237. 416 N.W.2d 883 (Wis. 1987).
federal district court decision asserted that courts initially committing individual for involuntary treatment contemplated and tacitly approved the administration of psychotropic drugs, and thus antipsychotic drugs could be administered without further court authorization. The Wisconsin Supreme Court disagreed and asserted that an involuntary commitment was not equivalent to a finding of incompetency to make treatment decisions, that such decisions invoked protected civil rights, and that further court involvement was required before disregarding an individual's objection to treatment.

A class action suit had been brought on behalf of criminal defendants committed following an insanity acquittal. Although the court did not directly address whether a distinction should be made between MDOs and involuntarily committed patients in general, the court did not differentiate between the two groups in its holding. The court asserted that just as an involuntarily committed civil patient could still be competent to make decisions regarding the acceptance of psychotropic drugs, so, too, could individuals found incompetent to stand trial and insanity acquittees be competent to make these treatment decisions. The court thereby disregarded, at least for this issue, one of the prevalent concepts of the 1980s and 1990s, namely, that all patients are not equal.

The court also asserted that the finding of dangerousness made when such individuals were committed was irrelevant in determining whether to override a patient's objection to treatment. Although it is a prerequisite for commitment, the court argued that such a finding is not necessarily related to whether the person is competent to accept or refuse psychotropic drugs. The court instead focused on the dan-

239. 416 N.W. 2d 883 (Wis. 1987).
240. It was also brought on behalf of involuntary civil psychiatric patients.
241. See also People v. Gilliland, 769 P.2d 477 (Colo. 1989) (same standard applied as used for civilly committed patients); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988) (no distinction in right to refuse treatment between groups of patients: this right applied wherever right of privacy infringed by intrusive medical treatment). But see State v. Otero, 570 A.2d 503 (N.J. Super. Ct. Law Div. 1989) (court can order defendant to take antipsychotic medication to achieve sufficient competency to stand trial).
242. See also Williams v. Wilzack, 573 A.2d 809, 820 n.8 (Md. 1990) ("The fact that the inmate has been involuntarily institutionalized in a psychiatric facility is not tantamount to a finding that he is mentally incompetent to make treatment decisions.").
243. See also Jarvis, 418 N.W.2d at 139 (The court did not address the danger of such objections and noted only that by shifting responsibility for such decisions to a judicial forum, the physician and hospital were now completely free from future potential liability).
244. State ex rel Jones v. Gerhardtstein, 416 N.W.2d 883, 894 (Wis. 1987) ("While dangerousness may legitimately justify the state's authority to involuntarily commit an individual, it does not justify the abrogation of the individual's right of informed consent with respect to psychotropic drugs.").
gers posed by such drugs, including their potential for causing substantial side effects, and the counter-therapeutic effect of forcing their administration. Thus, a second prevalent concept of the 1980s and 1990s, that the dangerousness of the MDO is an overriding and critical issue, was also largely disregarded by the Wisconsin court. The court did note, however, that in the midst of an emergency, where necessary to prevent serious physical harm to the patient or others, the procedural safeguards it was prepared to impose could be bypassed. 245

Moreover, the court made it clear that it was not willing to defer to the professional judgment of the treating staff regarding such decisions, 246 thereby obviating another recurring premise of the 1980s and 1990s. The court asserted that "[c]onstitutional guarantees may not be replaced by professional judgment, and their protection and enforcement cannot be considered to be judicial interference." 247 The court strongly criticized the federal district court's argument that sufficient safeguards were provided by requiring that a physician prescribe the psychotropic drugs. The state court responded that professional standards and the exercise of professional judgment did not guarantee the appropriate application of the law. The court concluded that a judicial ruling was required to determine that an individual was incompetent to make a treatment objection, and that the professional judgment of a treating physician to that effect was not sufficient by itself. 248

245. See also Williams, 573 A.2d at 809 (right to forcibly medicate in emergency situation not contested).

246. See Jarvis, 418 N.W.2d at 147-48 (The court, refusing to accept a deferential role regarding treatment decisions, asserted "courts cannot abdicate all responsibility for protecting a committed person's fundamental rights merely because some degree of medical judgment is implicated."). The court reasoned that the Youngberg professional judgment rule provided insufficient protection of individual's rights. See Youngberg v. Romeo, 457 U.S. 307, 321 (1982). "When medical judgments collide with the patient's fundamental rights, as in this case, it is the courts, not the doctors, who possess the necessary expertise. . . . [This] is ultimately not a medical decision, but a personal choice." Jarvis, 418 N.W. 2d at 147-48. The court also implied that mental health professionals could not be trusted to protect best interests of patient, and noted "we recall that mental patients in the past have been used as tools for experimentation and new techniques." Id. at 148. The court concluded that additional restrictions would not place unreasonable burdens on treating professionals.

247. Jones, 416 N.W.2d at 896.

248. See also People v. Gilliland, 769 P.2d 477 (Colo. 1989).
Finally, the court concluded that a full judicial hearing was required in order to protect the individual's rights, with the burden on the State to show the patient was not competent to make such an objection. The court asserted that "an adversarial setting is necessary in order to avoid having individuals routinely declared incompetent for the sake of mere convenience, control or expense." Thus, the court dismissed the other prevalent concept of the 1980s and 1990s, namely that an informal, non-adversarial procedure could be the most appropriate procedure for resolving issues pertaining to the MDO.

The decision by the Wisconsin Supreme Court in *Jones* closely resembles a number of other state court opinions that mandate judicial review before overriding an objection to psychotropic medication. Similar review procedures have been required for MDOs and patients civilly committed, with the individual's interests in refusing such medication outweighing the State's interests in administering psychotropic medication over objection. In addition, state courts have set out specific procedural requirements besides judicial review that must be satisfied, including: (1) the MDO be given advance notice of the proceeding; (2) the MDO have the right to be present, to present evidence, to cross-examine witnesses, and to have the assistance of an advisor who understands the psychiatric issues involved; and (3)

249. See also *Williams*, 573 A.2d at 809 (right to judicial review of administrative panel decision before implementation of decision); *Gilliland*, 769 P.2d at 477 (absent emergency, antipsychotic medication may be administered to nonconsenting hospitalized insanity acquittee incapable of making informed treatment decision only after trial court conducts full and fair hearing and is satisfied by clear and convincing evidence the requisite standard for administering treatment over objection is met); *Steen*, 437 N.W.2d at 101 (because of patients' vulnerability, representation by counsel and/or a guardian ad litem should be integrated into proceedings); *Jarvis*, 418 N.W.2d at 139 (court established formal, adversarial judicial procedure for reviewing treatment decisions; number of very specific factors pertaining to prescribed treatment had to be considered).

250. *Jones*, 416 N.W.2d at 898.


252. See, e.g., *Williams*, 573 A.2d at 809 (proceeding inadequate where involuntarily hospitalized insanity acquittee only given five minutes notice of review proceeding).

253. *Id.* (proceeding inadequate where individual not permitted to be present except to explain reasons for refusing drugs, and where neither he nor his lawyer given opportunity to present evidence or cross-examine witnesses).
that where an objection is overridden, the order be specific both as to the nature of the treatment to be provided and its duration.254

Like the Wisconsin court, other state court opinions have generally disregarded the precepts otherwise driving judicial determinations of the 1980s and 1990s concerning the MDO. Why this result? Perhaps these courts believed that any behavioral outburst associated with a refusal of treatment would be manifested within the confines of a relatively secure mental health facility and be addressed by mental health professionals equipped to handle these outbursts.255 Because staff retain the ability to administer treatment over objection in a true emergency, the state judiciary may have concluded that there was little likelihood that the public would be placed at risk by outbursts that might occur as a result of the more extensive review process they imposed and, therefore, the interests of the MDO (as well as civil patients in general) should be given greater recognition in this context. It remains to be seen whether state courts will continue to adhere to such a position if community placements are utilized more frequently for MDOs, creating the possibility that a behavioral outburst associated with a refusal to accept psychotropic medication will occur in the midst of the community. In addition, unlike a right to treatment that would encompass a wide range of issues and have the potential to embroil the courts in many aspects of mental health treatment, the state judiciary may have considered formal judicial review procedures for overriding an objection to psychotropic medication relatively easy to administer.

In contrast to these state court holdings, the federal courts continue to take a relatively restrictive view of the right of MDOs to refuse treatment and, in so doing, adhere to many of the fundamental premises underlying judicial opinions of the 1980s and 1990s regarding MDOs in general.

For example, the Fourth Circuit Court of Appeals, sitting en banc, ruled on an objection to anti-psychotic medication by an individual involuntarily committed for psychiatric evaluation and treatment af-

254. See, e.g., In re Lambert, 437 N.W.2d 106 (Minn. Ct. App. 1989) (need for specific court order outweighs burden on physicians from having to spend more time in court shaping such orders); In re Steen, 437 N.W.2d 101 (Minn. Ct. App. 1989) (treating physician not to be given carte blanche in determining course of subsequent treatment; trial court’s selection of six-month period of medication unsupported by evidence in record and order failed to state acceptable dosage of medication; order should be sufficiently flexible to allow for modification of levels or substitution of equivalent drugs, but cannot permit open-ended orders regarding duration and levels of unspecified medications).

255. In contrast, a right to treatment might hasten release from a mental health facility, and thereby place the community at risk.
The court rejected the MDO’s argument that a judicial determination of incompetency to make medical decisions was required before he could be medicated without consent. Instead, the court emphasized: (1) the limited ability of the judiciary to make treatment decisions; (2) the superior skill of the treatment staff and the necessity of deferring to their professional judgment; and (3) the inappropriateness of an adversarial hearing to resolve such issues. Although it did not specifically address the need to protect society from the MDO, the court did stress the government’s “duty to attempt to restore [the individual’s] mental competency so [he] may be returned to the free society.” The court was also concerned about the administrative burden and delay that would be imposed by court review of an objection to treatment and believed that it would hamstring the ability of treatment staff to respond to their patient’s needs and inappropriately force the courts to make treatment decisions. Other federal courts have reached similar decisions.

These cases generally do not address the need to protect treating staff from sudden and violent outbursts by the MDO. Judicial opinions typically fail to note that treating professionals have relatively

257. Id. at 312.
258. Id.
259. Id.
260. Id. (The patient’s proposed regime would make it “practically impossible for the responsible medical personnel to act as expeditiously as sound medical judgment might dictate in some circumstances.”).
261. Id. at 310 (Judicial review process “poses high risks to the integrity and trustworthiness of the courts’ already perilous involvement—out of necessity—in the adjudication of complex states of mental pathology.”).

The interests of the state weigh heavily in restraining and treating an assaultive person vis-à-vis that person’s individual right to refuse treatment. . . . Dautremont was administered psychotherapeutic drugs to prevent possible injury to himself or others in light of his threat to assassinate the President and in light of his demonstrated ability to willfully injure himself.eb;
limited ability to reject or remove difficult and/or dangerous clients that are MDOs and, short of medicating the MDO, may have limited ability to control the MDO's behavior. Most courts do recognize a right to administer antipsychotic medication over a patient's objection when an emergency arises (i.e., when necessary to prevent physical harm to the patient or others). It may be that courts feel treatment staff are adequately protected by this allowance. However, courts generally attach limitations to this staff prerogative and the complexity of determining what constitutes an emergency may result in staff hesitating or failing to respond quickly to a dangerous patient, thereby placing themselves at risk from a subsequent violent outburst. As will be discussed, this interest has been given somewhat more attention by the courts when the right to refuse treatment is raised by sentenced MDOs.

(b) Prisons.

Historically, few judicial opinions have addressed whether sentenced MDOs, i.e., prison inmates, have a right to refuse psychiatric treatment. This may have been a function of the relatively limited amount of such treatment historically given in prison. In addition, wide discretion was traditionally given prison officials in administering their prisons. However, with (1) an increase in recognition of the right of prisoners to mental health treatment, (2) accompanying expansions in the nature of the treatment provided and the number of inmates receiving it, and (3) closer judicial scrutiny of the treatment provided, it was perhaps inevitable that closer attention be given to an asserted right of prisoners to reject the treatment offered.

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263. See, e.g., Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984) ("The third interest asserted by defendants is the jail's duty to protect the jail staff and others from a violent detainee. Admittedly, this is a serious concern... [Plaintiff] does not dispute that forcible medication with antipsychotic drugs may be required in an emergency."). cert. denied, 469 U.S. 1214 (1985).

264. Id. at 1387.

265. There were earlier cases that challenged entire treatment programs designed specifically for prison inmates. See, e.g., Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973). However, these cases questioned the constitutionality of the program per se, and did not focus on the right of the individual prisoner to reject a treatment program that was otherwise acceptable and appropriate for other inmates. As a result, these cases will not be discussed in this part. See infra part III.B.3.

266. See, e.g., Charles H. Jones & Stephen M. Latimer, Liles v. Ward: A Case Study in the Abuse of Psychotropic Drugs in Prison, 8(1) New Eng. J. On Prison L. 1 (1982) (major legal barrier to recognition of right to refuse treatment co-terminus with that of non-sentenced MDOs and civil patients has been that the latter can rely on legal right to privacy denied to prisoners); Barbara A. Weiner, Legal Issues Raised in Treating Sex Offenders, 3(4) Behav. Sci.
Courts are beginning to address this issue. As with non-sentenced MDOs, the courts have almost exclusively focused on the administration of antipsychotic medication. Furthermore, although there are few cases, there appears to be a potential split similar to that found with non-sentenced MDOs. Namely, the state courts may recognize a relatively expansive right, while the federal courts narrowly circumscribe it.

On the federal side, the Supreme Court in *Washington v. Harper* ruled that although an inmate has a protected constitutional liberty interest in avoiding the forced administration of antipsychotic drugs, this interest must be balanced against the State's interests in prison safety and security. In considering this balance, courts must consider the impact of any proposed policy on the allocation of prison resources generally and the need to ensure the safety of prison guards, administrative personnel, other inmates, and the prisoner. The Court particularly emphasized the danger posed to others by a behavioral outburst by a MDO in this setting. In line with other cases of the 1980s and 1990s that tend to defer to the professional judgment of treatment staff, the Court stated that "prison authorities are best equipped to make difficult decisions regarding prison administration."

The Court found that, taking these considerations into account, the procedure used by the State of Washington to override an inmate's objection to antipsychotic medication was constitutionally sound. An inmate could be subjected to involuntary treatment with drugs only if the inmate suffered from a mental disorder and was gravely disabled or posed a likelihood of serious harm to him or herself, others, or their property. The order for medication had to be

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& L. 325 (1985) (since mental patient is deprived of liberty for specific purpose of treatment, a prisoner incarcerated for punishment should have a greater right to refuse to participate in treatment program); Kevin Walker, *Prisoner Medical Refusals: A Response for New Jersey*, 16 RUTGERS L.J. 117 (1984) (like their civilian counterparts, prisoners have right to be "let alone," although this right diminishes when the safety of the community is involved).


269. *Id.*

270. *Id.* at 225 ("There are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, 'by definition,' is made up of persons with 'a demonstrated proclivity for antisocial criminal, and often violent, conduct.'" (quoting *Hudson v. Palmer*, 468 U.S. 517, 526 (1984))).

271. *Id.* at 223-24.

272. *Id.* at 230.

273. *Id.*
made by a psychiatrist, and if the inmate objected, the inmate was entitled to a hearing before a special committee consisting of a psychiatrist, psychologist, and the associate superintendent of the facility, none of whom could be involved in the inmate's treatment or diagnosis at the time of the hearing, contrary to previous procedures which allowed such involvement. The committee could override the inmate's objection by a majority vote, provided the psychiatrist was in the majority. The inmate had to be given twenty-four hours' notice of the hearing, during which time the inmate could not be medicated. The inmate also had to be given notice of the tentative diagnosis, the factual basis for the diagnosis, and the reason the staff believed medication was necessary. At the hearing, the inmate had the right to attend, present evidence (including witnesses), cross-examine staff witnesses, and be assisted by a lay advisor who understood the psychiatric issues involved and was not otherwise involved in the case. The inmate had a right to appeal the decision to the superintendent of the facility within twenty-four hours and also to seek judicial review by a special writ. Finally, medication could continue only with periodic review.

The Court held that the decision to medicate did not have to be made by a judge or some "outside decisionmaker." Indeed, the Court suggested that the inmate's interests may be better served by allowing such decisions to be made by medical professionals from the treatment facility. As in other cases of the 1980s and 1990s involving MDOs in general, the Court noted the limitations on the judiciary's ability to make such decisions and indicated that medical personnel associated with the treatment facility are better equipped to make such decisions. In particular, the Court pointed out that where a patient is mentally disturbed, it will be difficult to assess the intentions of the patient and such intentions are likely to change over

274. Id. at 228.
275. Id. at 215.
276. Id. at 268.
277. Additionally, minutes of the hearing were to be kept and a copy provided to the inmate.
278. The review had to be filed in state court by means of a personal restraint petition or extraordinary writ.
279. A similarly composed committee had to initially review the treatment after seven days, and the treating psychiatrist had to review the case and prepare a report for the Department of Corrections medical director every 14 days thereafter.
280. Id. at 235 n.13.
281. Id. at 235.
282. Harper, 494 U.S. at 235 ("[I]t is only by permitting persons connected with the institution to make these decisions that courts are able to avoid unnecessary intrusion into either medical or correctional judgments." (quoting Vitek v. Jones, 445 U.S. 480, 496 (1980))).
time. As a result, a single judicial hearing is not likely to assess the patient’s intention accurately or be able to make a substituted judgment approximating those intentions. Instead, what was needed were frequent and ongoing clinical observations by medical professionals. In addition, although noting that the decision to medicate has societal and legal implications, the Court emphasized the predominantly medical nature of the inquiry into whether the inmate suffered from a mental disorder and whether, as a result of that disorder, the inmate was dangerous to him or herself, others, or their property. Furthermore, the Court was concerned that requiring judicial hearings would divert scarce prison resources, including both money and staff time, from the treatment of mentally ill inmates. As a result, the Court held that “[a] State may conclude with good reason that a judicial hearing will not be as effective, as continuous, or as probing as administrative review using medical decisionmakers. We hold that due process requires no more.”

Even before Harper, as with non-sentenced MDOs, federal courts had generally limited the right of a sentenced MDO to object to treatment. In particular, adopting themes utilized throughout the 1980s and 1990s in decisions pertaining to the MDO in general and relying heavily on the rationale set out by the Supreme Court in Youngberg, federal courts had restricted the role of the judiciary in reviewing a decision to proceed with treatment over the MDO’s objection.

These courts focused heavily on the dangerousness issue. One court stressed that, “Correctional officers and agencies have a duty

283. Id.
284. Id. at 244.
285. Id. at 232.
286. Id. at 233. The Court also held that where the State provided the inmate with the assistance of an independent lay advisor who understood the psychiatric issues involved, it was not constitutionally required that the inmate be represented by counsel. Id. at 236.
288. See, e.g., Gilliam v. Martin, 589 F. Supp. 680 (W.D. Okla. 1984) (prison officials’ administration of antipsychotic medication over prisoner’s objection upheld under Due Process Clause and Eighth Amendment Cruel and Unusual Punishment Clause; no need to establish an appeal process, judicial or otherwise); Osgood v. District of Columbia, 567 F. Supp. 1026 (D.D.C. 1983) (dismissal of claims that forcible administration of psychotropic drugs interfered with plaintiff’s Sixth Amendment right to assistance of counsel, Eighth Amendment right to be free from cruel and unusual punishment (noting that nothing in the record suggested that it was administered as punishment rather than treatment), and Ninth Amendment right to privacy; plaintiff might have a due process or First Amendment Free Exercise of Religion claim, but these must give way where such action is mandated by compelling state interest in need to protect safety of others).
289. See, e.g., Gilliam, 589 F. Supp. at 682. Noting the inmate’s lengthy medical and psy-
not only to protect society from dangerous inmates, but must also take whatever procedures are appropriate in protecting inmates from each other and protecting correctional officers from violent inmates." These courts also recognized the importance of deferring to the professional judgment of the treating staff when assessing the objection to treatment. Nevertheless, at least one court ruled that an inmate's objection to psychotropic medication can be overridden only when there is no less intrusive alternative action available, a theme widely espoused in the 1960s and 1970s. However, the Supreme Court in Harper seemed to discount this position when it concluded that physical restraints or seclusion are not acceptable substitutes for antipsychotic drugs, that the absence of ready alternatives is evidence of the reasonableness of a prison regulation, and that prison officials do not have to "set up" and then "shoot down" every conceivable alternative method of accommodating the inmate's constitutional complaint. Finally, federal courts have concluded that regardless of the procedure set in place to override an inmate's objection to psychotropic medication, that process could be bypassed in an emergency to protect the safety of the inmate or others.

chotic history, when tranquilizer medication was removed he quickly regressed to violent, abusive, destructive and disruptive behavior, his failure to recognize medication had positive effect upon him, and his unwillingness to concede that he now or ever had suffered from mental illness, court found,

In this court's view, any rights which may be possessed by petitioner to be free from being subjected to the forcible administration of medication are overridden by the clear indication, established on numerous occasions, that the failure of petitioner to take such medications will result in his regression and the reappearance of his dangerous, psychotic behavioral tendencies. Id.

Osgood, 567 F. Supp. at 1030 ("[T]he constitutional rights [plaintiff] asserts were violated by the forcible administration of Haldol are not absolute, and must give way at least where such action is mandated by a compelling state interest: in this case, the need to protect the safety of others.").

290. See, e.g., Gilliam, 589 F. Supp. at 682.

291. See, e.g., Osgood, 567 F. Supp. at 1036 (citing Youngberg, court stated, "In resolving these issues some deference must be afforded to the findings of the professionals involved.").

292. Id. at 1031 ("A 'compelling state interest' will justify actions of the type at issue . . . only when there is no reasonable alternative action that is less intrusive upon those rights").


Physical restraints are effective only in the short term, and can have serious physical side effects when used on a resisting inmate, as well as leaving the staff at risk of injury while putting the restraints on or tending to the inmate who is in them. Furthermore, respondent has failed to demonstrate that physical restraints or seclusion are acceptable substitutes for antipsychotic drugs, in terms of either their medical effectiveness or their toll on limited prison resources. (citations omitted).

Id. at 226-27.

294. Id. at 224.

295. Id. at 225.

296. See, e.g., Chambers v. Ingram, 858 F.2d 351 (7th Cir. 1988) (without deciding whether
Although it can be expected that the Supreme Court's opinion in *Harper* will carry considerable weight, state courts may still find a right to judicial review based on state law.\textsuperscript{297} Indeed, the state trial court that initially heard *Harper* was asked to decide whether the failure to provide a judicial hearing violated state tort law and the Washington State Constitution (as well as the federal constitution).\textsuperscript{298} However, as the Washington Supreme Court based its determination exclusively on federal law, and it was this interpretation of federal law that was reviewed by the United States Supreme Court, the potential remains that, similar to what has occurred with non-sentenced MDOs, a separate body of state law concerning an inmate's objection to treatment may yet evolve.\textsuperscript{299}

Although state courts have had little opportunity to address this issue since *Harper*, earlier state court opinions did recognize a right to judicial review of an inmate's objection to treatment under state law.\textsuperscript{300} In addition, a wide range of other requirements have been imposed.\textsuperscript{301} Yet, unlike state court opinions recognizing a right of non-

forcing inmate placed in correctional facility's psychiatric unit to ingest psychotropic drugs (Haldol) violated due process clause, court concluded that there was an emergency exception to this right when patient constituted an immediate threat to own life or safety of others.)


\textsuperscript{298} Harper v. State, 759 P.2d 358 (Wash. 1988), rev'd, 494 U.S. 210 (1990). The trial court had ruled that a failure to provide judicial review did not violate state law.

\textsuperscript{299} See also People v. Delgado, 262 Cal. Rptr. 122 (Cal. Ct. App.), review denied, opinion withdrawn by order of court, 1989 Cal. LEXIS 2460 (1989) (procedure for overriding objection to treatment governed by state, not federal, law).

\textsuperscript{300} See, e.g., Large v. Superior Court, 714 P.2d 399 (Ariz. 1986) (upheld prisoner's right to file petition with judiciary seeking to prohibit being forcibly administered psychotropic drugs after transferred to mental health inpatient treatment facility operated by Arizona Department of Corrections); Keyhea v. Rushen, 223 Cal. Rptr. 746 (Cal. Ct. App. 1986) (statutory enactment creating "bill of rights" for prisoners broadly read as establishing right for prisoners to refuse long-term treatment (in excess of 10 days by agreement of parties) with psychotropic drugs absent judicial determination of incompetency). But cf. Harmon v. McNutt, 587 P.2d 537 (Wash. 1978) (inmate could object at a judicial hearing to transfer to separate mental health unit and treatment expected to receive there; however, once transfer authorized and completed, inmate not entitled to judicial hearing when he subsequently objected to forcible injection of psychotropic medications designed to alleviate his psychosis).

\textsuperscript{301} See, e.g., People v. Woodall, 257 Cal. Rptr. 601 (Cal. Ct. App.), review denied, opinion withdrawn by order of court, 1989 Cal. LEXIS 3119 (1989) (prison officials must show no less intrusive means of insuring prison security; in rejecting State's argument that no generally accepted medical alternative to stabilize an acutely psychotic patient, notes availability of physical restraints or isolation; requirement will help prevent inappropriate use of involuntary medication for convenience of staff; burden can be met by testimony of state's physician); Keyhea, 223 Cal. Rptr. at 756 ("Mental health professionals and prison administrators may find this requirement [of judicial review] cumbersome, but this is a price of life in a free society. Forced drugging is one of the earmarks of the gulag. It should be permitted in state institutions only after adherence to stringent substantive and procedural safeguards.").
sentenced MDOs to refuse treatment, these opinions also placed an emphasis on the importance of not jeopardizing institutional security or public safety. Furthermore, although generally finding that neither was jeopardized by recognizing a right to judicial review, they also placed an emphasis on the importance of not jeopardizing institutional security or public safety. Furthermore, although generally finding that neither was jeopardized by recognizing a right to judicial review, they also appeared prepared to place limitations on the right to object to treatment.

Judicial opinions addressing the right of inmates to refuse treatment, as was the case for non-sentenced MDOs, also typically give little attention to the potential impact of recognizing a right to object to treatment on the treating mental health professional. This may reflect a questionable assumption on the part of the judiciary that the secure nature of the prison environment minimizes the likelihood this issue will impact on the safety of the treating staff or other inmates/patients or effect the therapeutic relationship. In addition, it may be a result of the fact that the interests of the treatment staff are typically not directly represented in such controversies.

The lack of attention in these cases to public safety issues may also result from the courts' narrow perspective. While the MDO is securely held within the confines of a psychiatric facility or a prison, there may be little potential impact on public safety (setting aside the

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302. See, e.g., Keyhea, 223 Cal. Rptr. at 755 n.12 ("Public safety is not an issue here"); recognition of this right will not threaten prison security (court focused solely on issue of prisoner transportation and attendance at judicial hearings). See also Harmon, 587 P.2d at 537.

303. See, e.g., Woodall, 257 Cal. Rptr. at 601 (holding that intermediate standard of clear and convincing evidence should be applied in determining whether required showing that inmate was dangerous to others had been met, rejecting inmate's assertion that reasonable doubt standard should be applied; court reasoned that intermediate standard properly balanced reasonable security interests of facility where inmate held while yet respecting inmate's rights).


305. For example, it can be argued that the recognition of this right: (1) undercuts the authority of the treatment staff leading to a lack of confidence in and reliance upon the staff by the MDO; (2) introduces multiple decision makers that slow progress because of the uncertainty and confusion resulting from conflicting treatment decisions; (3) undermines the confidence and morale of the treating staff as they become preoccupied with what the judiciary will rule regarding their decisions; and (4) results in treatment decisions being made according to legal rather than clinical criteria.

306. These lawsuits generally align a patient or group of patients against the State which has committed or incarcerated the patient(s) or against the agency or facility housing them. The treating mental health professional is often not a party to such lawsuits, and if he or she is, generally the mental health professionals' position is subsumed by that of the State, agency, or facility. Because they indemnify the mental health professional, the State, agency, or facility may presume to speak on behalf of the treating staff. However, their interests and those of the treating mental health staff may not fully coincide.

If treatment staff feel their concerns are not being adequately addressed in these judicial opinions, there are a number of options they can pursue. For example, they can launch empirical studies substantiating their concerns, they can lobby with the party representing them to more directly raise their concerns, or they can contact their professional organizations to interject themselves more frequently in such controversies as amici.
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possibility of escape). This, however, fails to recognize that ultimately the MDO is released back into the community. If the psychological problems of the MDO have been left untreated, the likelihood of a relapse may increase, potentially endangering public safety.\footnote{307}

It should be noted that where the sentenced MDO is placed in a situation where he or she can directly interact with the community, for example, as a resident of a half-way house or while on probation, the courts have been far more responsive to issues of public safety. As will be discussed in the section on status changes,\footnote{308} in such a context, the courts have been less willing to accord an expansive recognition of the rights of the MDO vis-a-vis the State.

One final issue that courts have only begun to explore involves whether an inmate on death row can be administered psychotropic medication over objection so that the inmate can be restored to competency in order to be executed. Because capital punishment cannot be carried out on an individual who is not currently competent,\footnote{309} ostensibly an inmate can avoid the death penalty indefinitely by refusing psychiatric treatment that would restore competency. A Louisiana trial court ruled that state prison officials can forcibly medicate an inmate under these circumstances. However, the U.S. Supreme Court in a one sentence \textit{per curiam} decision vacated and remanded this decision for further consideration in light of its opinion in \textit{Harper}.\footnote{310} This issue likely will receive further attention by the judiciary.

3. \textit{The Treatment Program}

As discussed, there is now a general expectation that some form of treatment will be provided an involuntarily confined MDO, regardless of the setting. Furthermore, incentives for participating in treatment programs have been upheld.\footnote{311} Notwithstanding an MDO's right

\footnote{307} Furthermore, there is some indication that for certain diagnoses, the longer treatment is deferred, the more recalcitrant the problem becomes and the less responsive to subsequent treatment.\footnote{308} \textit{See infra} part III.C.\footnote{309} \textit{See, e.g.}, Ford v. Wainwright, 477 U.S. 399 (1986).\footnote{310} Perry v. Louisiana, 498 U.S. 38 (1990). The questions placed before the Court were: (1) does the Eighth Amendment's prohibition against cruel and unusual punishment bar a State from forcibly medicating an inmate to restore competency? and (2) does the Fourteenth Amendment's due process guarantee allow the prisoner the right to refuse such medication? \textit{See Forcible Medication to Restore Competency for Execution Reviewed}, 10(2) \textit{Dev. in Mental Health L.} 27 (1990).\footnote{311} \textit{See, e.g.}, Patterson v. Webster, 760 F. Supp. 150 (E.D. Mo. 1991) (upholding use of Missouri Sexual Offenders Program which all prisoners convicted of sexual assault crimes were required to complete prior to qualifying for early release/parole and before being given other privileges available to inmates in general).
to object to treatment, are there limitations on what constitutes an acceptable treatment program?

While this question has not been widely discussed, courts have imposed at least four such limitations. First, the courts have looked closely at whether the treatment program is being used more for punishment than for treatment, with accompanying physical or psychological pain. Second, they have been somewhat reluctant to approve experimental programs where there is little evidence that a successful outcome will result. Third, courts have focused on the intrusiveness of the treatment program. Fourth, and somewhat overlapping with the first three, courts tend to scrutinize whether the informed consent of the MDO to participate in the treatment was appropriately obtained. Each of these limitations, however, is potentially subject to modification when the protection of society becomes a factor. Typically, the rationale used in analyzing treatment programs for the MDO has differed little from that used in evaluating treatment decisions in general regarding the MDO.

(a) Aversive Therapies.

"Aversive therapies," those therapies that cause the patient physical or psychological harm, have particularly drawn the attention of the courts. Relying on the psychological principles of punishment or negative reinforcement, these therapies typically attempt to associate an unpleasant event with an undesirable behavior in an effort to reduce the frequency of the undesirable behavior. Critics of this approach question whether one human being can ethically inflict pain on another and whether these techniques have the ability to induce long-term beneficial effects. Of greater interest to the judicial system, however, have been claims that aversive therapies were used to administer punishment rather than provide treatment, or, alternatively, used for administrative convenience and control rather than as an effort to help the individual improve and recover.

One of the first attacks on a therapeutic program, regardless of the setting, led to an opinion by the Ninth Circuit Court of Appeals and involved a sentenced-MDO. With his consent, a state prison inmate had been sent to a state medical facility to receive "shock treat-

312. Although the majority of these cases involved sentenced MDOs in establishing these bounds on what constitutes permissible treatment, courts provided little indication that these rationales would not apply equally to non-sentenced MDOs.
314. Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973).
ment." He complained that while there, without his consent and not as part of the shock treatment, he was administered a "breath-stopping and paralyzing fright drug" (succinylcholine) as part of a systematic program of aversive treatment for criminal offenders.315 The Ninth Circuit ruled that if the inmate could prove his claim, it would "raise serious constitutional questions respecting cruel and unusual punishment or impermissible tinkering with the mental processes."316

Similarly, the Eighth Circuit Court of Appeals ruled that administering a drug (apomorphine) designed to induce vomiting as part of an aversive therapy program for inmates at the Iowa Security Medical Facility constituted cruel and unusual punishment under the Eighth Amendment.317 The drugs were administered following alleged violations of a behavioral protocol established for the inmates by their treatment staff.318 The court noted testimony that characterized this approach as a "highly questionable technique" with a relatively low success rate.319 However, the court did not totally ban the use of this technique, but instead established strict procedures governing its use.320 Without extensive discussion, the court indicated that the key factor in determining its acceptability was whether this technique was being used for treatment or punishment, with only the former being permissible.321 The court was also particularly concerned about the "painful and debilitating" aspects of this treatment.322

Shortly thereafter, another federal court issued a similar ruling with regard to non-sentenced MDOs.323 A federal district court in

315. Id.
316. Id. at 878. A lower court dismissed the inmate's complaint prior to trial as not stating a constitutional claim. The Court of Appeals reversed this finding, thereby allowing the inmate to go forward in an attempt to prove his allegations. Id.
318. Id. at 1138.
319. Id.
320. Among these procedural requirements was that it be administered only to patients who knowingly and intelligently consented to it. See infra part III.B.3.d.
322. Id.
Pennsylvania noted that the involuntary administration of drugs that have a painful or frightening effect to an inmate at a state hospital for the criminally insane may amount to an unwarranted governmental intrusion into the patient's thought processes in violation of his constitutional right of privacy.  

A state court opinion issued during this time period further indicates that the judiciary is likely to be skeptical of and closely scrutinize an aversive therapy program. In reviewing a number of techniques used to treat psychological disorders, including aversive therapy, the Minnesota Supreme Court said that in assessing such techniques it would examine the extent and duration of their impact, the risk of side effects, and the amount of pain induced. However, this court also noted that this assessment would be weighed against any legitimate and important State interest that would be furthered by using this technique, suggesting that it might be more amenable to the technique if it furthered security or personal safety interests.

In a more recent federal court opinion, the court expanded the nature of the harm imposed by a treatment program that is subject to scrutiny, and insisted on an individualized treatment program. This court held that the "Levels System" used at the Kentucky correctional institution for women violated the Due Process Clause because it imposed restrictions on certain basic privileges and was not shown to be reasonably related to a legitimate penological goal. The court was concerned that the treatment program regulated virtually all aspects of the lives of the inmates. In assessing the system, the court refused to defer to the mental health professionals in charge of the program, noting that "[c]ourts are not the best forum for testing the validity of scientific theories, but Courts are well equipped to determine if a system is punitive." While recognizing that there could be situations where such a program could be appropriately applied to

324. As in Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973), the court refused to dismiss the inmate's complaint for failing to state a recognizable legal claim.
326. Id. at 913. Other factors the court said it would examine were whether the technique was widely accepted among treatment professionals or regarded as experimental, the intrusiveness of the technique, and the patient's ability to assess the treatment. See infra part III.B.3.b.-d.
327. Id. at 911.
329. Id. at 206.
330. Id. at 180 ("The Levels System is a behavior modification program which regulates virtually every dimension of each inmate's life at KCIW. It controls visitation, phone calls, receipt of packages, bedtime, personal belongings, clothing, cosmetics, television viewing, recreation, bedding, and many other facets of daily existence.").
331. Id. at 187.
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individual inmates, the court rejected its imposition here on an across-the-board basis. The court ruled that the Due Process Clause creates

the right to be free from the unique kinds of deprivations of liberty which are necessary components of this punitive form of behavior modification, unless the state shows that the imposition of such a system is appropriate for a particular individual. Absent such an individualized showing, the imposition of a punitive behavior modification system on an inmate would be punishment that is purely arbitrary and thus violative of due process.332

The court rejected the State's argument that this program promoted the maintenance of institutional security or preserved internal order and discipline, asserting instead that it may well have impeded the achievement of these goals.333 Furthermore, the court found that the harmful impact of the program was established by the inmates' "unusually high levels of stress, tension and sleep disturbance, and by [their] widespread reliance on psychotropic drugs."334 The court concluded that "'[p]ersons convicted of crimes deserve to be punished, but this does not give the state license to make prisoners objects of unguided behavior control experiments.'"335

(b) Experimental Techniques.

A variable that may trigger extensive judicial scrutiny of a treatment program administered to an MDO is its lack of wide use and acceptance among mental health professionals. The controversy over the use of aversive therapies has been fueled in part by a lack of consensus over their efficacy and concern that such techniques are util-

332. Id. at 208-09.
333. Id. at 209.
334. Id. at 188.
335. Id. at 209. But cf. Green v. Baron, 879 F.2d 305 (8th Cir. 1989) (holding that behavioral modification program for pretrial detainees based on deprivation and reward framework constitutional; patients initially confined in barren isolation cells and earned necessities, comforts, and privileges by proper behavior; impermissible to deprive detainees of basic human necessities (including light, heat, ventilation, sanitation, clothing, proper diet), as they retain their right to a safe and healthy environment; however, not an absolute prohibition against deprivation of necessities as part of treatment program, depends on degree and duration of such deprivations and surrounding circumstances; program must be related to legitimate governmental purpose and not be excessive in relation to purpose; one permissible purpose is to stabilize detainee's behavior so can attend and participate in criminal trial; discomfort alone does not violate Constitution; this program not attempted until all other treatment efforts failed, deprivations considered vital to success of program, program designed and supervised by medical personnel, detainee not endangered and deprivations not excessive).
ized on a let's-try-it-and-see-if-it-works basis when all else has failed.

Modern law regarding human experimentation developed from the Nuremburg Code, which in turn was established by the international court that tried twenty-three German physicians for their experiments on prisoners of war and civilians during World War II.336 The international court, which tried these physicians, ruled that before an individual could be placed into an experimental program, the person's informed consent had to be obtained first.337 Without that consent, the individual could not be a participant.

One of the most frequently cited opinions on the use of an experimental treatment program was issued by a Michigan trial court.338 In this case, an individual who had been committed under the Michigan Criminal Sexual Psychopathic law challenged a proposal to expose him to experimental psychosurgery. The court was concerned that the therapy involved was irreversible and often led to the blunting of emotions, memory, affect, and creativity.339 The court concluded that the individual had a First Amendment right to be free from interference with the mental processes.340 The standards developed in this case "have been widely quoted and applied to most forms of physically invasive psychiatric treatments."341

In a more recent case, the Michigan Court of Appeals overturned a sentence of five years probation issued to a defendant convicted of first-degree criminal sexual conduct.342 As a condition of probation, the defendant was required to submit to the administration of the experimental drug Depo-Provera in order to help control his sexual urges.343 In justifying this sentence, the trial court cited the necessity of protecting the public.344 On appeal, however, without reaching any constitutional issues, the court ruled that under Michigan law this program was an "unlawful" condition of probation.345 Focusing in

337. Id.
338. Kaimowitz v. Department of Mental Health, No. 73-19434-AW (1973) (reported in MENTAL & PHYSICAL DISABILITY L. REP. 147 (1976)).
339. Id.
340. Id.
343. Id. at 314.
344. Id.
345. Id.
part on its experimental nature, the court stated, "Our research reveals that no appellate court in the United States, either state or federal, has ever passed upon or approved either voluntary or mandatory treatment of sex offenders with . . . Depo-Provera." The court added, "The Depo-Provera treatment prescribed by the trial judge also fails as a condition of probation because it has not gained acceptance in the medical community as a safe and reliable medical procedure."

Although not frequently the center of discussion, other courts have been concerned about the experimental nature of treatment programs for MDOs they have struck down. In general, these courts also appeared to be seeking evidence that showed either that the treatment was being used elsewhere on similar patients in similar environments or that it had been approved by the medical community.

The small number of cases discussing the use of experimental techniques in treating the MDO may be a result of the relative lack of such programs attempted with this population. Alternatively, it has been suggested that judicial opinions that have struck down or greatly restricted correctional research have had such a chilling effect that research has virtually halted in correctional settings to the detriment of the MDO.

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346. _Id._ at 315. The court also noted the wide range of adverse reactions produced by the drug, that participation in its use had always been voluntary and in conjunction with psychotherapy, and that its originator had received criticism for it.

347. _Id._

348. _Id._ at 316. It should be noted that commentators have attacked this opinion as overstating the experimental nature and risks of Depo-Provera. See, e.g., Dennis H. Rainear, _The Use of Depo-Provera for Treating Male Sex Offenders: A Review of the Constitutional and Medical Issues_, 16 TOLEDO L. REV. 181 (1984).

349. See, e.g., Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973) (use of apomorphine at inmate medical facility); Mackey v. Procunier, 477 F.2d 877, 878 n.1 (9th Cir. 1973) (plaintiff can attempt to show "defendants are engaged, without patient consent, in a course of medical experimentation to ascertain whether, by instilling of fright and infliction of pain, accompanied by psychological suggestion, behavior patterns can be affected"); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988). With regard to civil patients, see Lojuk v. Quandt, 706 F.2d 1456, 1466 (7th Cir. 1983) (discussing alleged administration of ECT without consent, notes arguments concerning effectiveness of approach, with concern that "since the procedure is still so little understood, other adverse effects such as permanent brain damage and a slowing of brain waves are possible.").

350. See, e.g., Knecht, 488 F.2d at 1138 ("no evidence that the drug is used at any other inmate medical facility in any other state").

351. See, e.g., _id._ ("not possible to say that the use of apomorphine is a recognized and acceptable medical practice in [such] institutions"); Jarvis, 418 N.W.2d at 139 (acceptance by medical community of state is one of the criteria for determining whether treatment sufficiently intrusive to require judicial review prior to administration over objection).

352. _See_ Bruce J. Winick, _A Preliminary Analysis of Legal Limitations on Rehabilitative
In addition, all facilities that receive federal funding, which includes most psychiatric facilities, must follow certain federal guidelines governing research and experimentation involving patients. Among the requirements are that these facilities establish an institutional review board (IRB) to review such activities. Although state prisons typically do not receive federal funding and thus are exempt from these requirements, some states include similar requirements within their statutory schemes. For example, California has been the forerunner in legislatively limiting therapy and experimentation and has dictated that biomedical and behavioral research may not be conducted on prisoners without their informed consent unless an IRB concludes that the risks are outweighed by the sum of the benefits to the prisoner and the importance of the knowledge to be gained. Outside California, however, commentators have noted that few statutory controls exist on therapeutic interventions and experimentation with sentenced-MDOs, although increased regulation at both the federal and state levels is anticipated.

A mental health professional should carefully review state and federal law before embarking on an experimental program with sentenced or non-sentenced MDOs in order to ensure that the procedures utilized comply with applicable requirements. In addition, most professional codes of ethics similarly contain provisions relating to the conduct of experimental programs or research.

*Alternatives to Corrections and on Correctional Research, in* NEW DIRECTIONS IN THE REHABILITATION OF CRIMINAL OFFenders 328 (1981). "[R]ecent cases have had a chilling effect on correctional research—almost no research is presently being conducted in correctional settings in this country. . . . Although concern with prison experimentation is certainly legitimate, the categorical response it has evoked . . . seems inappropriate." *Id.* at 355. A continuum should be constructed for classifying various types of correctional research with emphasis on intrusiveness. *Id.* at 338. When research seriously invades bodily privacy or interferes with mental processes, strict judicial scrutiny of governmental interests asserted as well as means chosen to accomplish this end is appropriate; when this is not the case, research should be permitted either pursuant to informed consent or within appropriate procedural framework where informed consent not forthcoming. *Id.* at 346-50.


355. See Winick, supra note 352. In addition, California has generally, with certain limitations, granted competent prisoners and mental patients the right to refuse psychosurgery, shock therapy, or aversive conditioning, with a judicial order necessary for overriding objections. *Id.* at 330.

356. *Id.* at 331-32.

357. Although not yet recognized by the courts, some scholars suggest that researchers may
(c) Intrusive Treatments.

The intrusiveness of a treatment program has clearly served as a factor guiding judicial examinations of both aversive and experimental treatment programs. However, it has also been a key element in its own right for the judiciary when scrutinizing MDO treatment programs in general.358

For example, the Supreme Court of Minnesota held that involuntary treatment with neuroleptic drugs was an intrusive treatment per se and thus required court approval prior to administration.359 An earlier Minnesota opinion had identified ECT and psychosurgery as "intrusive" forms of treatment requiring prior judicial approval.360 The court based this conclusion upon a determination that such forms of treatment seriously infringe upon a committed mental patient's right of privacy.361 The Minnesota Supreme Court extended this classification to include neuroleptic drugs and reiterated that the potential impact of the more intrusive forms of treatment can be so severe that treatment decisions involving them cannot be left solely within the discretion of medical personnel.362 Although the court set forth several criteria for determining whether a treatment required judicial review,363 it focused heavily on a treatment's intrusiveness. In gauging intrusiveness, the court asserted that one should begin by examining "the probable effects of the particular therapy on the patient's body."364 The court also scrutinized the risk of adverse side effects and their potential for being permanent, irreversible, and life threatening.365 The court appeared to give the greatest weight to the

ultimately be subject to a duty to protect patients similar to that imposed on clinicians, particularly where the interaction between the researcher and research participant resembles that of the therapist-patient relationship. See Paul S. Appelbaum & Alan Rosenbaum Tarasoff and the Researcher: Does the Duty to Protect Apply in the Research Setting? 44 AM. PSYCHOLOGIST 885 (1989). Where the research subjects are MDOs, events or communications triggering such a duty may be more likely to occur because of the closed environment where the MDO resides and the relative volatility of the population may increase the likelihood of harm, potentially placing a greater burden on researchers to take appropriate steps. If given legal recognition, such holdings could further retard experimental studies conducted with MDOs.

358. As discussed earlier, the intrusiveness of the treatment has also been a central element in court decisions to grant MDOs a right to refuse the administration of psychotropic drugs. See supra part III.B.2.

361. Id. at 913.
362. Jarvis, 418 N.W.2d at 145.
363. Among the other criteria were the experimental nature of the treatment, its acceptance by the medical community of the state, and the patient's ability to competently determine for him or herself whether the treatment is desirable. Jarvis, 418 N.W.2d at 139.
364. Id. at 145.
365. Id. at 145-46.
risk of these side effects and their "potentially devastating" effect.\(^{366}\)

Although other courts have not placed as much weight on the intrusiveness of a challenged treatment program, it almost always assumed a key role in their discussion.\(^{367}\) This analysis has been relatively the same for both sentenced and non-sentenced MDOs.\(^{368}\) In addition to examining the nature of the intrusion,\(^{369}\) courts frequently compare the intrusiveness of the treatment (particularly potential side effects) to that of possible alternative programs.\(^{370}\) In addition, courts may consider the steps that can be taken to ameliorate the adverse effects associated with the treatment.\(^{371}\) Where a program is notably intrusive, particularly if it appears to be imposed more for the purpose of controlling behavior than for providing treatment, courts are more likely to disallow or place restrictions on its use.\(^{372}\) It should be noted, however, that courts tend to reach such conclusions only in the most egregious situations where there has

\(^{366}\) Id. at 146.

\(^{367}\) See, e.g., Large v. Superior Court, 714 P.2d 399 (Ariz. 1986) (court upheld prisoner's right to file petition with judiciary seeking to prohibit forcible administration of psychotropic drugs after transfer to mental health inpatient treatment facility operated by Arizona Department of Corrections); Wisconsin ex rel. Jones v. Gerhardstein, 416 N.W.2d 883 (Wis. 1987) (class action suit challenging involuntary treatment with psychotropic drugs).

\(^{368}\) See, e.g., Large, 714 P.2d at 399 (right to freedom from bodily restraint not affected by individual's status as convicted prisoner); Winick, supra note 352, at 338-44 (discussing right of prisoners to refuse treatment, court constructed continuum of intrusiveness on which various rehabilitative techniques used for all MDOs can be placed; court suggested analysis used in reviewing their appropriateness should not differ between sentenced and non-sentenced MDOs).

\(^{369}\) See, e.g., Large, 714 P.2d at 399 (extensive discussion of range of side effects and potency of antipsychotic drugs, their physical and emotional facets, and their seriousness and potential permanency).

\(^{370}\) See, e.g., Washington v. Harper, 494 U.S. 210, 226 (1990) ("respondent has failed to demonstrate that physical restraints or seclusion are acceptable substitutes for antipsychotic drugs, in terms of either their medical effectiveness or their toll on limited prison resources"); Jones, 416 N.W.2d at 890 ("It is undisputed that some of these drugs cause numerous side effects that are more prevalent than with any other drugs used in medicine."); id. at 891 ("The experts stated that there are alternatives to administering psychotropic drugs, e.g., psychosocial treatment, verbal psychotherapy, milieu therapy. It was apparent from the testimony that the environment to which the patient is discharged . . . is generally more important for recovery than the treatment modality used at the hospital.").

\(^{371}\) See, e.g., Large, 714 P.2d at 399 (discussion of whether side effects associated with antipsychotic drugs can be controlled); Jones, 416 N.W.2d at 890 (Some of the side effects associated with administering psychotropic drugs can be reversed if they are detected early enough and the drugs are discontinued. Others can be controlled with medication. "However, it is undisputed that conditions caused by some of the side effects are oftentimes irreversible and can even be fatal. One does not need a medical degree to realize we are not discussing aspirin.").

\(^{372}\) See, e.g., Large, 714 P.2d at 406 ("To the extent that medication is administered forcibly for the purpose of controlling behavior, it is a bodily restraint insubstantially different from the shackles of old.").
been a clear showing that the MDO is directly and substantially harmed by the treatment. It is likely that most therapy programs used for MDOs would not be subject to successful judicial challenge.373

(d) Informed Consent.

Except for those treatment programs that are disallowed because their nature is considered too aversive, experimental, or intrusive, MDOs can generally participate in a treatment program where participation is consensual. Even where the program is subject to scrutiny because of its nature, courts have often permitted participation when the MDO has consented to the treatment, although the court may more closely examine the validity of that consent.374 Nevertheless, unless the State has an overriding need to impose a treatment program, e.g., during an emergency, the MDO’s lawful consent is generally considered a prerequisite to the implementation of a treatment program.375 The crucial question then becomes whether the MDO’s participation is truly consensual, particularly when given within an institutional environment.

Three elements are widely viewed as necessary for a legally acceptable consent to participate in a treatment program. First, the individual must possess the requisite capacity to give consent. In other words, the individual’s intelligence and mental status must be sufficient to allow the individual to understand to what he or she is con-

373. See Winick, supra note 352. The author reasons that some techniques are so non-intrusive that constitutional protections are not invoked, such as, traditional verbal therapies and behavioral approaches using positive reinforcement without making basic rights and privileges contingent on compliance. A second group is sufficiently intrusive that constitutional protections are triggered but may be outweighed by a sufficiently important government interest, although it may have to be shown that this is the least restrictive alternative, such as in ascending order of intrusiveness: drastic aversive conditioners, medication, ECT, castration for sex offenders, and psychosurgery. At the high end of the continuum are techniques so intrusive they should not be allowed regardless of the governmental interest involved. Evaluation of intrusiveness should include extent of physical or mental intrusion, nature, extent and duration of effects, and extent to which effects may be avoided or resisted by unwilling subjects. The author concludes most therapy programs used for MDOs, regardless of setting, fall along lower end of continuum, but as programs become more intrusive, not only do they become more suspect, but also procedural requirements before they can be imposed increase.


[It is not possible to say that the use of apomorphine is a recognized and acceptable medical practice in institutions such as ISMF. Neither can we say, however, that its use on inmates who knowingly and intelligently consent to the treatment, should be prohibited on a medical or a legal basis.

Id.; see Winick, supra note 352.

senting. Many courts now presume that even involuntary patients are competent to make treatment decisions, and this presumption, absent an emergency, will not be overcome without a specific judicial determination that this particular patient is indeed incompetent. Therefore, mental health professionals must determine on a patient-by-patient basis whether a patient lacks the capacity to consent to treatment, even though the specific criteria for finding a lack of capacity have been poorly defined. Furthermore, as the nature of the treatment program becomes more aversive, experimental, or intrusive, the courts will scrutinize the patient's capacity to consent more closely.

The second component generally recognized for a legally acceptable consent to treatment is that the patient be fully informed of the risks and benefits of the program and available alternatives. The criteria for meeting this component have also not been clearly established. Judicial discussion of this component has focused on the disclosures a physician must make to a patient prior to providing medical treatment. However, these rulings appear to be generally applicable as well to mental health professionals treating MDOs. Courts have split between using a "reasonable patient" standard, i.e., what a reasonable patient would need to know in order to make an informed decision, and a "reasonable physician" standard. The courts adopting the latter view are further split into two camps. One camp uses the "traditional" or "professional" standard that requires the treatment provider to make such disclosures as comport with the prevailing professional standard in the community. The other camp ignores the community standard and only requires such disclosures as would be made by a reasonable treatment provider under similar circumstances.

Proponents of the "reasonable physician" standard argue that the treatment provider is best situated to evaluate the risks associated with a treatment procedure, and that requiring the treatment provider to review every possible risk with the patient interferes with the flexibility a treatment provider needs in deciding what treatment is best for the patient. However, courts recently have tended to reject this

376. See supra part III.B.2.
377. See Mills & O'Keefe, supra note 341.
380. See, e.g., Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Largey v. Rothman, 540 A.2d 504 (N.J. 1988) ("professional" standard rests on belief that (1) only a physician can effec-
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approach in favor of the "reasonable patient" standard. Among the reasons given for this repudiation are: it conflicts with the patient's general right of self-determination; it is difficult to discern professional custom and how it applies to a particular case; it is inappropriate to allow the whims of the professional community to dictate the applicable standard; professional custom is irrelevant in determining what information to convey since non-medical factors, such as a patient's emotional condition, are important in deciding what information to convey; this approach gives a treatment provider in tune with the standards of his or her community virtually unlimited discretion, an approach inconsistent with a patient's right of self-determination; and this approach is unfair to patients who may have problems locating a treatment provider willing to testify against a colleague.

The rationale for recognizing the "reasonable patient" standard is consistent with judicial opinions discussing the treatment rights of MDOs in general. Where no risk to the community is involved, as would be the case within a secure treatment facility, the MDO's rights have been given considerable recognition even at the risk of leaving the treating professional at a disadvantage. Courts recognizing the "reasonable patient" standard have noted that it may be difficult for the treatment provider to determine the scope of the required disclosure, but they have evidently felt that any resulting confusion was not a sufficient basis for outweighing what they perceived as the patient's right of self-determination. In addition, because of the limited number of treatment alternatives available for the MDO, requiring relatively extensive discussion with the patient of these alternatives may not place a great burden on the treating mental health professional, and the lack of data on their effectiveness and risk may raise issues that can only appropriately be decided by the MDO.

The third necessary component to meet the legal requirement of an informed consent to treatment is that the choice be voluntary and not tively estimate the psychological and physical consequences that a risk inherent in a medical procedure might produce in a patient, and (2) a general standard of care, as required by reasonable patient rule, would require physician to waste unnecessary time reviewing with patient every possible risk, interfering with flexibility physician needs in deciding what form of treatment is best for the patient).

381. See, e.g., Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); Largey, 540 A.2d at 508 (citing twelve other states that have rejected the "reasonable physician" standard).

382. See Largey, 540 A.2d at 508-09.

383. See supra part III.B.1.-2.

384. See Largey, 540 A.2d at 509.

coerced. Several commentators agree that this is the most critical element in evaluating any consent forthcoming from an MDO. When given within an institutional context, the MDO's consent may reflect a belief that providing consent will be viewed favorably by staff and the courts as an indication of the MDO's compliance with hospital or prison regulation rather than indicate a true willingness to participate in the treatment program. This may particularly be the case for a non-sentenced MDO whose release from a psychiatric facility is generally contingent on demonstrating recovery, and voluntary participation in a treatment program may be used to assess the patient's progress. However, participation in treatment may also affect a sentenced MDO's ability to qualify for early release or parole.

Alternatively, acceptance of the program may have been motivated by a decision to accept the uncertain, long-run risks of the treatment rather than continue to accept the more concrete risks and impositions of a long-term stay in prison or an institution. Furthermore, the treating staff may subtly or not so subtly place pressures on the MDO to accept the treatment program, not because of its beneficial impact on the MDO, but for their own administrative convenience. For example, it may be easier to administer a treatment program implemented on a ward-wide basis. Additionally, the program may be viewed as a way to control or subdue otherwise annoying or offensive behavior. It has been argued that combining incarceration with a treatment program that is risky and/or experimental makes it almost impossible to obtain a truly informed consent because of the pressures on the MDO to participate.

Courts have also raised these concerns when a treatment program is included as a condition of probation or parole for the sentenced MDO. Similarly, as an outpatient, the non-sentenced MDO is expected to comply with a prescribed treatment program and may be reinstitutionalized for a failure to comply with that program. However, most courts would probably acknowledge that out-patient treatment (as well as probation or parole) brings into consideration the safety of the community, as well as the high cost of incarceration, and if a treatment has been proven highly effective and is not physically detrimental to the MDO, the voluntariness of consent may be-

386. See Demsky, supra note 375; Weiner, supra note 84; Winick, supra note 352.
387. See Demsky, supra note 375.
388. See Weiner, supra note 84.
MENTALLY DISORDERED OFFENDERS come subsidiary to concerns for the protection of the community. Thus, the judiciary may apply a different standard when assessing the necessary legal consent to be obtained from MDOs under such circumstances, noting the implied dangerousness inherent in their prior criminal acts, the desirability of hastening their ability to regain capacity to stand trial, or a general desire to protect society from behavioral outbursts during such placements. However, there is little indication that the courts will make this distinction while the MDO is held within the confines of a prison or secure psychiatric facility.

A mental health professional may wonder what the personal impact will be for failing to obtain informed consent from an MDO prior to implementing a treatment program. Although the issue has not been widely discussed in the context of an MDO, it has been asserted that while facilities have been found liable for proceeding without informed consent, "no psychiatrist has been found guilty of malpractice for coercing treatment." However, the U.S. Supreme Court recently held that a patient is entitled to pursue a § 1983 action for a violation of his civil rights if he can show that he was indeed incompetent at the time he signed forms requesting voluntary admission to a psychiatric hospital and authorizing the treatment provided there. The Court noted that the presence of mental illness may require treating staff to exercise additional caution in obtaining informed consent. As a result, the Court ordered that the patient be given an opportunity to prove his allegations that he was hallucinating, confused, disoriented, or clearly psychotic at the time he signed the forms. Pursuant to § 1983, a plaintiff may recover monetary

390. See Weiner, supra note 84, at 325, 334. See generally Winick, supra note 352, at 350.  
391. Mills & O'Keefe, supra note 341.  
393. Id. at 133 n.18 ("The characteristics of mental illness thus create special problems regarding informed consent. Even if the State usually might be justified in taking at face value a person's request for admission to a hospital for medical treatment, it may not be justified in doing so, without further inquiry, as to a mentally ill person's request for admission and treatment at a mental hospital.").
damages for the violation of his or her civil rights by an individual acting on behalf of the State, and those damages come from the named individuals responsible for the civil rights violation, although they may typically be indemnified by the State.

4. Disclosure of Information

Another aspect of the treatment of the MDO scrutinized by the courts involves the disclosure of clinical conversations, conclusions, or records compiled in the course of treatment.94 These cases can be divided into two groups.95 The first involves releases of information that have occurred contrary to the expectation of the patient. Subsequent to the release, the patient attempts either to recover monetary damages or impose sanctions upon the treating professional for the unexpected disclosure. In these cases the burden frequently falls on the therapist to justify the release of information. The second group centers on attempts by MDOs to prevent the release of such information, generally in the course of judicial or administrative proceedings. In these cases the burden usually falls on the MDO to establish why the information should not be released. For both groups of cases, the assignment of the burden of persuasion tends to be based on a belief that this assignment promotes a greater goal (including the protection of society) that outweighs the interests of the individual on whom the burden is placed.

394. The cases described in this section focus on the legal concepts of confidentiality and privilege. A privilege is typically established and defined by statute, focuses on specific relationships (e.g., doctor-patient, psychologist-client, priest-penitent), is relatively narrow in scope, and is generally restricted to placing limitations on the testimony an individual (e.g., a therapist) can provide at a trial. In contrast, the duty of confidentiality tends to be a product of common law rather than a statutory creation (although given portions of it may be codified), encompasses all patient-staff relationships within the clinical setting, is relatively broad in nature, generally including all communications and records, and is not limited to trial testimony but includes all non-authorized disclosures. Proponents of both privilege and confidentiality assert that the principle of non-disclosure is necessary to encourage frank and full discussions between the therapist and patient, and that treatment would be impossible without these discussions. However, because they are typically asserted in different contexts, each concept has additional and somewhat different justifications. Nevertheless, the basic underlying principles for the two are sufficiently similar to permit their simultaneous discussion in this section. See Richard G. Taranto, The Psychiatrist-Patient Privilege and Third-Party Payers: Commonwealth v. Kobrin, 14(I) LAW, MED. & HEALTH CARE 25 (1986); Mills & O'Keefe, supra note 341.

395. A third possible group, which overlaps with both of these groups and will be discussed generally infra part III.C., focuses on obligations imposed on treating professionals to act upon or release such information to protect others, particularly members of the community. In these cases, the burden often falls on the treating professional to establish that he or she has acted appropriately.
(a) Breach of Expectation of Nondisclosure.

There are few cases on record where an MDO has brought a legal action or sought sanctions against a mental health professional for a breach of his or her expectation that clinical information provided to the therapist would not be disclosed. The cases that address these issues typically involve mental health professionals in general practice. However, in light of the surge in litigation centering on and initiated by the MDO, it seems likely that such issues will more frequently be raised in conjunction with MDOs.

In general, mental health professionals typically have both a legal and an ethical obligation not to disclose information obtained in the course of treatment. For example, Ethical Standard 5.02 of the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct reads:

Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional or scientific relationships.\textsuperscript{396}

Furthermore, Ethical Standard 5.05(a) reads:

Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.\textsuperscript{397}

A mental health professional who violates such ethical principles may face an administrative proceeding by a state licensing board that reviews the actions of the mental health professional, which in turn can result in sanctions and revocation of the mental health professional's


\textsuperscript{397} Id. at 1606.
license to practice. These proceedings are typically initiated by a complaint from an individual that received mental health services from the professional. Licensing boards, in their review, often stress the importance of assuring the public and future clients that treating professionals will respect patient confidences. These assurances are considered a prerequisite for encouraging reticent clients to make disclosures needed in the course of treatment. Indeed, this assurance is considered so important that even though the initiating complaint is subsequently withdrawn, the licensing board may independently continue its investigation.

Alternatively, an individual may file a tort action for invasion of privacy in a court of law seeking financial compensation for harm allegedly resulting from a wrongful disclosure by a mental health professional of information obtained from the individual in the course of treatment. Although it has been asserted that suits successfully es-

398. See, e.g., Mississippi State Board of Psychological Examiners v. Hosford, 508 So. 2d 1049 (Miss. 1987) (at custody hearing, husband submitted affidavit prepared by psychologist (who provided counselling to the couple prior to their filing for divorce) regarding the parenting skills of the two parents and asserted child should be placed with the father; because wife had not consented to release of this information, she lodged complaint with Mississippi licensing board arguing psychologist violated profession’s confidentiality principle; board agreed and suspended psychologist’s license for 90 days, which Mississippi Supreme Court upheld on appeal).

399. Id. at 1055 (“Perhaps more so than is the case with either lawyers or physicians, we recognize a public imperative that the psychology profession as a whole enjoy a impeccable reputation for respecting patient confidences.”).

400. Id. at 1049 (court reasoned that it did not matter that the initiating complaint was withdrawn because the board’s interest is in protecting the integrity of the profession and the long range interests of the consuming public, an interest independent of a given client).

401. A less frequently asserted alternative, where there has been a “publication” (i.e., an unauthorized release to a third party) of confidential information injuring the reputation of the patient, is that the patient may pursue a legal action based upon the tort of defamation. If the publication is oral, the tort is called slander; if it is written, the tort is called libel. Among the available defenses are that the information released is true, that the information was provided in a setting where the release was immune from attack such as in judicial or quasi-judicial proceedings, or provided in a good faith effort to discharge a legitimate duty (e.g., to warn another of danger). See Reisner & Slobogin, supra note 379, at 249-55.

Alternatively, it may be claimed that there was a contractual relationship between the patient and the therapist that required the therapist to keep in confidence all disclosures made by the patient regarding his or her condition or all discoveries made by the therapist in the course of treatment. See, e.g., Doe v. Roe, 400 N.Y.S.2d 668 (Sup. Ct. 1977). There may be an implied covenant, enforceable by injunction and compensable in damages, to keep in confidence patient’s disclosures concerning the patient’s physical or mental condition as well as all matters discovered in the course of an examination or treatment, a covenant that is necessary to protect the patient who is “called upon to discuss in a candid and frank manner personal material of the most intimate and disturbing nature.” Id. at 674 (quoting Melvin S. Heller, Some Comments to Lawyers on the Practice of Psychiatry, 30 Temp. L. Rev. 401, 405-06 (1957)).

Finally, the State may authorize by statute a cause of action for disclosure, typically where it considers it particularly important that the information be kept confidential. See, e.g., V. v.
tablishing liability for a therapist’s breach of a patient’s right to confidentiality are extremely rare (although much discussed),⁴⁰² there are, nevertheless, recorded cases where a court has ruled that a plaintiff had a cognizable privacy interest in keeping communications with a mental health professional confidential, that this interest outweighed any competing interest of the professional in disclosing that information to a third party, and that the plaintiff was entitled to monetary compensation.⁴⁰³

The information that is protected from disclosure has been given a broad scope, although perhaps broader under governing ethical principles than under legal standards. This protection has not been limited to the words spoken by the patient, but extends as well to communications from the treating professional to the client, clinical records, and opinions or impressions formed by the treating professional that were based on communications with the client.⁴⁰⁴ However, to recover under a lawsuit for wrongful disclosure, the plaintiff generally must establish that there was a protected patient-therapist

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⁴⁰² See Mills & O'Keefe, supra note 341.
⁴⁰³ See, e.g., Leggett v. First Interstate Bank, 739 P.2d 1083, 1086 (Or. Ct. App. 1987) (jury award of $27,000 for invasion of privacy and $150,000 in punitive damages to plaintiff referred by employer to clinical psychologist after series of incidents where co-workers provoked emotional outbursts by surprising her with rubber spiders, thereby triggering phobia about insects and spiders.). Initially, with plaintiff's consent, the psychologist wrote a letter to the plaintiff's employer recommending two-week medical leave because of plaintiff's "severe anxiety neurosis." Later, without the plaintiff's consent, the psychologist met with the plaintiff's supervisors and told them that a transfer would not resolve her problems and she would not adversely react to being fired. One week later the plaintiff was fired. The jury found that the plaintiff suffered an invasion of her privacy when her employer sought and obtained confidential information from the psychologist. On appeal, the court ruled, "In this case, the jury could reasonably have found that defendant wrongfully and intentionally invaded plaintiff's privacy, that the intrusion would be offensive to a reasonable person and that the seriousness of the intrusion on plaintiff's privacy outweighed defendant's interest." Id.
⁴⁰⁴ See, e.g., State v. Brelsford, 587 A.2d 1062 (Conn. App. Ct. 1991) (treatment provided by psychiatrist to prison inmate; patient-psychiatrist privilege includes observations as well as communications and records); Hosford, 508 So. 2d at 1049. But see People v. Doe, 430 N.E.2d 696 (Ill. App. 1981) ("communications" includes only information obtained from conversations with the patient and not observations); Commonwealth v. Clancy, 524 N.E.2d 395 (Mass. 1988) ( privilege does not extend to fact that defendant hospitalized, dates of hospitalization, or purpose of admission).
relationship,\textsuperscript{405} that the communication occurred in the course of the treatment relationship, that the invasion of privacy was intentional,\textsuperscript{406} that the intrusion would be offensive to a reasonable person,\textsuperscript{407} and that the patient incurred damages.\textsuperscript{408}

Certain exceptions to the general rule of confidentiality have been noted. First, if disclosure is made pursuant to a court order or in the course of a judicial or quasi-judicial proceeding, even if the basis for the disclosure is subsequently reversed on appeal, the treating professional is immune from sanction.\textsuperscript{409} Second, if there is no expectation of confidentiality by the individual receiving services (e.g., the release of information occurred with the patient's informed consent), there will be no sanction for subsequent disclosures.\textsuperscript{410} Third, the treating professional is not subject to sanction if there was a legal excuse or justification for the disclosure, such as attempting to protect others from danger.\textsuperscript{411} Indeed, the therapist may be subject to sanction for

\textsuperscript{405} See, e.g., State v. Cole, 295 N.W.2d 29 (Iowa 1980) (to establish doctor-patient privilege, three elements must be established: (1) relationship of doctor-patient, (2) acquisition of the information during this relationship, and (3) necessity of the information to enable doctor to treat patient skillfully); Doe, 400 N.Y.S.2d at 668 (potential liability extends to co-author of book containing disclosures made in the course of a patient-therapist relationship, even though co-author was not the therapist).

It should also be noted that family members such as a spouse are not privy to the information arising in the course of a patient-therapist relationship absent the permission of the patient. See, e.g., MacDonald v. Clinger, 446 N.Y.S.2d 801 (N.Y. App. Div. 1982). However, when the therapist examines or diagnoses a person at the request of a third party duly authorized to make such a request (e.g., a court of law), and the information is provided to the third party, no duty of confidentiality will arise. See, e.g., Cole, 295 N.W.2d at 29 (court-ordered evaluation). See also REISNER & SLOBOGIN, supra note 379, at 260. At the same time, it has also been held that unless the person being examined is specifically informed (by something akin to a Miranda-warning) that the purpose of the examination is not for treatment, any disclosures made will not be admissible at a subsequent criminal trial. Id. at 280.

\textsuperscript{406} See, e.g., Doe, 400 N.Y.S.2d at 668; Leggett, 739 P.2d at 1083.

\textsuperscript{407} See, e.g., Leggett, 739 P.2d at 1083. It should be noted, however, that this limitation and the one requiring intent may not apply to a licensing board's review of a complaint of wrongful disclosure where the board is applying a more restrictive ethical (as opposed to legal) standard designed to guide professional conduct in general rather than redress individual wrongs.

\textsuperscript{408} See, e.g., Doe, 400 N.Y.S.2d at 668. Furthermore, the patient may be able to recover punitive damages if he/she can show that the wrong committed was willful and malicious. See, e.g., Doe, 400 N.Y.S.2d at 668; Leggett, 739 P.2d at 1083.

\textsuperscript{409} See also Doe, 400 N.Y.S.2d at 668 (curiosity or education of medical profession does not supersede duty of confidentiality, although an important scientific discovery could take precedence).

\textsuperscript{410} See, e.g., id. at 668. However, this consent may be questioned if obtained in the course of treatment. See, e.g., Commonwealth v. Wiseman, 249 N.E.2d 610 (Mass. 1969), cert. denied, 398 U.S. 960 (1970); Doe, 400 N.Y.S.2d at 668.

\textsuperscript{411} See, e.g., Menendez v. Superior Ct. (People), 279 Cal. Rptr. 521 (Cal. Ct. App.) (communications revealed to therapist's wife and therapist's paramour after therapist concluded that he and everyone with whom he was closely associated were endangered; exception
failing to act under such circumstances. However, this dangerousness exception has been variously construed, in some instances limited to only where "life and limb" are in danger, while in other rulings expanded to include the potential for emotional or psychological harm. There are few bright lines that guide the treating professional as to when and to whom it is appropriate to disclose information under various circumstances. This, in turn, has led to extensive discussion and concern by therapists about their potential liability should they make the wrong choice, liability which may take the form of either monetary or professional sanctions.

Furthermore, a therapist responding to the needs of the MDO often faces multiple demands for information received in the course of treatment. For example, within a correctional setting, this information may be greatly coveted by a parole board deciding whether to release an inmate or a prison's disciplinary board determining whether to impose sanctions on an inmate for an infraction of the prison's disciplinary code. Assessments of dangerousness may be desired in conjunction with the former, and evaluations of competency or responsibility may be sought for the latter. The inmate may be quite willing to waive any right to confidentiality when it will promote his or her release or exonerate the inmate from disciplinary

to therapist/patient privilege exists where reason to believe (1) patient is dangerous and (2) necessary for therapist to disclose the communication, review granted, 812 P.2d 153 (Cal. 1991); MacDonald, 446 N.Y.S.2d at 801 (where patient is a danger to himself or others, therapist required to disclose to extent necessary to prevent harm). But see Mississippi State Bd. of Psychological Examiners v. Hosford, 508 So. 2d 1049 (Miss. 1987) (while noting that five states had ruled that protecting best interests of child does override psychologist-patient privilege, court held that child custody dispute did not provide sufficient basis for disclosure absent specific showing that child endangered by given placement).

412. Id.
413. See, e.g., Hosford, 508 So. 2d at 1049.
414. See Diane Steelman, The Mentally Impaired in New York Prisons (1987) (based on interviews, concluded mental health professionals in a correctional setting feel parole officials have unrealistic expectations of what mental health professionals are capable of assessing or wanted them to do their job and relieve them of criticism when parolee committed particularly violent crime; in contrast, parole officials feel they would be able to do their job more responsibly if mental health professionals provided them with information that more clearly addressed inmates' dangerousness and that mental health professionals incorrectly viewed relationships with patients inside prisons as ordinary doctor-patient relationships that relieved them of obligation to share information with other officials).
415. See, e.g., Powell v. Coughlin, 953 F.2d 744 (2d Cir. 1991) (court upheld policy allowing clinical staff to consult with hearing officer as part of disciplinary proceeding outside presence of inmate, provided information discussed pertained to inmate's mental health status at time of incident or at time of hearing, with information obtained to be kept confidential and not disclosed to the inmate or other persons).
416. See Steelman, supra note 414 (discussion of nature of assessments of dangerousness).
sanctions. However, where such outcomes are not likely to result, waivers are not likely to be forthcoming. Yet, it may be precisely in such situations that the information is most needed for the protection of others and society in general. Similar predicaments may face a professional treating a non-sentenced MDO seeking either out-patient placement or the termination of his commitment.

(b) Attempts by MDOs to Prevent Disclosure.

As noted, the generally accepted exceptions to the principle of confidentiality include disclosures made pursuant to a court order, in the course of judicial proceedings, or to prevent danger to others. MDOs in a number of cases have attempted to stop the release or prevent the use of clinical information concerning them despite these exceptions. Courts have generally rejected these attempts and have expressed a paramount concern for the safety of society. The burden is generally placed on the MDO to show why the disclosure should not be made.

For example, a number of special rules permitting disclosure of clinical information regarding MDOs have been upheld in the context of a criminal trial. These situations include: allowing a treating professional to testify at a homicide trial regarding details learned of the homicide in the course of clinical conversations; allowing a thera-

417. However, this is not universally the case as the stigma from being labeled mentally ill and the subsequent ramifications from receiving such a label may outweigh the inmate’s desire for release or exoneration.

418. For a description of the difficulties that may accompany an attempt to obtain an MDO’s psychiatric records, see Tamsen v. Weber, 802 P.2d 1063 (Ariz. Ct. App. 1990). In addition, the agency or facility providing treatment may attempt to block the release of information. See, e.g., Commonwealth v. Wiseman, 249 N.E.2d 610, 615 (Mass. 1969) (Commonwealth of Massachusetts and the superintendent of psychiatric facility where insanity acquittees committed sought to block release of film depicting conditions within the facility; in crafting an order designed to insure film only shown to people with legitimate interest in the matters portrayed and not the general public, court concluded that a number of inmates pictured in the film either had not consented to their inclusion or were incompetent to do so, the film showed many inmates in situations “degrading to a person of normal mentality and sensitivity,” and release of this film to the general public would constitute a “massive, unrestrained invasion” of inmates’ privacy), cert. denied, 398 U.S. 960 (1970); In re New York News, Inc., 494 N.E.2d 1379 (N.Y. 1986) (order to give to media portions of retention hearing transcript involving woman who subsequent to release pushed another woman into path of oncoming subway train; court held legitimate public interest in information regarding procedures for release of mental patients outweighed needs of confidentiality where, as here, patient’s identity already known).


420. See, e.g., Whitehead v. State, 511 N.E.2d 284 (Ind. 1987) (testimony by treating psychologist permitted; statute establishing psychologist-patient privilege included exception for homicide trials when disclosure concerned facts or circumstances of the homicide; since privilege solely a statutory creation, legislature could include whatever exceptions they felt appropriate; no authority for claim exception unconstitutional because it infringed defendant’s right to privacy or violated his/her equal protection rights), cert. denied, 484 U.S. 1031 (1988).
pist to testify regarding confidential information the therapist disclosed earlier to avert danger to others;\textsuperscript{421} allowing the introduction of a psychiatric report where the report did not recount any statements or substance of statements made by the defendant;\textsuperscript{422} and allowing the introduction of statements made to a mental health professional that were not intended to be confidential, where the expectation of nondisclosure was waived (e.g., by the patient raising his or her mental condition as a defense at trial), or where the statements were made outside the course of the therapist-patient relationship.\textsuperscript{423}


\textsuperscript{422} See, e.g., United States v. Crews, 781 F.2d 826 (10th Cir. 1986) (report compiled as part of pre-trial competency exam to establish defendant's mental condition).

\textsuperscript{423} See, e.g., Crews, 781 F.2d at 826, 829-30 (After watching a television movie depicting nuclear annihilation, a psychiatric patient became upset, requested sedatives, and told a nurse, "If Reagan came to Sheridan, I would shoot him." The nurse reported the statement to the administrative staff which contacted the Secret Service. A Secret Service agent subsequently interviewed the patient, who "said he had told the nurse that it 'would be in the best interest of this nation if that red-necked, bigoted, war-mongering mother fucker were shot.'" The patient was convicted of making a threat to kill the President. In upholding the conviction, the court held that the patient waived the psychotherapist-patient privilege when he disclosed his own version of the conversation to the agent. Another waiver occurred when the patient talked after the agent told him that he was not in custody or under arrest and could leave the interview at any time, that he could not be forced to talk, and was formally given Miranda rights. Although recognizing that the patient may not have been competent to waive any privilege, the court noted that the jury found him competent to stand trial and it was the jury's duty to determine whether the patient was competent at the time he made the alleged threat.); In re Lifschutz, 467 P.2d 567 (Cal. 1970) (therapist-patient privilege waived with respect to those mental conditions patient placed in issue in course of litigation); People v. Superior Ct. (Broderick), 282 Cal. Rptr. 418 (Ct. App. 1991) (psychotherapist-patient privilege waived if, without coercion, patient discloses or consents to another individual disclosing confidential communication; privilege waived when patient calls therapist in unrelated trial and elicits confidential information in that context; however, waiver does not necessarily extend to communications made after waiver and waiver does not necessarily extend to all prior communications); Menendez v. Superior Ct. (People), 279 Cal. Rptr. 521 (Ct. App.) (since requires trust and confidence, any therapeutic relationship disintegrated once patient threatened therapist's life; also clear that patient's primary objective was not to receive therapy but to establish possible psychiatric defense), review granted, 812 P.2d 153 (Cal. 1991); State v. Brelsford, 587 A.2d 1062 (Conn. App. Ct. 1991) (inmate's privilege waived by placing mental health (dependency on an antidepressant drug) into issue at criminal proceeding); State v. Ortiz, 555 So. 2d 623 (La. Ct. App. 1989) (permissible to take into account at sentencing statements by defendant about additional criminal acts made in the course of mental health exam requested by defendant; court reasoned that since courts have consistently held physician-patient relationship does not exist where doctor ordered to testify in court about defendant's condition, similar rule applies where defendant requests mental health examination), aff'd in part and rev'd in part, 567 So. 2d 81 (La. 1990); State v. Rainey, 580 A.2d 682 (Me. 1990) (testimony of psychiatrist who examined defendant before trial pursuant to court order regarding defendant's criminal responsibility and competency to stand trial admissible where defendant put mental state at issue as defense); State v. Andring, 342 N.W.2d 128 (Minn. 1984) (communications made in the presence of others are nonprivileged; however, statements made during group therapy session where sessions are integral and necessary part of patient's treatment are privileged); State v. Gullekson, 383 N.W.2d 338
In addition, a criminal defendant's right against self-incrimination has been ruled inapplicable in a number of contexts with regard to information disclosed in the course of a therapeutic relationship.

(Minn. Ct. App. 1986) (after entering intensive treatment program for sexual aggressives as condition of probation and attending unsupervised group therapy session, defendant approached therapy group's counselor and volunteered he committed a crime two years earlier for which he had not been convicted; subsequently, program director (accompanied by two other individuals), after telling defendant anything he said would be reported to the authorities, asked defendant to repeat earlier statement, which he did; when ultimately brought to trial, defendant objected to use of disclosure to program director; court reasoned that five conditions needed before psychiatrist-patient privilege controls: (1) confidential relationship must exist, (2) acquired information must be of type contemplated by privilege statute, (3) information must be acquired while psychiatrist attending patient, (4) information must be provided for purposes of diagnosis and treatment, and (5) third persons could not be present unless necessary and customary participants in consultations or treatment; because defendant had been told statements would be reported to authorities and because not customary for him to meet with program director and the two other individuals for treatment, court concluded statements not privileged); People v. Edney, 350 N.E.2d 400 (N.Y. 1976) (where insanity asserted as defense, privilege waived and prosecution can call psychiatric expert to testify regarding defendant's sanity even though psychiatrist treated defendant); State v. Valley, 571 A.2d 579 (Vt. 1989) (therapist treating defendant following child's death could testify at subsequent child abuse trial where defendant raised insanity defense and placed mental health condition into issue). But see State v. Wallace, 801 P.2d 27 (Haw. 1990) (although statements made to mental health experts are admissible on issue regarding mental condition (defense of mental irresponsibility), testimony not allowed regarding statements which constitute an admission of guilt of crime charged).

Typically, in cases such as Gullekson and Crews, the initial patient-therapist conversation is not entered into evidence, but only the subsequent follow-up conversation where the patient has waived his or her privilege or right to confidentiality. However, it should be noted that non-binding language contained in a footnote in a U.S. Supreme Court opinion specifically left issues regarding the admissibility of MDO-therapist conversations that initiate a criminal investigation unresolved. In Minnesota v. Murphy, 465 U.S. 420 (1984), as part of probation, a defendant was required to participate in a treatment program for sexual offenders. During treatment, he admitted to a prior crime and the counselor told his probation officer. The probation officer confirmed this information in a subsequent discussion with the defendant, although the defendant was very upset over what he considered a breach of confidence by the counselor. The probation officer turned the material over to the police and charges were filed. In a footnote, the Court declared, “Although the . . . counselor legitimately informed Mur- phy's probation officer of his incriminating admissions, we assume, without deciding, that the counselor could not have provided the information to the police. We assume, as well, that the probation officer could not have made the counselor's information available for use in a crimi- nal prosecution.” Id. at 423 (internal citations omitted).

424. See, e.g., Russell v. Eaves, 722 F. Supp. 558 (E.D. Mo. 1989) (can require prison inmate to participate in rehabilitation program to become eligible for parole, and as part of participation “accept responsibility” for crimes), dismissed, 902 F.2d 1574 (8th Cir. 1990); Broderick, 282 Cal. Rptr. at 418 (submitting discovery request to third party for defendant's psychiatric records permissible where records generated before alleged crime and not prepared in conjunction with defendant's defense; discovery may still be foreclosed by psychotherapist-patient privilege); State v. Manfredi, 569 A.2d 506 (Conn.) (Fifth Amendment privilege waived when defendant presented psychiatric evidence to court even though he had not filed notice of intention to rely on mental status defense), cert. denied, 498 U.S. 818 (1990); Gullekson, 383 N.W.2d at 338 (inculpatory statements made to treatment personnel in a security hospital do
Among the rationales provided for these rules are that disclosure is not prohibited where there was no expectation that the communications were to be confidential or private;\textsuperscript{425} fairness and justice required disclosure;\textsuperscript{426} a restrictive view of the confidentiality assured an MDO is appropriate when the safety of the community is imperiled;\textsuperscript{427} and confidentiality is designed to facilitate treatment, not prevent use of a defendant's statements at trial, and where there is no expectation of treatment, disclosure is permitted.\textsuperscript{428}

The exceptions to traditional rules of nondisclosure have not been limited to criminal trials, but have also been applied to post-conviction proceedings, including MDO commitment and recommitment hearings. For example, the U.S. Supreme Court permitted into evidence testimony of an examining psychiatrist where the proceeding was pursuant to a Sexually Dangerous Persons Act,\textsuperscript{429} stating that constitutional guarantees against compulsory self-incrimination are not applicable to civil proceedings that are designed to provide care

\begin{itemize}
  \item \textsuperscript{425} See, e.g., \textit{Crews}, 781 F.2d at 826; \textit{Broderick}, 282 Cal. Rptr. at 418 (once privilege waived, expectation of privacy in communications to therapist no greater than for any other communication); \textit{Whitehead} v. \textit{State}, 511 N.E.2d 284 (Ind. 1987), \textit{cert. denied}, 484 U.S. 1031 (1988); \textit{Ortiz}, 555 So. 2d at 623 (for statement to psychologist to be privileged, examination had to be intended to be private and confidential and since defendant requested and submitted to exam with full expectation and knowledge that it would be used to assist sentencing judge, defendant had not intended information conveyed to be private and confidential); \textit{Gullekson}, 383 N.W.2d at 338 (statements not privileged because made at meeting that was not intended to be confidential).
  
  \item \textsuperscript{426} See, e.g., \textit{Breitsford}, 587 A.2d at 1062 (it would not serve the ends of justice to allow defendant to describe his belief that he was dependent on antidepressant drug and use this as excuse for crime, and also allow him to assert patient-psychiatrist privilege to suppress available proof of his false statements).
  
  \item \textsuperscript{427} See, e.g., \textit{Whitehead}, 511 N.E.2d at 284.
  
  \item \textsuperscript{428} See, e.g., \textit{People v. Clark}, 789 P.2d 127 (Cal.) (purpose of psychotherapist-patient privilege is not to prevent use of defendant's statements against him in legal proceedings but to prevent unnecessary disclosure of statements made in confidence during course of treatment and thereby facilitate treatment; if statements already properly revealed to third persons, statements no longer confidential; psychotherapist-patient privilege ceases to exist when therapist revealed communication to third party in order to prevent danger to others), \textit{cert. denied}, 498 U.S. 973 (1990); \textit{Whitehead}, 511 N.E.2d at 284 (purpose of such privileges not to suppress truth, but promote and protect certain types of confidences and evidently legislature concluded that disclosures regarding homicide not worthy of such protection).
  
  \item \textsuperscript{429} ILL. REV. STAT., ch. 38, para. 105-1.01 et seq. (1985).
\end{itemize}
and treatment, rather than punishment, to the MDO.\textsuperscript{430} Similarly, state court opinions have permitted the introduction of confidential information at recommitment hearings for the MDO, also emphasizing that the purpose of such proceedings is to afford the MDO treatment and not punishment.\textsuperscript{431}

One judicial opinion particularly provides an example of the lengths a court supervising an MDO will go in breaching traditional notions of confidentiality and privilege, additionally emphasizing the importance of protecting the safety of the community. In this New York case, the MDO had been found incompetent to stand trial for first degree manslaughter and subsequently civilly committed to a psychiatric hospital pursuant to a "Jackson" petition.\textsuperscript{432} The District Attorney (DA), on behalf of the People of New York, sought a judi-

\textsuperscript{430} See Allen v. Illinois, 478 U.S. 364 (1986) (pursuant to Illinois Sexually Dangerous Persons Act, defendant ordered to submit to two psychiatric examinations; defendant objected that testimony of examining psychiatrists should not have been permitted into evidence because privilege against self-incrimination entitled him to refuse to answer questions posed, and absent "Miranda-like" warnings prior to sessions, any information elicited was inadmissible; Court ruled the privilege against self-incrimination is not available in such proceedings because they are essentially civil, rather than criminal, in nature; State obligated to provide care and treatment to persons adjudged sexually dangerous and to release person when found to be no longer dangerous, and since there was no attempt to punish the individual, the procedures were not criminal in nature and constitutional protections guaranteed criminal defendants did not apply).

\textsuperscript{431} See, e.g., People v. Henderson, 172 Cal. Rptr. 858 (Ct. App. 1981) (statements made by defendant to hospital staff could be used at hearing to extend the commitment of an MDSO and were not an inadmissible self-incrimination because purpose of extended commitment was to provide the defendant treatment, not punishment); State v. Edmundson, 805 P.2d 1289 (Mont. 1990) (testimony based on regularly written reports kept by staff therapist at group home where insanity acquittee conditionally released was admissible and not a violation of Sixth Amendment right to confront accusers; Confrontation Clause does not attach to hearings civil in nature); State v. Hungerford, 267 N.W.2d 258 (Wis. 1978) (under state law physician-patient privilege does not apply in proceedings to hospitalize a patient for mental illness, and this rule should also apply to recommittal proceedings and commitment procedures pursuant to Wisconsin Sex Crimes Act). \textit{But see} Asherman v. Meachum, 932 F.2d 137 (2d Cir. 1991) (under Fifth Amendment privilege against self-incrimination inmate placed in supervised home release could not have this status revoked when because he had a writ of habeas corpus pending seeking a retrial the defendant refused to discuss his criminal conviction at a mental health evaluation that was a condition of his release; although inmate could be forced to undergo psychiatric evaluation, an adverse inference could not be drawn from his silence); Pens v. Bail, 902 F.2d 1464 (9th Cir. 1990) (Fifth Amendment right against self-incrimination violated when exceptional 20-year minimum sentence imposed based on statements made during post-conviction, court-ordered sexual psychopath treatment program; however, court also noted MDO not entitled to immediate release, but subject to indefinite commitment if State can prove requisite continued dangerousness).

\textsuperscript{432} People v. Villanueva, 528 N.Y.S.2d 506 (N.Y. Sup. Ct. 1988). In conjunction with the "Jackson" petition the court found there was no substantial probability that he would attain the capacity to stand trial in the foreseeable future, requiring the state to either institute a customary civil commitment proceeding with its standard protections or release the defendant.
cial order requiring the hospital to give the DA ten days' notice prior to transferring or releasing the defendant so the DA would have the opportunity to challenge the move.\(^{433}\) The court ruled that because such a notice requirement could not be attached to civilly committed patients in general, it would be impermissible to apply it to this individual.\(^{434}\) However, the court added that "[b]ecause the indictment is still pending, the court and the People have an important interest in monitoring the condition and location of the defendant."\(^{435}\) To meet these interests, the court appointed an independent expert to monitor the defendant's progress. The independent expert was to report to the court, the DA and defendant's attorney on a regular basis, and to notify all three of any significant changes in the defendant's condition or placement.\(^{436}\) To facilitate this monitoring, the court then proceeded to give this expert full access to all of the defendant's clinical records, notwithstanding any confidentiality provisions, and permission to converse fully with the treatment staff, notwithstanding any therapist-patient privileges.\(^{437}\) It appears the court believed that it had avoided these limitations on disclosure by making the expert an extension of the patient, thereby obviating the need for a waiver of confidentiality or privilege, even though there was no indication that the patient was consulted or acquiesced in this arrangement.

Similarly, notwithstanding traditional notions of nondisclosure, it has been ruled that psychiatric reports and mental health evaluations concerning the MDO introduced at commitment and review hearings are subject to release to the general public.\(^{438}\) The MDO's expectations of privacy were considered to have disappeared when the records were introduced into public court, except when it could be

\(^{433}\) Id. at 507.
\(^{434}\) Id. at 510.
\(^{435}\) Id. at 511.
\(^{436}\) Id.
\(^{437}\) Id. at 512.
\(^{438}\) See State v. Cribbs, 469 N.W.2d 108 (Neb. 1991) (in conjunction with the common law right of access to judicial records, shooting victims' daughters permitted access to MDO's psychiatric records; review hearing an open hearing and report stipulated to by both State and insanity acquittee; however, lower court encouraged to make explicit in record factors used in decision). See generally People v. Adams, 555 N.E.2d 761 (III. App. Ct. 1990) (requirement that habitual child sex offender register with the chief of police in municipality where he resides for up to 10 years upheld in part because requirement does not have significant impact on defendant's privacy interests as convictions a matter of public record), aff'd, 581 N.E.2d 637 (Ill. 1991); Commonwealth v. Milice, 584 A.2d 997 (Pa. Super. Ct. 1991) (trial court did not abuse discretion in refusing to close involuntary commitment hearing of insanity acquittee despite presentation of confidential information about his mental illness; substantial public interest in hearing, heightened by fact that victims of crime were neighbors of the acquittee who had legitimate concerns about his potential return to the community or placement in a less secure facility close to that community).
established that the access to the records was sought for improper purposes (e.g., an intent to sensationalize the records, gratify public spite, or promote public scandal). Although a balancing of the conflicting rights of the public and the MDO was endorsed, a presumption remained in favor of public access.439

Perhaps not surprisingly, although the MDO may find his or her expectation of nondisclosure disregarded in conjunction with a criminal or post-conviction proceeding, the MDO may find the court less willing to similarly disregard the expectation of nondisclosure of the victim of the crime when the MDO seeks clinical information regarding the victim.440 Emphasis is generally placed on protecting the privacy of the victim, with the burden placed on the MDO to show the necessary basis for the release of the clinical information.441

C. Changes in Status

In general, recent courts have increasingly scrutinized status changes of the MDO, including moves between and within facilities and changes made as part of the MDO's leave-taking of such facilities. The tension between the opposing interests typically at stake in cases involving MDOs is perhaps most clearly expressed in judicial opinions reviewing these status changes. Courts pay particular attention to protecting the interests of the MDO when that individual poses no imminent threat to society. In such cases, decisions that reduce or further limit the liberty of the MDO tend to be closely scrutinized and subjected to a review process that takes into account and protects the rights of the MDO. This emphasis changes, however, as the freedom of the MDO increases and the potential for harm to members of the community increases. Thus, when status changes are made that may directly impact the safety of the community by increasing the likelihood of the MDO's return to the community, either by escape or as part of a planned program of reintegration back into society, then the interests of the community tend to be recognized as

439. See Cribbs, 469 N.W.2d at 108 (considerable discretion to be afforded trial court in making determination).

440. See, e.g., State v. Ortiz, 555 So. 2d 623 (La. Ct. App. 1989) (although defendant entitled to exculpatory and impeachment evidence in the possession of the prosecutor, defendant not entitled to privileged medical and psychological records of child victims that are not relevant to his defense; improper to release all such records, including statements that school problems corrected or that discuss prior aggressive or violent behavior by the victims), aff'd in part and rev'd in part, 567 So. 2d 81 (La. 1990); Commonwealth v. McDonough, 511 N.E.2d 551 (Mass. 1987) (court refused to allow into evidence conversations between a psychotherapist and the defendant's victim, citing their possible inadmissibility under statutory privilege).

441. See, e.g., Ortiz, 555 So. 2d at 623.
paramount and the rights of the MDO minimized. Regardless of which concern is recognized as paramount, the likely impact of these status changes on the treatment staff generally receive little attention, although their decisions and recommendations tend to be closely scrutinized regardless of the scenario.

1. Secure Facility to Secure Facility Transfers

One group of cases has considered transfers of MDOs from one secure facility to another. However, while the facilities under scrutiny in these cases typically have a comparable level of internal security, they provide significantly different levels of mental health services.

When the transfer is to a facility that focuses on providing mental health care, the MDO has generally been able to establish a significant personal interest in avoiding this move, with any countervailing risk to society considered relatively insignificant. As a result, courts have determined that these transfer decisions must be subject to review (sometimes judicial in nature), with basic procedural protections associated with this review. In making this determination, courts have typically reached conclusions similar to those reached in MDO treatment cases, namely, refusing to defer to the professional judgment of the treatment staff, equating the interests of the MDO with those of individuals subject to involuntary civil commitment, and identify-

442. The general willingness of the courts to place MDOs in secure facilities should also be noted. See, e.g., United States v. Buker, 902 F.2d 769 (9th Cir. 1990) (although federal law permits court to sentence defendant to provisional term at suitable facility for treatment in lieu of imprisonment, mere finding that defendant suffers from mental disease or defect does not mandate this placement); Commonwealth v. DelVerde, 517 N.E.2d 159 (Mass. 1988) (after being found incompetent to stand trial on a charge of first degree murder and rape, defendant objected to trial court order moving him from county house of correction to maximum security psychiatric facility for six months; on appeal, defendant was found to meet statutory criteria for the proposed placement; court concluded he could not be returned to the county house of correction because earlier series of events there had shown he was likely to behave in a violent and assaultive manner and “create a likelihood of serious harm to others” upon return; court also stressed that criminal charges still outstanding).

443. However, if the proposed transfer centers on a prison-to-prison transfer with no substantial change in the level of mental health services provided, such decisions are left to the discretion of prison officials with no procedural review required prior to transfer. See, e.g., Vitek v. Jones, 445 U.S. 480 (1980) (transferring inmate from one prison to another did not create any procedural rights because the inmate had no expectation that such moves would be made only “upon the occurrence of specified behavior”); People v. Lego, 570 N.E.2d 402 (Ill. App. Ct. 1991) (request for transfer of death row inmate to different prison so he would have closer access to his experts, including his psychiatrist, denied because of concerns over cost of transfer, security risks, and need to leave authority for placements within discretion of correctional officials).

444. See infra part III.B.
ing a need for a relatively formal, adversarial review process. Because the transfers between secure facilities expose the community to neither the premature release or escape of the MDO, risks to the security of the community have not arisen as a consideration.

The cases in this area have primarily centered on the transfers over objection of prison inmates to psychiatric facilities during the term of their incarceration. *Vitek v. Jones*, issued by the U.S. Supreme Court in 1980, remains the leading case in this area. *Vitek* recognized that an inmate's liberty interest is potentially infringed by such transfers and thus the inmate has an accompanying entitlement to certain procedural protections prior to transfer.

In *Vitek*, a prison inmate, after setting a mattress on fire and burning himself severely, was transferred to the security unit of a state mental hospital. State law allowed this type of transfer as soon as a physician or psychologist found that the prisoner suffered from mental illness and could not be given proper treatment in the prison.

The Supreme Court ruled that this transfer procedure provided a prisoner inadequate notice and opportunity for a hearing in violation of the due process clause of the Fourteenth Amendment. The Court concluded that this transfer would have a substantial adverse impact on a prisoner and constitute a major change in the conditions of his or her confinement. The Court found a prison inmate has an objective expectation that he or she will not be transferred to a psychiatric hospital unless the inmate suffers from a mental disease or defect that cannot be adequately treated in the prison, and that expectation entitles an inmate to the benefits of an appropriate procedure to assure that the conditions warranting transfer are met.

In reaching its conclusion, the Court refused to distinguish these inmate-patients from other groups of involuntarily hospitalized patients, rejecting arguments that psychiatric hospitalization would have less impact on an inmate because he or she was already incarcerated than it would for a civil patient or that a criminal conviction entitles the State to impose psychiatric hospitalization.

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446. *Id.* at 484.
447. *Id.* at 483.
448. *Id.* at 493-94.
449. *Id.* at 493.
450. *Id.* at 493-94.
451. The Court asserted that both experienced "a massive curtailment of freedom." *Id.* at 491.
452. *Id.* at 493 ("None of our decisions holds that conviction for a crime entitles a State not only to confine the convicted person but also to determine that he has a mental illness and
In *Vitek*, little attention was given to potential countervailing interests of the State.\(^{453}\) It can be inferred that the Court did not perceive the State interest to be of significant importance in this context. In contrast, in *Jones v. United States*,\(^ {454}\) where the placement decision had the potential of permitting the immediate return of the MDO to the community, the Court paid considerably more attention to the interests of the State in upholding the automatic commitment and psychiatric hospitalization of an NGRI acquittee following trial.\(^ {455}\)

In addition, in mandating a more formal review process, the Court in *Vitek* was unwilling to defer to the judgment of mental health professionals. The Court did acknowledge the essentially medical nature of the transfer decision,\(^ {456}\) but was unwilling to defer to the judgment of the treating professional in making this decision. Although the basis for this position was largely left unstated, the Court implied that the subjective nature of the transfer decision, when combined with its serious potential adverse impact on the inmate, required that the decision not be left in the hands of the treating professional.\(^ {457}\) This may reflect a perception that the MDO was at a disadvantage in these proceedings with no countervailing need to protect society justifying this imbalance.

The Court did determine, however, that involving judges is not necessarily the most appropriate means for resolving these transfer decisions. It required only that "an independent decisionmaker," not necessarily a judge, determine whether there was a sufficient basis for the proposed transfer.\(^ {458}\) However, demonstrating some ambivalence to subject him involuntarily to institutional care in a mental hospital. Such consequences visited on the prisoner are qualitatively different from the punishment characteristically suffered by a person convicted of crime. Our cases . . . reflect an understanding that involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual."\(^ {459}\).

453. The Court's discussion of the State's interest in a truncated transfer procedure was limited to a single sentence. See *Vitek*, 445 U.S. at 495 ("Concededly the interest of the State in segregating and treating mentally ill patients is strong.").


455. See supra part III.A.2.

456. See *Vitek*, 445 U.S. at 495 ("We recognize that the inquiry involved in determining whether or not to transfer an inmate to a mental hospital for treatment involves a question that is essentially medical. The question whether an individual is mentally ill and cannot be treated in prison 'turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists.'").

457. Id. ("The medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings.'").

458. Id.
on the issue, the Court also required an adversarial hearing.\textsuperscript{459} Thus the State had to provide: (1) written notice to the prisoner that a transfer was being considered; (2) a hearing, sufficiently after the notice to give the inmate enough time to prepare, at which the evidence serving as the basis for the transfer would be disclosed to the prisoner and opportunity given to the prisoner to appear and contest the evidence;\textsuperscript{460} (3) a written statement by the factfinder of the basis for the decision; (4) legal counsel or independent assistance to the inmate;\textsuperscript{461} and (5) effective and timely notice of all these rights.\textsuperscript{462}

Perhaps the Court's somewhat ambiguous position on what form the procedural protections should take was a function of the relatively early date, 1980, that \textit{Vitek} was issued. At this time, courts were generally still reluctant to intrude into treatment decisions regarding the MDO,\textsuperscript{463} and, as noted, the Court considered the involuntary transfer of an inmate from a correctional facility to a psychiatric facility to be essentially a medical/treatment issue.\textsuperscript{464} However, just as courts became more vigorous in their scrutiny of treatment decisions concerning the MDO, they also assumed a more active role in reviewing the transfer of sentenced MDOs to psychiatric facilities. The \textit{Vitek} language permitting the use of an independent decision maker without legal training has been only sporadically utilized, with the review of a transfer recommendation generally provided by the judiciary.\textsuperscript{465} In addition, these recommendations have been given closer scrutiny.

\textsuperscript{459} Id. at 494.

\textsuperscript{460} The prisoner's right to present evidence, and confront and cross-examine the State's witnesses could be denied upon a finding of good cause.

\textsuperscript{461} The District Court would have limited this provision to legal counsel alone, as would have four members of the Supreme Court. However, Justice Powell in his decisive concurring opinion provided the alternative of independent assistance, in essence making the process less formal and adversarial. Justice Powell's discussion of this issue provides a further indication of the deep split in the judiciary over what constitutes sufficient procedural protection of the rights of the MDO. He explicitly noted the disadvantage the sentenced MDO may face in such matters; however, he argued that a more formal, adversarial procedure would not necessary correct this imbalance.

\textsuperscript{462} Id. at 494-95.

\textsuperscript{463} \textit{See supra} part II.B.

\textsuperscript{464} \textit{See Vitek}, 445 U.S. at 495.

\textsuperscript{465} \textit{See, e.g., In re Foster}, 426 N.W.2d 374 (Iowa 1988) (initial review of transfer decision under Iowa state law provided by a "judicial hospitalization referee" (a licensed attorney appointed by the courts), a judge, or a magistrate). This review is the same as used for reviewing applications for involuntary hospitalization in general. \textit{See} \textsc{Iowa Code Ann.} \textsection 229.21 (West 1985); \textit{In re Moll}, 347 N.W.2d 67, 70 (Minn. Ct. App. 1984) ("Under the commitment statute, it is the trial court, not a medical expert, that must determine whether a person is mentally ill."); \textit{Harmon v. McNutt}, 587 P.2d 537 (Wash. 1978) (judicial hearing mandated prior to transfer in non-emergency).
An example of this scrutiny was provided by the Iowa Supreme Court when it ruled that there was an insufficient basis to justify the involuntary commitment for psychiatric evaluation of a prison inmate.\textsuperscript{466} The court refused to create a separate categorization for sentenced MDOs, and thus applied the relatively restrictive statutory criteria used for civil involuntary hospitalization in Iowa, with the burden placed on the state to justify the transfer.\textsuperscript{467} By adopting two of the prevailing themes of the 1960s and 1970s, namely that predicting dangerousness is difficult and speculative and that the least restrictive alternative should be used, the court provided the MDO subject to transfer considerable procedural and judicial protection.\textsuperscript{468} The interests of the treating mental health professional in the transfer decision received little attention. The court indicated staff would have to adapt their procedures to meet the needs of the inmate.\textsuperscript{469}

\textsuperscript{466} See Foster, 426 N.W.2d at 380.

\textsuperscript{467} See id. at 376-77 (under civil commitment standard State had to show inmate "likely . . . to inflict physical [self-injury or injury on others], or to inflict emotional injury on the designated class of persons" and that this dangerousness be demonstrated by a "recent overt act, attempt or threat;" not enough that inmate's behavior could provoke other inmates to acts of aggression, but State had to show threat or act of unprovoked physical aggression by the inmate).

\textsuperscript{468} Id. at 379.

\textsuperscript{469} For other state court opinions that also imposed vigorous scrutiny and heightened procedural protections prior to the transfer of a sentenced MDO from a prison setting to a mental health facility, see Moll, 347 N.W.2d at 70 (psychiatric basis for transfer closely reviewed, with refusal to defer to psychiatric expertise; although ultimately concurred with psychiatric expert's finding, court noted, "Under the commitment statute, it is the trial court, not a medical expert, that must determine whether a person is mentally ill"; noted that inmate recently admitted himself to mental health unit, thereby minimizing any unfairness of forcing him to accept treatment he recently sought, and that no reasonable alternatives to commitment); Harmon, 587 P.2d at 537 (refusal to distinguish between sentenced MDO and other groups of non-sentenced MDOs in deciding that procedural rights guaranteed; judicial hearing mandated prior to transfer in non-emergency, with sentenced MDO entitled to counsel at hearing).

In contrast to the courts' willingness to provide procedural protection to a sentenced MDO being involuntarily transferred from a prison to a secure psychiatric facility, the courts have not been willing to impose similar procedural barriers when a civil patient objects to being transferred to or placed in a secure psychiatric facility that houses sentenced MDOs, provided the secure nature of the facility does not result in a predominantly prison environment. See, e.g., Doe by Roe v. Gaughan, 617 F. Supp. 1477, 1485-86 (D.C. Mass. 1985) ("the state action in confining civilly committed mental patients in Bridgewater together with mental patients serving criminal sentences is not a \textit{per se} violation of the plaintiff's constitutional rights"; might rule differently if civil patient thrust into overwhelming penal atmosphere, but this facility served broad spectrum of patients, all of whom met same admission criteria, provided a host of programming, and no indication civil patients lost any additional freedoms by being confined with convicted criminals; noted that transfer preceded by initial court order guaranteeing that specific admission criteria met and that this a particularly dangerous group of patients for whom increased security of facility totally appropriate), aff'd, 808 F.2d 871 (1st Cir. 1986); Ray v. Bachik, 791 P.2d 150 (Or. Ct. App.) (placement of civil patient in maximum security ward that houses mostly patients committed to hospital through criminal justice system not prohibited), review denied, 796 P.2d 1206 (Or. 1990).
Somewhat ironically, while some prisoners with mental health problems have fought their transfer to a psychiatric facility, other prisoners have sought means to force this transfer even though treating mental health professionals have concluded that the individual is not in need of such treatment. Some inmates perceive a psychiatric facility as less restrictive than the general prison environment, and thus a more preferable placement. This may particularly be the case if the prisoner is being held within the restrictive conditions of disciplinary segregation at the prison following an infraction of the prison’s disciplinary code. Generally the secure psychiatric facility to which they are sent does not contain cells but houses the sentenced MDO in a dormitory environment, limits sanctions for disciplinary violations since treatment not punishment must be provided in this setting, provides considerably more diversion in the form of regularly scheduled therapeutic activities, and may provide a more pleasant and permissive environment as part of its treatment milieu.

Typically, an inmate seeking such a placement places pressure on the treating mental health professional who must decide whether referral is appropriate and/or when an inmate’s placement in a psychiatric facility should end. As such beds are limited, an inappropriate transfer or retention may deny placement for a prisoner truly in need of the care provided at the psychiatric facility. The courts have not indicated that they will require a formal review process when an inmate demands transfer to a psychiatric facility or objects to his or her return to prison. On the other hand, if the professional inappropriately rejects a proposed transfer or prematurely returns the inmate to prison and the inmate indeed needs the treatment associated with the psychiatric placement, the professional may be liable for harm that the inmate causes to himself or herself or others within the prison setting.

470. See, e.g., Jackson v. Fair, 846 F.2d 811, 818 (1st Cir. 1988) (statute setting out procedures for prisoner to challenge involuntary transfer to psychiatric facility did not also apply to prisoner seeking to block return to correctional environment; procedures did not give committed patients a right to stay in psychiatric institutions and indeed automatically released patient upon expiration of commitment order unless State sought new commitment order; court noted that inmate unable to cite a single applicable case involving a challenge by a psychiatric patient to release from a psychiatric institution; no right to hearing prior to return; “at some point committed prisoners, if their condition improves, must . . . return to the general prison population”).

471. Alternatively, the inmate may file suit asserting that the treatment provided within the prison is inadequate. See, e.g., Jackson, 846 F.2d at 811 (while ruling that inmate could not block return to prison from psychiatric facility, court was willing to undertake review of treatment provided within prison setting to determine if met constitutional minima). See generally supra part III.B.1.
What perhaps gets overlooked in these transfer cases is the frequent necessity of effecting a prompt transfer to a secure psychiatric facility. When the required transfer machinery (judicial or otherwise) is cumbersome and nonresponsive, the psychological deterioration that necessitated the initial request for transfer may continue to progress, increasing the risk of serious harm to the MDO, treatment or correctional staff, or other inmates. Furthermore, by waiting until the MDO is in an emergency state, treatment staff at the receiving facility may have to respond immediately to a crisis situation based on limited knowledge about the patient, making it difficult for them to provide an appropriate response. Although emergency transfer in response to imminently dangerous behavior is typically provided for by law, if transfer can be made prior to this extreme state, the safety of both the individual patient and others will be greatly promoted. Unfortunately, the mechanism for processing both non-emergency and emergency involuntary transfers may be slow and cumbersome, preventing timely and appropriate interventions.172

A Pennsylvania appellate court explored the dangers that may arise from a failure to quickly and appropriately respond to an MDO's psychiatric needs and to assure that the needed information flows between the sending and receiving facilities.473 A psychiatric nurse at a state psychiatric facility sought damages after she was suddenly attacked by a patient who had been recently transferred there from a prison pursuant to a court-ordered involuntary commitment. The nurse sued those individuals she considered responsible for the transfer.474 Among her complaints were that the defendants had: (1) not provided adequate programming for the patient at the prison, implying that such programming would have obviated the need for transfer or minimized the risk upon arrival; (2) failed to recommend the necessary level of security at the hospital (the patient was placed in an open admissions ward after being confined to her cell at the prison for attacks upon staff); (3) allowed the patient's transfer to an inappropriate setting; and (4) failed to provide adequate follow-up in conjunction with the transfer.475 Although the prison, the deputy warden of the prison, the county mental health program, and its administrator were held to be entitled to governmental and official immunity under state law, except for these statutory protections, these parties

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472. See W. Lawrence Fitch, Assembly Amends Jail to Hospital Transfer Laws, 6(1-2) DEV. MENTAL HEALTH L. 7 (1986) (discussion of 1986 changes in the Virginia statutory scheme to facilitate psychiatric hospitalization of persons in jail needing emergency treatment).
474. Id. at 977.
475. Id. at 977-78.
may have been found liable for this transfer.\textsuperscript{476} It should also be noted that a doctor at the receiving hospital, whose role in the incident was undefined, was not dismissed from the suit and remained potentially liable.

In general, as long as no risk to the community is perceived to be associated with transfer decisions between secure facilities, it is likely that the increased recognition of the procedural rights of MDOs to challenge such transfers will continue. However, increased recognition of the right of the MDO to object to transfer decisions from one secure facility to another may fail to recognize that by making such transfers more difficult to accomplish, the MDO may not receive needed treatment, placing the community and the MDO at risk when the MDO is ultimately released, as well as endangering staff and other individuals housed with the MDO in the interim.

2. More Secure to Less Secure Facility Transfers

Moving an inmate from a correctional facility to a secure psychiatric facility is generally viewed as requiring some sort of procedural protection because of the negative impact such transfers have for the individual. But what about movements from a more secure to a less secure facility? While the MDO may prefer such transfers as providing greater freedoms, they may also increase the risk to the community. As security decreases, there may be greater opportunity for the MDO to escape. Similarly, programming in a less secure facility typically involves a gradual, planned reintegration of the MDO back into the community. As a result of its fear of the MDO, the community, typically represented by the District Attorney's Office, may seek to block the movement of an MDO to a less secure environment, and recent courts have shown some willingness to respond to the community's concerns.\textsuperscript{477}

\textsuperscript{476} Id. at 979-81.

\textsuperscript{477} This is particularly true for non-sentenced MDOs. Although most correctional systems have a range of facilities varying from maximum security to minimum security, the public typically expresses little alarm at the placement of a particular inmate within a minimum security correctional facility. Generally, the public does not perceive the risk of escape or harm to the community to vary greatly among the different security levels. In addition, such movements are generally handled internally with very little outside publicity. However, there have been cases where the movement of a well-known sentenced MDO from a maximum to a minimum correctional facility has created the same public outcry as for non-sentenced MDOs. Nevertheless, probably in part because there is not a ready legal avenue for the public to challenge such moves, there are few, if any, cases discussing objections by the public to transfers of sentenced MDOs to a less secure correctional setting. In contrast, with non-sentenced MDOs the District Attorney, who frequently attempts to speak on behalf of the general community, may remain an active party to litigation concerning the commitment, recommitment and release of such individuals, and may exercised this legal standing to object to and/or block proposed transfers to less secure facilities.
MENTALLY DISORDERED OFFENDERS

One of the clearest examples of the State opposing the proposed transfer of an MDO from a more secure to a less secure facility because of the potential harm that society might incur, and the courts' willingness to closely scrutinize the proposal, came in a decision by the Supreme Court of Ohio.478

A criminal defendant had been found not guilty by reason of insanity to a charge of aggravated murder and had been committed to a maximum security treatment facility. After four years, the facility, pursuant to statute, sought a judicial order transferring him to the less restrictive environment of a more characteristic psychiatric center. The State opposed the transfer, and on appeal, the court rejected this proposed movement and adopted many of the themes used by courts in the 1980s and 1990s to restrict the freedom of the MDO outside secure institutional confinement in general.479

First, the court shifted the usual evidentiary burden, and in so doing emphasized the need to protect society.480 Under Ohio law, the burden of proof was placed on the State at the initial involuntary commitment proceeding of the MDO to justify retention and establish that the individual was being placed in the least restrictive alternative.481 The court concluded that this evidentiary burden was not appropriate for this transfer decision. The rationale for this evidentiary burden at the initial proceedings, the court explained, was to minimize the risk that a person might be committed for mere idiosyncratic behavior.482 However, when considering subsequent transfer to a less restrictive facility, the patient's mental illness was already established and the need for involuntary hospitalization conceded.483 In such cases, the court considered both the patient's welfare and the public safety.484 As a result, the court concluded, neither party should have the burden of proof in such proceedings.485

Second, in reviewing this particular application for transfer, the court focused on the public safety and, as might be expected, used a relatively broad net to encompass potential dangerousness. The court noted the patient had a history of instability brought on by his use of

479. Id. at 653-54.
480. See id. at 654-55.
481. It should be recalled, however, that many states have adopted a procedure that allows for the automatic commitment of an NGRI acquittee because of a presumption drawn from their criminal conviction that they are indeed dangerous. See supra part III.A.2.
482. Johnson, 512 N.E.2d at 655.
483. Id.
484. Id.
485. Id. at 655-56.
illicit drugs.\textsuperscript{486} Furthermore, the court remarked that the facility to which the MDO was to be transferred had been experiencing a serious drug abuse problem, allowed patients to move throughout the facility freely and unescorted, and allowed visitors inside the facility all day, every day.\textsuperscript{487} The court concluded that this atmosphere would provide the MDO with an easy access to drugs, and thus there was a high potential for his destabilization.\textsuperscript{488} Based on this, the court denied the application for transfer.\textsuperscript{489}

3. \textit{Intra-Facility Transfers}

Another potential status change for the MDO placed within a psychiatric hospital involves transfers between wards within a given facility. Often a psychiatric facility housing MDOs will include one or more secure wards where patients will be placed who are considered in need of close supervision because they are deemed dangerous and/or escape risks, with their freedoms restricted accordingly. When patients no longer meet these criteria they may be moved to a less secure ward where they are not as closely supervised and may be given a range of additional freedoms, including off-ward privileges.\textsuperscript{489} Although these intra-facility transfers have also received relatively little judicial attention, when addressing these transfers, the courts have generally ruled that if such moves are made for therapeutic rather than punitive reasons, the transfer decision lies within the discretion of the facility's administrative staff and should not be subject to judicial review.

For example, in one case,\textsuperscript{491} an NGRI acquittee was initially placed in the forensic unit at the psychiatric hospital to which he was committed. At a hearing on his need for continued commitment, the hos-

\begin{itemize}
\item \textsuperscript{486} \textit{Id.} at 656.
\item \textsuperscript{487} \textit{Id.} at 656-57.
\item \textsuperscript{488} \textit{Id.} at 657.
\item \textsuperscript{489} \textit{Id.}; see also McSwain v. Stricklin, 540 So. 2d 81 (Ala. Civ. App. 1989) (NGRI acquittee's petition for placement in less restrictive facility denied even though previously in less restrictive facility and only moved to more secure facility because State decided to house all NGRI acquittees together); People v. Villanueva, 528 N.Y.S.2d 506 (Sup. Ct. 1988) (District Attorney sought 10-day notice prior to any transfer of non-sentenced MDO, ostensibly to file objection to and block any such transfer considered a risk to the community; although request ultimately rejected, procedure was imposed that would closely monitor any change in status that might impose such risk); State v. Lanzy, 569 N.E.2d 468 (Ohio 1991) (trial court has authority to place conditions on insanity acquittees' transfer to less restrictive facility, including requiring prior court approval before receiving escorted or non-escorted off-grounds privileges; responsibility of court to protect public safety).
\item \textsuperscript{490} See infra part III.C.4.
\item \textsuperscript{491} State v. Lake, 515 N.E.2d 960 (Ohio Ct. App. 1986).
\end{itemize}
pital proposed transferring the MDO to a less secure ward; however, the trial court rejected the proposal. An Ohio appellate court reversed the trial court's ruling, stating that while the trial court had the power to choose the facility where an acquittee was to be placed, it did not have supervisory powers over the details of a patient's treatment. Thus, it could not dictate the choice of particular units or wards within the facility. The court stressed the judiciary's lack of expertise in making such treatment decisions and the need to defer to treatment professionals trained to make such decisions. It concluded that intra-hospital transfers were best left to the discretion and expertise of the hospital's administrative staff.

This "hands-off" approach may seem incongruous in conjunction with recent judicial opinions that appear unwilling to defer to professional judgment in treatment cases or where the result is to give the MDO greater freedom. Arguably, it was because neither of the paramount concerns typically connected with MDO cases were raised here. The interests of the MDO were protected as treatment was to be provided and the individual could be expected to benefit from the less restrictive placement. Similarly, the interests of the community were not endangered as the patient remained within the same facility and could be returned to the secure ward if a risk to the community became apparent. However, where the change in status extends beyond a simple change of wards and specifically involves reentry into the community, courts are more likely to interject themselves into the decision-making process.

Most of the case law on intra-facility transfers involving MDOs has arisen primarily in conjunction with the movement of sentenced MDOs into segregated prison housing for protective (as opposed to therapeutic) purposes. Here, too, the courts have generally deferred to the judgment of administrative officials without imposing proce-

492. Id. at 961.
493. Id. at 963.
494. Id. ("A court is not in a position to prescribe the exact method of an individual's treatment.").
495. Id. at 962 ("The least restrictive alternative requirement relates to choice of a facility and not to particular units or wards within the facility. The placement of an NGRI patient within the particular facility involves treatment considerations within the sole discretion and expertise of the hospital's administration. A court-ordered ward-to-ward transfer would be too intrusive into hospital affairs and possibly inconsistent with the goals established by the patient's doctors.").
496. Id.
497. See infra part III.B.4.
498. For the leading case on the transfer of prison inmates into administrative segregation for non-psychiatric reasons, see Hewitt v. Helms, 459 U.S. 460 (1983).
dural requirements where there is no indication that the move was made for punitive purposes.

For example, the Court of Appeals for the Seventh Circuit discussed the legality of a long-term placement of a transsexual in administrative segregation.\textsuperscript{499} The court found that placing this inmate in restrictive segregation did not violate the due process clause when done for nonpunitive reasons, and that the inmate had no right to remain in the general prison population.\textsuperscript{500} Such a placement was not improper simply because it imposed harsh and restrictive conditions.\textsuperscript{501} Instead, the court looked at any threat posed to the inmate's physical health, the length of confinement, and the existence of feasible alternatives. However, the court also noted that in conducting such a review it would consider the management problems posed for administrative officials by this individual, including the possibility that leaving the individual in the general population would create a "volatile and explosive situation."\textsuperscript{502} The case was remanded for a determination of the actual conditions of plaintiff's confinement and the existence of any feasible alternatives.\textsuperscript{503}

This analysis appears generally applicable to a sentenced MDO exhibiting psychiatric symptoms. Such individuals may not meet the criteria required for transfer to a psychiatric facility, but the manifestation of their mental illness may provoke other inmates or leave them vulnerable to attack. Prison officials may consider it necessary to confine such inmates in administrative segregation for their safety. Within limits and where treatment is provided, this action appears permissible. Indeed, often the sentenced MDO seeks such a placement.\textsuperscript{504}

A more controversial status change is the placement of a mentally ill inmate in punitive segregation after a major violation of the pri-

\textsuperscript{499} Meriwether v. Faulkner, 821 F.2d 408 (7th Cir.), cert. denied, 484 U.S. 935 (1987).

\textsuperscript{500} Id. at 414 ("[T]he Supreme Court expressly held that a prisoner has no protected liberty interest in being confined in the general prison population rather than in restrictive segregation.").

\textsuperscript{501} Id. at 416 ("The Supreme Court has cautioned, however, that conditions are not unconstitutional simply because they are harsh and restrictive.").

\textsuperscript{502} Id. at 417 ("A prisoner such as the plaintiff poses particularly serious management problems for prison officials. Given her transsexual identity and unique physical characteristics, her being housed among male inmates in a general population cell would undoubtedly create, in the words of the district court, 'a volatile and explosive situation.'").

\textsuperscript{503} Id. at 417-18.

\textsuperscript{504} Typically, however, the demand for such placements, with the increased privacy that accompanies them, greatly exceeds their availability.
son’s disciplinary code. Such a placement is clearly intended to serve as punishment. Most legal challenges to such placements have centered on the failure of prison officials to respond to the mental health needs of these inmates while segregated.

For example, the Seventh Circuit upheld a finding that the placement of a resident of a juvenile correctional institution in punitive segregation was prohibited cruel and unusual punishment. The girl, aged sixteen, was placed in segregation after an attempted escape. The court concluded there was a sufficient basis for the jury to find that the staff psychologist had acted improperly by refusing to see her during most of her stay in segregation.

Notably, the Seventh Circuit found no cases regarding the propriety of such placements at the time, and the issue of providing mental health services to inmates in disciplinary segregation has not been fully resolved. Assuming that such services are required, there are, nevertheless, some commentators who argue that placing a mentally ill inmate into disciplinary segregation will inherently exacerbate that individual’s psychiatric symptoms and thus should not be allowed. However, others argue that there is no such universal effect, that such placement may be beneficial for the inmate, that this disciplinary alternative needs to be available for the entire prison population, and, at most, because of the vagaries of mental illness, the appropriateness of such placements should be evaluated on a case-by-
case basis for each individual rather than uniformly prohibited.510 Closely linked to this issue is the question of whether a psychiatric evaluation should be provided as part of the prison disciplinary process to determine the likely impact on the MDO of being placed in punitive segregation.

One lower state court has concluded that a psychiatric evaluation must be conducted on any inmate with a well-documented history of serious psychiatric problems before he or she can be held accountable for misbehavior and that the hearing officer must take the inmate's mental state into consideration in reaching a decision (i.e., that the officer consider the equivalent of an insanity defense).511 Others argue that such an evaluation should be conducted following disposition and prior to placement to determine the inmate's ability to tolerate the strictures of disciplinary segregation.512 A third group, and perhaps the one that comprises the majority to date, argues that regular monitoring of MDOs placed in disciplinary segregation will provide sufficient warning of any deleterious effects from this placement and allow for the removal of the MDO from disciplinary segregation prior to any serious or permanent harmful effect.513

Interwoven with these positions are concerns of prison mental health professionals that they should not be involved in this decision-making process. They argue that requiring them to provide such anticipatory evaluations may require predictions beyond their evaluative capability514 and put them in a position where they make the ultimate decision on the placement of the inmate. This, in turn, may undercut their ability to develop a trusting therapeutic relationship with their

510. See, e.g., James Bonta & Paul Gendreau, Solitary Confinement Is Not Cruel and Unusual Punishment—People Sometimes Are, 26 CANADIAN J. OF CRIMINOLOGY 467 (1984); James Bonta & Paul Gendreau, Reexamining the Cruel and Unusual Punishment of Prison Life, 14 LAW & HUM. BEHAV. 347, 361 (1990) (after reviewing the literature, "[t]he real culprit may not necessarily be the condition of solitary [confinement] per se but the manner in which inmates have been treated."); Luise, supra note 508, at 314 ("The courts are reluctant to conclude that psychological deterioration resulting from such isolation constitutes cruel and unusual punishment."); Peter Suedfeld & C. Roy, Using Social-Isolation to Change Behavior of Disruptive Inmates, 19(1) INT'L J. OFFENDER THERAPY 90 (1975); Peter Suedfeld et al., Reactions and Attributes or Prisoners in Solitary Confinement, 9 CRIM. JUST. & BEHAV. 303 (1982) (study found no major psychological damage to inmates experiencing solitary confinement).


513. See ME. REV. STAT. ANN. tit. 34-A, § 3032(D) (West 1988 & Supp. 1993) (when segregation exceeds 24 hours, an examination of the inmate's health shall be conducted once every 24 hours by a physician, medical staff members, or staff member with appropriate in-service training, with chief administrative officer to give "full consideration" to any recommendations made with regard to conditions of confinement effecting the inmate's health).

514. Such professionals may not be trained to provide the requisite evaluations.
patients as they come to perceive the therapist as aligned with the disciplinary forces at the prison.

4. Passes/Privileges

Conceptually, it might be difficult to predict how the courts would react to the granting of passes and privileges to the MDO. Providing individuals greater access to passes and privileges as they gradually improve is widely accepted as an integral component of treatment plans for individuals with a mental disability who have been placed in an institution. The goal is to gradually integrate the individual back into the community under circumstances that allow staff to assess the individual’s ability to successfully handle the responsibilities and pressures that may accompany this increased freedom. However, as this approach diminishes the institution’s control of the individual and provides the individual greater access to the community, it may also place society at greater risk from an unanticipated harmful or violent act by the individual. In assessing their issuance, there is some indication that as the individual is perceived as more dangerous, the courts are more reluctant to grant the individual increased access to passes and privileges. As a result, their issuance to MDOs has received more scrutiny than generally given for civil patients, but the results have not always been consistent.

For example, the Minnesota Supreme Court ruled that the issuance of passes to patients committed as mentally ill and dangerous was a treatment method and not a form of discharge. As a result, passes did not have to be approved in advance by a special review board created to evaluate proposed discharges of this group of patients. The pass program had been challenged as creating a significant risk of harm to the public. Instead the court found that it played a central role in the treatment of such patients because it was integral to their treatment plan, furthered the goal of enabling the patient to reenter the community safely, helped the treatment team evaluate the patient’s progress, provided the patient with an incentive as well as additional recreational and social opportunities, and its denial would “tie the hands” of the treating physician and eviscerate the physician’s discretion. The court concluded the public safety was sufficiently protected by the commitment and discharge process.

515. County of Hennepin v. Levine, 345 N.W.2d 217 (Minn. 1984). Although this case dealt with patients who were civilly committed as mentally ill and dangerous to the public, and thus not technically MDOs, this group of patients under Minnesota law is distinguished from patients committed simply as mentally ill, and thus because of their prior classification as being dangerous are probably closely analogous to non-sentenced MDOs.
Furthermore, the court implied that a certain degree of trial and error was necessary in the pass program and that society must accept some of the burden of errors, in part because "[f]urther attempts to predict dangerousness result in an exercise in futility."  

In contrast, the Georgia Court of Appeals upheld a trial court's refusal to grant off-campus privileges to a committed insanity acquittee. The court made this ruling even though the unanimous recommendation of the treating professionals was that off-campus privileges under a gradual release program would further the acquittee's progress. The court provided little explanation other than stating that courts retain ultimate discretion to make such decisions.

Unfortunately for the mental health professional responsible for implementing a treatment program for the MDO, the failure of the courts to establish a firm position on the issuance of passes and privileges leaves the mental health professional potentially subject to liability should the wrong choice be made. For instance, the Ninth Circuit Court of Appeals ruled that the state director of mental health and three hospital administrators were potentially liable for not setting up a separate, more restrictive procedure for granting MDOs ground passes. After being admitted to a state hospital after an insanity acquittal to a charge of raping and murdering a young woman, the acquittee subsequently assaulted and attempted to rape a

516. Id. at 223; see Amadon v. State, 565 N.Y.S.2d 677 (Ct. Cl. 1990) (MDO taken off close observation (every 30 minutes) and allowed to go off unit when escorted; MDO subsequently escaped and murdered decedent; decedent's estate sued State for negligence in placing MDO on open unit and reducing degree of supervision; suit dismissed for plaintiff's failure to produce expert testimony to show negligence; such expert testimony required because judge/jury without sufficient knowledge, training, or experience to rule on such questions of medical science or practice).


518. Id. at 49 (Although "a committing court has the authority to allow an insanity acquittee to pursue treatment, educational or other goals outside of the confines of the treating facility[,] . . . a committing court is [not] mandated to approve such a plan. As is the case in a petition seeking an outright release of the insanity acquittee, '(t)he (committing) court is entirely free to reject the recommendation of the staff of the institution."' (citations omitted)). See also O'Neal v. State, 365 S.E.2d 894 (Ga. Ct. App. 1988); State v. Lanzy, 569 N.E.2d 468 (Ohio 1991) (trial court had authority to require prior court approval before any off-grounds privileges issued to insanity acquittee; necessary to protect public safety).

519. Estate of Conners by Meredith v. O'Connor, 846 F.2d 1205, 1208 (9th Cir. 1988), cert. denied, 489 U.S. 1065 (1989). This opinion is of particular note in that it was a 42 U.S.C. § 1983 action. This meant that plaintiffs had to show not only that the defendants were negligent, but also that there was a "conscious indifference amounting to gross negligence." Furthermore, in as much as this decision was issued by a federal court, it stands in contrast to those federal court opinions discussed earlier that were typically inclined to defer to the professional judgment of the therapeutic staff when a treatment decision was involved, and suggests that greater scrutiny will be given to a treatment decision that results in the MDO having access to the general public.
female patient at the hospital.\textsuperscript{520} Two to three weeks later, he lured another female patient from her ward, took her to a remote part of the hospital grounds, and raped and strangled her.\textsuperscript{521} For the latter act, the woman’s estate sued the state director of mental health, and the executive director, clinical director, and medical director of the hospital alleging gross negligence and reckless indifference to patient safety in approving ground privileges for such patients.

In assessing liability, the court adopted the professional judgment standard.\textsuperscript{522} Nonetheless, the plaintiff introduced the affidavit of a psychiatrist who had worked at the hospital for more than seven years who attacked the hospital’s approach for determining the risk of violence from a patient. The psychiatrist asserted that criteria for assessing violence were informal and vague, resulting in patients with considerable potential for violence being granted ground’s passes; that staff received no training in assessing this potential; that MDOs were not given special consideration in decisions to award ground passes nor were they given special treatment to reduce their potential for violence; and that despite a history of violence among MDOs, staff had made no attempt to rectify the problem. The court concluded that if plaintiff could prove these allegations, defendants would be liable for damages.\textsuperscript{523}

Simultaneously, there have been legislative attempts to ensure the safety of the community by restricting the access of MDOs to passes

\textsuperscript{520} Id. at 1207 n.2.
\textsuperscript{521} Id. at 1206-07.
\textsuperscript{522} Id. at 1208 ("Liability may be imposed on a professional state officer only when his or her decision is so objectively unreasonable as to demonstrate that he or she actually did not base the challenged decision upon professional judgment.").
\textsuperscript{523} Like other courts in the 1980s and 1990s, this court was thus quite willing to allow a distinction between MDOs and other patients, particularly where the dangerousness to others of the former could be established. \textit{See also} Tamsen v. Weber, 802 P.2d 1063 (Ariz. Ct. App. 1990) (after attempting suicide twice while in jail, patient transferred and involuntarily committed to state hospital, where again attempted suicide and got in fight with staff member; nonetheless granted unsupervised grounds privileges, during which he escaped and subsequently abducted and assaulted passer-by; ruled that therapist who granted unescorted grounds privileges had duty to control involuntarily committed patient with known dangerous propensities; because patient within physician’s physical control the scope of duty greater than for psychiatrist treating outpatient who had freedom of movement and more difficult to monitor and control; psychiatrist’s duty not limited to victims within reasonably foreseeable zone of danger; if doctor knew or should have known of patient’s dangerous propensities, duty to act with due care to protect others by controlling patient); Department of Mental Health v. Allen, 427 N.E.2d 2 (Ind. Ct. App. 1981) (woman attacked and raped by MDO out on weekend pass from state psychiatric hospital sued the State and the state hospital for negligence in issuing pass; although court ruled the decision to release the MDO as part of treatment plan could not be basis for recovery, to the extent the actual release, the conditions of release, and the monitoring of compliance with conditions of release were conducted negligently, they could be basis for recovery); Amadon v. State, 563 N.Y.S.2d 677 (Ct. Cl. 1990).
and privileges. For example, Illinois enacted a statute whereby an 
NGRI felony acquittee subsequently committed and placed in a se-
cure setting was not to be allowed in the community, given escorted 
or unescorted off-grounds privileges, or unsupervised on-grounds 
privileges without prior court approval. Furthermore, the court 
could attach such conditions as it deemed necessary to reasonably as-
sure the defendant’s satisfactory progress in treatment and the safety 
of the defendant and others.

5. Outpatient/Conditional Release

In an attempt to further reentry into the community while retaining 
a certain level of control over MDOs, many states have imposed an 
intermediate step between inpatient care and outright release. Re-
ferred to as outpatient status or conditional release for non-sentenced 
MDOs, and parole or probation for the sentenced MDO, the intent is 
to provide close supervision of the MDO after institutional discharge. 
When warning signals occur, such as an increase in psychiatric symp-
toms or a lapse in adherence to the prescribed treatment program, 
these programs provide the State with a means for unilaterally revok-
ing a community placement, thereby ensuring the community’s safety 
by returning the MDO to an institutional setting.

This approach represents an attempt to balance the rights of the 
MDO with the interests of the community. By shortening or replacing 
institutional stay, it provides a far less intrusive alternative to the restric-
tions of institutional life. Community placement allows a considerably wider range of individual freedoms to the MDO, as well as an 
opportunity to establish or re-establish direct community links. At 
the same time, by requiring the MDO to comply with a given treat-
ment program, it allows mental health professionals an opportunity 
to gauge the MDO’s progress, and where appropriate, initiate steps 
that will forestall or minimize harm that might occur if the MDO 
suffers a relapse.

Nevertheless, the community placement of an MDO can bring the 
interests of the MDO and the community quickly into conflict. Re-
moved from the strictures of facility life, some individuals may dis-
continue aspects of a prescribed treatment program (e.g., 
medication), decompensate, and act out in ways that may be harmful 
to themselves or others. Alternatively, the variable and relatively un-
predictable course of mental illness may result in a sudden, unex-

525. Id.
pected deterioration of the mental health of the MDO. Because of the limited monitoring and supervision that typically accompanies a community placement, there is a reduced likelihood of early intervention and a correspondingly reduced ability to control harmful behavior. As a result, the community may be more at risk. Not surprising in light of the courts' tendency to favor the interests of the community over those of the MDO when the community is placed directly at risk, judicial decisions regarding outpatient or conditional release have generally stressed the importance of protecting the safety of the community.

Unlike other areas of the law addressing the MDO, courts have remained relatively consistent over time in their appraisal of the use of conditional release and outpatient treatment for the MDO.\textsuperscript{526} From the outset,\textsuperscript{527} courts have indicated the need to closely scrutinize these placements. Typically, they have retained for themselves considerable discretion in reviewing and assessing these placements, and have often adopted an active role in monitoring them.\textsuperscript{528} In so doing, they

\textsuperscript{526} It should be noted that outpatient care and conditional release for treating both MDOs and involuntarily hospitalized patients in general are more likely to be used of late. See, e.g., \textsuperscript{PERLIN, supra note 2, at 453} ("Outpatient commitment will likely be one of the one or two major 'growth areas' . . . in involuntary civil commitment law in the near future"); Samuel J. Brakel, \textit{Discharge and Transfer}, in \textit{SAMUEL J. BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW} 207 (1985) ("[S]ignificantly greater resources than before are devoted to planning the patient's post-hospitalization route, implementing the plans, and maintaining general liaison with community treatment programs and facilities.").

\textsuperscript{527} For one of the initial opinions that addressed the use of conditional release and outpatient care for the MDO, and an example of the decisional framework that the courts have consistently applied, see United States v. Ecker, 543 F.2d 178 (D.C. Cir. 1976), cert. denied, 429 U.S. 1063 (1977). This opinion is particularly noteworthy in that it came at a time, which the court itself recognized, when courts were not inclined to closely review treatment decisions and tended to defer to the professional judgment of the treatment staff.

\textsuperscript{528} See, e.g., \textit{Ecker}, 543 F.2d at 178 (refusal to allow conditional release of insanity acquittee); State v. Johnson, 753 P.2d 154 (Ariz. 1988) (NGRI acquittee refused \textit{conditional} release even though acquittee's appeal challenged the acquittee's being wrongfully denied \textit{unconditional} release by lower court; court stressed the limitations attached to conditional release and ability of court to refuse to grant such status or subsequently revoke such status if conditions not met); People v. Henderson, 233 Cal. Rptr. 141 (Ct. App. 1986) (placement of mentally disordered sex offender on outpatient status not allowed); People v. Cooper, 547 N.E.2d 449 (Ill. 1989) (until defendant proves to court that no longer sexually dangerous, conditional release status continues and court retains jurisdiction and supervision notwithstanding court order that appeared to automatically terminate conditional release on given date); People v. Butler, 550 N.E.2d 1250 (Ill. App. Ct. 1990) (State's petition for extension of conditional release not void even though filed after present period of conditional release expired; court must make current finding that no longer mentally ill before jurisdiction ends); People v. White, 518 N.E.2d 1262 (Ill. App. Ct. 1988) (legislative scheme did not limit terms and conditions that may be imposed on NGRI acquittee conditionally released); \textit{In re} Martin B., 525 N.Y.S.2d 469 (Sup. Ct. 1987) (extended order of conditions that required NGRI acquittee to
have emphasized their responsibility to ensure the protection of the general community. Simultaneously, they have refused to defer to the judgment of treatment professionals when making decisions about these placements, stressing the fallibility of mental health professionals in making predictions about the success of such placements. For example, courts have rejected proposals to place an MDO on conditional release even though treatment staff, the superintendent of the hospital where the MDO was residing, the State's representative, or a string of experts recommended this placement. Indeed, some courts have gone so far as to suggest that they should be suspicious of such recommendations when made by treatment staff. Even when the MDO has successfully completed prerequisites

comply with treatment plan for additional five years).

A failure to comply with a condition that the individual obtain or participate in mental health services has also been held to provide an adequate basis for the revocation of probation and the subsequent imposition of a prison sentence. See, e.g., State v. Fife, 771 P.2d 543 (Idaho Ct. App. 1989) (due to mental impairments probationer no longer responding to probation counselling); Stinchcomb v. State, 562 A.2d 781 (Md. Ct. Spec. App. 1989) (trial judge can order voluntary inpatient committed to a state mental health facility as condition of probation); State v. Emery, 593 A.2d 77 (Vt. 1991) (refusal to participate in sex offender's group therapy); State v. Foster, 561 A.2d 107 (Vt. 1989) (failure to complete required mental health screening).

529. See, e.g., Ecker, 543 F.2d at 182-83 (necessary to consider "public safety considerations inherent in a conditional or unconditional release proposal"); "when a district court is asked to review a conditional release certification . . . the court must decide whether the hospital's proposal 'provide[s] treatment and cure for the individual in [a] manner which affords reasonable assurance for the public safety'"; Johnson, 753 P.2d at 157 ("failure to demonstrate that a patient will follow a reasonable and properly prescribed outpatient program renders that patient ineligible for conditional release. This statutory provision is entirely appropriate as failure or refusal to follow the prescribed outpatient plan, including medication, may bear directly upon the patient's potential dangerousness."); Martin B., 525 N.Y.S.2d at 475 ("the function of the Order of Conditions is to provide a safeguard to the public that is peculiar to non-responsibility acquittees").

530. See, e.g., Ecker, 543 F.2d at 190 ("the court is under no obligation to accept the experts' opinions . . .").

531. Id. at 191 ("Of considerable importance . . . is the undeniable fact that this patient has been thought by the medical experts to be ready for a return to community life before, and that the experts have been proved tragically wrong. . . . Previously psychiatric records have indicated that appellant was ready and able to function in society. Yet little more than two years after one such determination and his resulting release from Shepard-Pratt Hospital, appellant committed the rape and murder which led to his current institutionalization.").

532. See, e.g., id. at 178 (conditional release recommended by superintendent and treatment staff of hospital where insanity acquittee initially placed, as well as four expert witnesses, including one called by the government); People v. Henderson, 233 Cal. Rptr. 141 (Cal. Ct. App. 1986) (three psychiatrists including the medical director of the psychiatric facility where the MDO judicially committed recommended outpatient status, and no clinical testimony provided in opposition to proposed placement).

533. See, e.g., Ecker, 543 F.2d at 185 n.20 (without discussion, suggested judiciary should be on guard against "'allowing the ultimate determination to be made according to the individual, subjective standards of the hospital staff'").


for such placements or the placement plan is relatively detailed and specifically designed to minimize any potential danger to the community, the courts have closely scrutinized and rejected plans they felt posed an unacceptable risk.334

The courts have tended to focus on the potential dangerousness of the MDO when assessing these placements.335 In doing so they have adopted relatively broad criteria for refusing or revoking such placements or for attaching conditions to them,336 including expansive definitions of dangerousness (not just present dangerousness, but also future337 and past338 dangerousness) and, to a lesser extent, of mental illness.339 Furthermore, they have indicated a willingness to adopt a continuum whereby they scrutinize more closely placements that in-

534. See, e.g., id. at 178 (insanity acquittee initially charged with rape and murder and subsequently committed to psychiatric hospital, unsuccessfully sought to compel conditional release; program recommended for acquittee involved attending vocational classes and visiting parents' home without hospital supervision, with acquittee at all times living at the hospital and participating in therapy there, and only through series of stages would acquittee gradually have access to community increased at hospital's discretion; however, from the start, there would be unsupervised contact with the community); Henderson, 233 Cal. Rptr. at 141 (MDO had successfully completed a screening program used to evaluate individual's preparedness for outpatient placement).

535. See, e.g., Ecker, 543 F.2d at 187 ("Continued confinement without conditional release is justifiable unless the district court determines . . . that the patient will not in the reasonable future endanger himself or others."); Henderson, 233 Cal. Rptr. at 145 ("[D]angerousness is a proper factor, indeed the paramount concern."); Bergstein v. State, 588 A.2d 779 (Md. 1991); State v. Jefferson, 471 N.W.2d 274 (Wis. Ct. App. 1991) (in revoking conditional release, court only required to determine whether conditions of release not adhered to and whether individual poses danger to safety of others or himself; court not required to consider alternative placements or fashion a specific remedy).

536. See, e.g., In re Martin B., 525 N.Y.S.2d 469, 476 (Sup. Ct. 1987) (rejected "void-for-vagueness" due process argument launched against statutory language that allowed extension of order of conditions "for good cause shown:" broad language necessary to give judiciary sufficient discretion to rule on such matters; while key terms difficult to define, "that difficulty is inherent in the judicial function", and "uncertainty of this sort is not what is proscribed by the void for vagueness doctrine").

537. See, e.g., Ecker, 543 F.2d at 178 (forced to choose between two standards, one requiring acceptance of the proposed program when the patient was "no longer likely to injure himself or other persons" and one where the patient "will not in the reasonable future be dangerous to himself or others," court chose the latter; former would require approval of placement even though acquittee presented a substantial probability of danger in the reasonable future because it could not be said this danger is "likely"); Henderson, 233 Cal. Rptr. at 141 (not necessary to show presently dangerous).

538. See, e.g., Henderson, 233 Cal. Rptr. at 144 (court can examine nature of criminal offense to determine danger MDO poses for community; "For example, the MDSO whose commitment offenses were child molesting and manslaughter, such as defendant's, potentially poses a greater risk of harm in society than a defendant whose commitment offense was merely a nonviolent child molestation"); Bergstein, 588 A.2d at 779 (inherent in insanity acquittal is indicia of continuing dangerousness).

539. See, e.g., Johnson, 753 P.2d at 154 (MDO still "suffering" from mental illness even though in remission due to treatment).
volve greater public exposure and less supervision.\textsuperscript{540} Throughout this analysis, the emphasis has been placed on protecting the community and the courts have required a relatively high degree of certainty that the community will not be endangered before approving a proposed placement\textsuperscript{541} or allowing a present one to continue.\textsuperscript{542} Even though it could be argued that for continued psychiatric inpatient care to be of value and to be appropriate under a commitment statute the MDO should be both mentally ill and dangerous, it is the MDO’s perceived dangerousness that is almost inevitably the decisive issue in these cases.

Courts have been willing to consider a relatively wide range of evidence in determining that the MDO may be dangerous.\textsuperscript{543} In conjunction with this evidentiary showing, the courts have tended to shift the burden to the MDO to establish that he or she is not dangerous.\textsuperscript{544}

\textsuperscript{540} See, e.g., Ecker, 543 F.2d at 183, 186 (“within the hospital grounds” court should give significant deference to hospital’s judgement; however, “when, and if, the patient is to cross the hospital boundary, then other factors affecting the public come into play, and both the statute and our decisions impose a different role and far heavier responsibilities on the courts”; in such circumstances, the court and not the hospital must make final determination on whether to conditionally release the patient; furthermore it might be proper that “review of unconditional releases should be broader than . . . review of conditional releases since the former pose an even greater risk to public safety than the latter”).

\textsuperscript{541} See, e.g., id. at 178 (same level of certainty required prior to approving conditional release program as for application for unconditional release); Lovette v. Psychiatric Sec. Review Bd., 795 P.2d 587 (Or. Ct. App.) (petition for conditional release rejected because evidence showed petitioner could not be “adequately controlled” in the community if released), review denied, 800 P.2d 789 (Or. 1990).

\textsuperscript{542} See, e.g., Bergstein, 588 A.2d at 779 (unintentional violation of conditional release can result in recommitment; test is whether patient would be danger to welfare of himself or society); State v. Edmundson, 805 P.2d 1289, 1293 (Mont. 1990) (more important than the violations of the conditions of his release, “the testimony regarding defendant’s bizarre behavior raised serious questions as to the safety of other group home residents and the community in general”).

\textsuperscript{543} See, e.g., Ecker, 543 F.2d at 185 (disregarding recommendation of treatment staff and experts testifying at trial, court could properly rely on “the patient’s hospital file, the court files and records in the case, and whatever illumination is provided by counsel!”); People v. Henderson, 233 Cal. Rptr. 141 (Ct. App. 1986) (decision based solely upon affidavit by acting clinical director of state hospital where defendant placed at time even though executed eight months earlier, provided little insight into nature of dangerousness, MDO had shortly thereafter been transferred to another facility, executed in preparation for the MDO’s placement on outpatient status and considered necessary to force defendant to comply with outpatient program, and four subsequent reports prepared by clinicians all recommended outpatient treatment); Bergstein, 588 A.2d at 779 (admissibility of reliable hearsay); Edmundson, 805 P.2d at 1289 (testimony based on regularly written reports kept by staff therapist at group home where insanity acquittee conditionally released was admissible).

\textsuperscript{544} See, e.g., Ecker, 543 F.2d at 178 (same burden of proof assigned when MDO sought to compel conditional release as in MDO-initiated release proceeding, namely, MDO carried burden of showing release will benefit individual and be safe for public; when hospital initiated release proceeding, no burden of proof assigned); State v. Johnson, 753 P.2d 154 (Ariz. 1988)
Finally, even where granted, such placements may be accompanied by an extensive set of conditions, violation of which constitutes the basis for reinstitutionalization.\textsuperscript{445}

In constructing their analyses, the courts generally distinguish outpatient/conditional release proposals for MDOs from those for involuntarily hospitalized patients in general, and impose different procedural schemes.\textsuperscript{446} Consistent with judicial opinions imposing greater restrictions on the MDO as part of their initial processing,\textsuperscript{447} courts have pointed to the prior criminal conduct of the MDO as a sufficient rationale for making this distinction.\textsuperscript{448} Also, the courts have tended to view these placements as privileges that are provisional in nature and not rights, thereby limiting the obligation of the state to grant them, diminishing the level of procedural review associated with a refusal to provide such a placement, and allowing the state to quickly and easily revoke them once given.\textsuperscript{449}
Interestingly, in according the interests of the MDO diminished protection in these cases, the courts have argued that a denial or revocation of a community placement benefits both the MDO and the community. They have also emphasized the necessity of providing a supervised transition when returning the MDO to the community, providing treatment staff the opportunity to analyze and easily monitor the MDO's adaptation to increased freedoms, and to quickly rescind the placement where the MDO fails to adjust. There has also been some suggestion that courts believe this approach may have been necessitated by the community's concern that the judiciary had gone too far in providing protections for the MDO at the expense of the community. In general, even though treatment staff may perceive these placements as integral to a patient's treatment plan, courts appear to consider conditional release/outpatient placements as more analogous to release/discharge decisions than treatment decisions.

whether sanity restored, thereby entitling him to unconditional release; after six years of hospitalization Barnes filed petition for such placement, but denied at a judicial hearing; on appeal he argued he was unconstitutionally denied a jury trial on whether he met criteria for local placement; noting "delicate balance" between society's right to be protected from potentially mentally ill and dangerous individuals and individual's right to be protected from inappropriate confinement, court rejected Barnes' argument, asserting that acquittee's ability to file new judicial application every year provided adequate procedural protection; Bergstein, 588 A.2d at 779; Martin B., 525 N.Y.S.2d at 475 (order of conditions ran longer (up to 10 years) and provided lower standard for recommitment than for involuntarily committed patients in general, but "[i]t is important to note, however, that the Order of Conditions is less restrictive than and provides an alternative safeguard to custody under an order of commitment").

550. See, e.g., Barnes, 231 Cal. Rptr. at 162 ("For those who will be released after the second proceeding, the program provides a bridge between life in a state institution and unsupervised life in the community. This transition period, in turn, should provide for a lower rate of recidivism, to the ultimate benefit of both the applicant and the public."); Bergstein, 588 A.2d at 784 (conditional release is not a tool of the penal system but part of a continuing course of treatment; rehospitalization is not imposed as punishment; the need for recommitment "is of paramount importance for both the public's and the patient's safety."); Martin B., 525 N.Y.S.2d at 469 (even though extending an order of conditions imposed a greater burden on discharged insanity acquittee than on patient involuntarily civilly committed, permissible because order of conditions related to treatment of defendant and not punitive in nature).

551. See, e.g., Barnes, 231 Cal. Rptr. at 162 ("The local program provides mental health professionals with a good opportunity to analyze whether the applicant's sanity has, in fact, been restored.").

552. See, e.g., Martin B., 525 N.Y.S.2d at 472 (statute authorizing orders of conditions enacted in 1980 in part due to turmoil resulting from "judicial redefinition" of rights of insanity acquittees; statute represented attempt to balance "competing aims;" while providing insanity acquittee certain procedural and substantive rights, "acts by the defendant which—but for the non-responsibility of the defendant—would be defined as criminal provide an adequate basis for recognition of a heightened interest as to the public safety. This justifies some differences in treating such a defendant from procedures followed in ordinary civil commitment proceedings.").

In conjunction with rulings suggesting that they will closely scrutinize transitional placements of the MDO into the community, courts have been inclined to assign the considerable responsibility of continued supervision of the MDO during his or her community placement to the facility or agency where the MDO was initially committed. Arguably, their staff are familiar with the patient's treatment program and needs, can provide continuity to the transition, have the necessary mental health skills, often run outpatient programs for civil patients, and are familiar to the court and relevant parties.

Typically, however, these agencies are reluctant to accept such responsibilities. Setting aside questions of liability if the MDO subsequently harms himself or others, such duties generally are considered onerous. They require an intensive investment of manpower to complete the tracking requirements, there is usually limited authority to force the individual to follow directives, and it imposes on such agencies the role of "super-cop" in monitoring the MDO, a role with which they are unfamiliar, uncomfortable, and consider antithetical to their usual treatment role. Nevertheless, such assignments of responsibility have been upheld.

A final issue of contention born from these placements is which court should have supervisory responsibility over the community placement. In some instances, jurisdiction over supervision has been assigned to the court located in the judicial district where the treating

554. See, e.g., People v. White, 518 N.E.2d 1262 (Ill. 4th DCA 1988) (Illinois Department of Mental Health and Development Disabilities unsuccessfully appealed order imposing upon it responsibility of monitoring conditionally released insanity acquittee's compliance with conditions of release, arguing its responsibility for care and supervision ended when individual conditionally released, and the entity providing outpatient care should provide any subsequent monitoring).

555. See, e.g., White, 518 N.E.2d at 1263, 1264, 1268 (trial court's order upheld mandating that Illinois Department of Mental Health and Developmental Disabilities monitor insanity acquittee's compliance with rather extensive set of conditions imposed after conditionally released from Department facility; Department ordered to report to court every 60 days regarding compliance, and report non-compliance as soon as reasonably possible; if conditions violated, acquittee to be returned to Department facility; court acknowledged that no statute permitted trial courts to impose extensive guidelines on Department while acquittee an inpatient, but noted that statute did specifically allow court to require Department to provide "periodic checks" of acquittee on conditional release). But see State v. Gravette, 393 S.E.2d 865, 868-69 (N.C. 1990) (judge did not have authority to compel Division of Adult Probation and Parole to supervise conditional release of pretrial detainee lacking capacity to stand trial without Division's consent; under statute this form of supervision only available upon conviction of crime, deferred prosecution, or agreement of supervising entity; probation office declined because of concerns about potential civil liability due to detainee's potential to harm; court recognized inadequacy of statutory provisions, particularly where defendant not subject to involuntary commitment but there is a need to protect the public).
facility is located. This approach is typically based on the rationale that because most key witnesses at a hearing concerning conditional release will come from that facility, including the MDO and the MDO's treatment staff, it will be more convenient to hold the hearing at the site convenient for the greatest number of witnesses. In addition, this is often considered the appropriate jurisdiction since any outpatient placement will typically occur in the area surrounding the psychiatric facility, a placement which facilitates monitoring and early response in case of emergency. However, the community where the trial or crime occurred may well continue to have a strong interest in the fate of the MDO, particularly if circumstances indicate the MDO might eventually return to that community. Some states allow such communities little notice of, input into, or control over a conditional release decision. Other states have tended to incorporate provisions that provide notice to the initial prosecuting attorney and allow alternate venues to host such hearings. It should be noted that feelings may run so strongly against an MDO in the area where the crime was committed that he or she may find it difficult to find a judge in that community willing to authorize a conditional release of the MDO regardless of the individual's progress in treatment. Therefore, it may be advisable to have recourse to a neutral site to decide such matters.

6. Release/Discharge

Release or discharge ostensibly marks the final severing of the ties binding the MDO to the system charged with housing, monitoring, and treating the MDO. As described in the preceding sections, often release is the culmination of a step-by-step approach intended to cautiously reintegrate the MDO back into the community by gradu-

556. See, e.g., State ex rel. Schafer v. Casteel, 732 S.W.2d 903, 906 (Mo. 1987) (court which committed NGRI acquittee does not retain inherent power over acquittee's release); State ex rel. Schafer v. Mason, 767 S.W.2d 93, 95 (Mo. Ct. App. 1989) (NGRI acquittee does not have right to choice of forum in seeking conditional release).

557. See, e.g., Schafer, 732 S.W.2d at 903.

558. See, e.g., N.Y. CRIMINAL PROCEDURE LAW § 330.20 (1986); People v. Cooper, 547 N.E.2d 449 (Ill. 1989) (the court that initially committed defendant under Sexually Dangerous Persons Act retains jurisdiction to revoke conditional release for violation of conditions).

559. The following discussion pertains primarily to non-sentenced MDOs. For a sentenced MDO, custody status is generally determined by the length of sentence imposed, although length of imprisonment may be shortened in conjunction with the inmate's placement on parole for a fixed period of time. Nevertheless, as a condition of parole, the sentenced MDO may be required to undergo mental health treatment, with parole subject to revocation should the parolee fail to adhere to a prescribed treatment program. The parolee is typically entitled to certain due process protections should the State attempt to revoke the parole.
ally imposing fewer restrictions on the MDO to ascertain whether any ill-effects will result from these greater levels of freedom. Such an approach attempts to insure that the public will not be endangered by the return of the MDO. If this approach proceeds as planned, it is believed that the resulting series of "successes" provides an indication that the MDO can be safely discharged back into the community.

However, difficulties may arise. The MDO may suffer an unexpected relapse. Such a "failure" does not necessarily indicate treatment is not progressing. On the other hand, a long period of time without a "failure" does not necessarily establish that a "cure" has been accomplished. Mental health professionals, throughout this sequence of trials, must make difficult judgement calls on whether each trial has been a success allowing the MDO to graduate to the next stage, and ultimately be discharged or released.

At the same time, the legal framework encompassing the MDO is often not crafted with gradual progression in mind. Indeed, constructing legal criteria for each of the clinical decision points would probably be unwieldy or even impossible considering the myriad factors, both individual and systemic, that go into each decision. As a result, the legal and clinical criteria for release may not lead to the same result and, in fact, clinicians may strongly disagree with specific legal determinations regarding the appropriateness of releasing various MDOs. Nonetheless, it is legal criteria that establish when release must occur and State control over an MDO must terminate.

Frequently, an MDO will want to end custody as soon as possible. The legal system has generally accepted that, with the exception of an initial evaluation period, the MDO is entitled to periodically obtain a hearing to determine whether the MDO meets the legal criteria for release. If those criteria are met, ostensibly the MDO must be released regardless of his or her status in the planned progression of successive tests mental health professionals have designed to assess the MDO's ability to successfully reintegrate into the community. Theoretically, respect for the rights of the MDO necessitates that since the MDO's mental illness and dangerousness were the basis for the State taking custody of the MDO, when those elements are no longer present, custody must cease. The legal determination may, however, subtly or not so subtly, take into account factors that attempt to further assure the safety of the public.

Numerous cases have discussed the release process and the interplay between the clinical and legal judgments involved. In many ways these judicial rulings are similar to those addressing conditional release, although it can be argued that because full releases provide less
opportunity to continue monitoring the progress of the MDO, courts have been even more cautious about approving them. A common thread running throughout all of these cases is the concern for the safety of the public. This concern may be particularly pronounced at the trial court level, reflecting its close linkage to the community and mirroring a general societal concern that MDOs released prematurely may wreak havoc upon its citizens.\footnote{560}

As with proposed conditional releases, the courts have tended to closely scrutinize proposals to release MDOs back into the community.\footnote{561} Furthermore, they afford themselves considerable discretion in making such decisions, including ignoring psychiatric testimony that recommends release.\footnote{562} Considerable attention is given to the

\footnote{560. See, e.g., Carlisle v. State, 512 So. 2d 150, 159-60 (Ala. Crim. App. 1987) (trial court inappropriately insisted on a guarantee from expert that the acquittee would remain on medication and seek outpatient treatment; this imposed a burden of proof that could never be met since psychiatry relies largely on subjective analysis).

561. See, e.g., People v. Superior Court (Almond), 268 Cal. Rptr. 375 (1990) (no less rigorous hearing required because treatment program agrees release of acquittee appropriate; court must not rubber stamp recommendation of medical experts); In re Watt, 525 A.2d 421, 422 (Pa. Super Ct. 1987) (NGRI acquittee recommitted to state hospital by judicial order on six different occasions).

562. See, e.g., Benham v. Ledbetter, 785 F.2d 1480, 1490 (11th Cir. 1986) ("The court may rely on the presumption [of continuing insanity] at both the commitment and the release hearing notwithstanding expert opinion to the contrary. Because it is characterized as opinion evidence, the court can ignore unanimous medical testimony that the insanity acquittee does not meet the commitment criteria." (citations omitted)); Carlisle, 512 So. 2d at 158 (although presence of mental illness is a medical judgment, continued dangerousness is a legal-social judgment, implying court could overrule medical opinion to contrary); State v. Gee, 695 P.2d 376, 379 (Idaho 1985) (Parole Board was given sufficient discretion to override recommendation of evaluating psychiatrist regarding inmate whose crime, history, or conduct indicated a sexually dangerous person); LaDew v. Commissioner of Mental Health & Mental Retardation, 532 A.2d 1051, 1054 (Me. 1987) (trial court's determination that acquittee failed to meet criteria for release upheld; even though only psychiatric testimony provided attested acquittee not suffering from mental disease or defect as required by statute, trial court not bound by this, but could examine other psychological reports and other evidence relevant to acquittee's mental condition); State v. Seidt, 805 S.W.2d 737 (Mo. Ct. App. 1991) (court not required to believe physician's opinion even though no evidence to contrary; trial court free to find Department of Mental Health wrong in its opinion that release not incompatible to welfare of society; trial court noted Department had been wrong when it previously recommended release of particular individual); Harris v. Oklahoma County Dist. Court, 750 P.2d 1129 (Okla. Crim. App. 1988) (week after releasing NGRI acquittee charged with first degree murder, trial court changed its mind and following a hearing, issued an order directing that acquittee be picked up and placed under psychiatric care at state hospital; acquittee objected that trial court could not issue order because it relinquished jurisdiction by signing release; trial court's order upheld because it initially failed to order required psychiatric evaluation and failed to make mandatory determination that acquittee not presently mentally ill and dangerous to the public, and having failed to do so, initial release in error and court had continuing authority to correct initial mistake and order acquittee's commitment).}
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likelihood of the MDO posing a danger to the community.\(^{563}\) Nominal, the courts have acknowledged that since the MDO must be both mentally ill and dangerous before he or she can be involuntarily hospitalized, a lack of either element should result in release.\(^{564}\) However, in reviewing these proposals, courts often use expansive definitions of both mental illness and dangerousness to block the MDO’s release and to raise other considerations.

For example, some courts have not required a showing that the MDO is currently dangerous. Future dangerousness has been held to satisfy the dangerousness criteria.\(^{565}\) Alternatively, prior criminal acts may suffice, even though a long passage of time has occurred since the acts were committed and the acts are not likely to be repeated.\(^{566}\) Furthermore, the nature of the prior criminal act may be taken into consideration, with release less likely when the crime was more serious.\(^{567}\) Courts have argued that, because the MDO has been confined to a mental hospital since the crime that initiated commitment occurred, the State would find it difficult to show recent evidence of

\(^{563}\) See, e.g., People v. Bolden, 266 Cal. Rptr. 724 (Cal. Ct. App.), review denied, 1990 Cal. LEXIS 217 (1990) (proceedings to extend commitment beyond maximum term often focus on whether respondent represents substantial danger of physical harm to others); LaDew, 532 A.2d at 1054 (“all the witnesses agreed that, if released, LaDew would pose a threat to the safety of himself and others”).

\(^{564}\) See, e.g., Foucha v. Louisiana, 112 S. Ct. 1780 (1992) (involuntary commitment of insanity acquittedee cannot continue after acquittedee found to be no longer mentally ill); Benham, 785 F.2d at 1480, 1486 (involuntary commitment of insanity acquittedee cannot constitutionally continue after basis for it no longer exists; acquittedee entitled to release when sanity recovered or individual no longer dangerous); Carlisle, 512 So. 2d at 158 (commitment could not continue after basis for initial commitment no longer existed).

\(^{565}\) See, e.g., Bolden, 266 Cal. Rptr. at 728 (can consider whether individual will continue to take medication if placed in unsupervised environment).

\(^{566}\) See, e.g., Canidate v. Stricklin, 568 So. 2d 1234, 1235 (Ala. Civ. App. 1990) (doctor’s opinion based on past history of violent behavior and failure to maintain treatment, and remaining delusional ideations); Yiadom v. Kiley, 562 N.E.2d 315 (Ill. App. Ct. 1990) (fact that no longer danger to himself or others does not entitle to release; primary basis for extended commitment was evidence of criminal acts or offenses); In re Watt, 525 A.2d 421, 423 (Pa. Super. Ct. 1987) (NGRI statute provided that “clear and present danger” criteria could be met by showing charged criminal conduct occurred and there was “reasonable probability that conduct will be repeated”; where criminal charge involved homicide, not necessary to show acquittedee would actually kill again but merely some form of violent conduct likely to occur). But see Carlisle v. State, 512 So. 2d 150, 158 (Ala. Crim. App. 1987) (inappropriate to focus on initial crime when evaluating whether MDO met criteria for release; number of issues considered in addition to post-criminal behavior, including whether individual had appropriate place to go after release and could be trusted to take medication).

\(^{567}\) See, e.g., Carlisle, 512 So. 2d at 156 (trial court opinion stressed that where a man’s life taken, more reluctant to release MDO); State v. Perez, 563 So. 2d 841, 845 (La. 1990) (“When the crime is a serious one like murder, a court should be especially cautious before releasing an insanity acquittedee.”).
actual violent conduct. In allowing prior criminal acts to be considered, the courts have specifically distinguished the MDO (and his or her criminal history) from patients who are civilly committed.

In addition, a broad range of information addressing the alleged dangerousness of the MDO may be considered admissible at an MDO's release hearing. For example, statements made to treating hospital staff in the course of the MDO's commitment may be admissible, notwithstanding the constitutional privilege against self-incrimination or a patient-psychotherapist privilege. In such cases, the need to gather information that will assist in making appropriate release decisions that will protect public safety is considered to outweigh the opposing interests of the MDO.

Alternatively, because current dangerousness may be difficult to show, courts may rely on the MDO's current manifestations of mental illness to establish the requisite level of dangerousness, even though technically the two criteria are distinct and should be independently established. However, here again courts have experienced difficulty, particularly when the mental illness is in remission. When such is the case, considerable emphasis is placed on testimony that indicates there is significant risk that the MDO will decompensate and show overt psychotic behavior under circumstances likely to await the MDO upon release. Furthermore, where such risk is pres-

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568. See, e.g., Watt, 525 A.2d at 423 (lack of recent evidence of actual violent conduct should be viewed in light of fact that insanity acquittee confined to mental hospital since crime occurred).

569. See, e.g., People v. Henderson, 172 Cal. Rptr. 858, 861-62 (1981) ("Defendant has been confined as an MDSO because he . . . is dangerous. The purpose of his confinement is not merely to treat his mental disorder, but to protect society. An important purpose of the close supervision given persons who are confined as MDSOs is to gather information through which it is possible to predict their future behavior. It seems apparent that one legislative purpose in providing psychotherapy for MDSOs is to monitor their progress so that the decision to release the MDSO from confinement may be based upon as much information as possible. We cannot find any legislative intent to exclude testimony such as that presented in this matter because of any psychotherapist/patient privilege."). See also supra part III.B.4.

570. See, e.g., Henderson, 172 Cal. Rptr. at 862 (psychotherapist has duty to abandon confidential character of patient-psychotherapist communication where necessary to avert danger to others).

571. See, e.g., Watt, 525 A.2d at 423 (court relied primarily on evidence that acquittee still suffering from paranoid schizophrenia since current dangerousness could not be shown).

572. See, e.g., id. (both treating psychiatrist and second psychiatrist from hospital testified MDO's psychosis in partial remission); Carlisle v. State, 512 So. 2d 150 (Ala. Crim. App. 1987) (hospital review panel concluded that acquittee still suffered from paranoid schizophrenia, but that illness was in remission because on medication).

573. See, e.g., Williams v. Wallis, 734 F.2d 1434, 1437 (11th Cir. 1984) (appropriate to take into account whether acquittee will take medication or be in structured environment after release when evidence acquittee no longer dangerous only because on medication or in structured environment); McSwain v. Stricklin, 540 So. 2d 81, 84 (Ala. Civ. App. 1989) (if released with-
ent, some courts have been unmoved by arguments that the MDO will not receive further benefit from the treatment provided at his or her current placement, even though arguably such treatment is one of the purposes for involuntarily hospitalizing the MDO.\textsuperscript{574} Courts have thereby implicitly acknowledged that the hospital would be used primarily to provide custodial care and to segregate the acquittee from the community. Typically, emphasis is placed on the fact that this is the least restrictive setting available to the MDO, and the court should not involve itself further in the nature of the treatment provided.\textsuperscript{575} This position stands in contrast to courts' willingness to deeply involve themselves in scrutinizing treatment decisions recommending the release of an MDO.\textsuperscript{576}

In addition, if the mental illness is in remission, it could be argued that the MDO does not meet the criterion of being currently mentally out any structure, insanity acquittee would be dangerous because he would revert back to previous behavior concerning alcohol, drugs, and "questionable sexual abuse"); \textit{Carlisle}, 512 So. 2d at 153 (testimony that acquittee would remain symptom-free if medication continued and not placed in stressful situation); State v. Johnson, 753 P.2d 154 (Ariz. 1988) (refusal to order acquittee's release based on uncontradicted evidence that acquittee's mental illness in remission, symptoms likely to reappear should medication be discontinued, and acquittee's history of discontinuing medication when unsupervised); State v. Fouche, 563 So. 2d 1138 (La. 1990) (defendant previously had drug-induced psychosis that could reassert itself if released), rev'd, 112 S. Ct. 1780 (1992); \textit{Watt}, 525 A.2d at 423 (testimony that significant risk acquittee would decompensate if placed in setting with less structure than provided at state hospital where currently resides). \textit{But see} Hopkins v. Lynn, 888 F.2d 35, 37 (5th Cir. 1989) (a single occasion of association during temporary release with someone involved with drugs does not permit fact-finder to infer insanity acquittee likely to use drugs again).

574. See, e.g., United States v. Steil, 916 F.2d 485 (8th Cir. 1990) (release denied even though appropriate place to retain not yet located); Yiadom v. Kiley, 562 N.E.2d 310, 312-13 (Ill. App. Ct. 1990) (determination that defendant would never regain fitness to stand trial did not require discharge); Mental Hygiene Legal Services v. Wack, 551 N.E.2d 95, 96 (N.Y. Ct. App. 1989) (irrelevant that no effective mode of treatment where experts agreed individual requires further in-patient care and attention); \textit{Watt}, 525 A.2d at 424 (rejected acquittee's complaint that because of improved condition not receiving any affirmative treatment at hospital). \textit{But see} Carlisle, 512 So. 2d at 160 (in light of evidence and fact that individual has received maximum benefit from hospitalization, due process requires acquittee be released into structured environment); People v. Williams, 244 Cal. Rptr. 429, 432-33 (Ct. App. 1988) (requiring NGRI acquittee to establish he is not dangerous in unmedicated condition as prerequisite to release would force him to languish indefinitely in treatment programs that provide no further assistance).

575. See, e.g., Yiadom, 562 N.E.2d at 310-11 (noting Department of Mental Health stated MDO being treated in least restrictive environment appropriate to his needs, determination on appropriate place for confinement best left to that agency); \textit{Watt}, 525 A.2d at 424 ("We find sufficient evidence that Watt is in a treatment plan structured around his specific needs and is in the least restrictive setting available to him. Pursuant to the Act, it is not within the province of the court 'to specify to the treatment team the adoption of any technique, modality, or drug therapy.'").

576. This stands in contrast to the courts more recent willingness to scrutinize treatment decisions in general where release of the MDO is not an issue. \textit{See supra} part III.B.
ill. However, courts have simply declared that mental illness in remission satisfies the continuing mental illness criterion, even though mental illness is only rarely viewed as "cured," and is often seen as in remission, thereby meaning that few MDOs would ever meet this basis for release.577 Alternatively, courts may conduct a broad-ranging search for evidence of mental illness,578 note the lack of change in the MDO's mental status since he or she was committed, notwithstanding a current evaluation indicating the absence of mental illness,579 establish a presumption of the continued existence of the mental state once proved to exist that the MDO must rebut,580 or refer to the mental illness as relatively incurable.581 These various means allow a court to ignore testimony by mental health professionals that assert the absence of the necessary mental illness element.582

Other considerations the courts have taken into account in determining whether the MDO is mentally ill or dangerous are whether the individual has an appropriate place to go after release, and whether the individual can be trusted to adhere to the prescribed treatment plan, including taking medication.583 Such assurances are considered

577. See, e.g., Carlisle, 512 So. 2d at 150; Johnson, 753 P.2d at 157 (reversed trial court's ruling that insanity acquittee no longer suffered from "mental disease or defect" where schizophrenia in remission as result of treatment and medication; "We hold that a person who has a mental disease or defect is still 'suffering' from it within the meaning of A.R.S. § 13-3994(C), even though the disease or defect is in remission due to treatment.").

578. See, e.g., LaDew v. Commissioner of Mental Health & Mental Retardation, 532 A.2d 1051 (Me. 1987) (due to lack of evidence indicating current mental illness, both trial court and appellate court willing to place great weight on acquittee's psychiatric history, primarily accumulated prior to criminal act that led to the current commitment).

579. See, e.g., LaDew, 532 A.2d at 1055 ("Even though the psychiatrists testifying gave their opinion that LaDew did not currently suffer from what they could medically diagnose as a mental disease or defect as that term is defined in their profession, they also testified that there had been no change in LaDew's mental condition since before he was committed some 16 months earlier.").

580. See, e.g., Benham v. Ledbetter, 785 F.2d 1480 (11th Cir. 1986) (presumption of continuing insanity upheld); Loftin v. State, 349 S.E.2d 777, 779 (Ga. Ct. App. 1986) (acquittee bears burden of proving to trial court that he/she is fit for release); Arnold v. State, 328 S.E.2d 572, 573 (Ga. Ct. App. 1985) (at release hearing for insanity acquittees, statutory scheme provides presumption of continued existence of mental state once proved to exist; as a result, court hearing petition for release is free to reject expert testimony as to sanity and instead rely on general presumption of insanity).

581. See, e.g., LaDew, 532 A.2d at 1055 ("Experts also testified at the hearing to the difficulty of curing such psychosis . . . ").

582. See, e.g., Benham, 785 F.2d at 1490 (trial court able to disregard unanimous medical testimony favoring release); Loftin, 349 S.E.2d at 779 (trial court free to reject recommendation of staff of institution where acquittee placed).

583. See, e.g., Williams v. Wallis, 734 F.2d 1434, 1437 n.4 (The court stated that the release criteria that Williams challenges as irrelevant, "such as whether there is an appropriate place for the acquittee to go and whether the acquittee can be trusted to take his or her medication, are relevant to a determination of continued mental illness or dangerousness." The court fur-
necessary to ensure that the MDO will not suffer a relapse after dis-
charge.

Another issue that has been raised in determining whether an MDO
meets the criteria for release is whether the determination should be
based on the MDO's status in a medicated or unmedicated state.\textsuperscript{584} Courts that have concluded that the MDO should be evaluated in a
medicated state argue that to require the MDO to prove he or she is
not dangerous without medication is to ask the MDO to return to a
state that initially triggered the need for commitment, would force
the MDO to languish indefinitely in treatment programs from which
there is little hope of release, forces continued commitment without
meaningful treatment, and ignores the fact that many people afflicted
with mental illness function successfully in society with the aid of
medication.\textsuperscript{585} Other judges, however, have asserted that the MDO
should be required to show he or she is not dangerous in an unmedi-
cated condition, noting that such individuals may show little insight
into the need for medication, that the MDO's behavior is likely to
drastically alter if medication is discontinued, and the safety of the
public is not adequately insured by placing the maintenance of the
MDO's sanity in the MDO's own hands with no independent guaran-
tee that medication will be continued.\textsuperscript{586}

It should be noted, in general, that a recent U.S. Supreme Court
opinion may limit efforts to bypass the mental illness element. The
Court in \textit{Foucha v. Louisiana}\textsuperscript{587} struck down a statutory scheme that
permitted the continued commitment of an insanity acquittee who
was no longer mentally ill. At the same time, the decisive concurring
opinion by Justice O'Connor in the 5-4 decision emphasized the nar-
rowness of the Court's holding. O'Connor stated, "I do not under-
stand the Court to hold that Louisiana may never confine dangerous

\textsuperscript{584} See, \textit{e.g.}, \textit{Carlisle}, 512 So. 2d at 151 (hospital review panel concluded acquittee suf-
fered from paranoid schizophrenia, but believed it was in remission because on medication).

\textsuperscript{585} See, \textit{e.g.}, \textit{Williams}, 244 Cal. Rptr. at 429.

\textsuperscript{586} See, \textit{e.g.}, \textit{id.} (Thaxton, J., dissenting); \textit{Carlisle}, 512 So. 2d at 150 (trial court opinion).

\textsuperscript{587} 112 S. Ct. 1780 (1992).
insanity acquittees after they regain mental health." Focusing on the uncertainty of psychiatric diagnoses, she reiterated the Court's earlier position in Jones that the courts should give deference to reasonable legislative judgments about the relationship between dangerous behavior and mental illness. Thus, she asserted that it might be permissible to confine an insanity acquittee who has regained sanity if "the nature and duration of detention were tailored to reflect pressing public safety concerns related to the acquittee's continuing dangerousness." To confine an insanity acquittee as a mental patient under such circumstances, she continued, would require "some medical justification" for doing so. This suggests that a relatively expansive definition of mental illness might be acceptable, and would need to take into consideration the nature of the acquittee's crime, meaning that an acquittee involved in a non-violent or relatively minor crime could not be included. Such an approach, she concluded, would leave states sufficient latitude to care for insanity acquittees in a manner consistent with public welfare.

While the dangerousness of the MDO has been the primary concern of courts in reviewing a proposed release, courts have also upheld a series of procedures that make it more difficult for the MDO to obtain release. For example, it has been ruled permissible to require a psychiatric evaluation of the MDO prior to release, to refuse the MDO's request that an independent evaluating psychiatrist be appointed for an indigent applicant, to place the burden on the MDO to establish that the criteria for release have been met, to impose a

589. Id.
590. See State v. Gee, 695 P.2d 376, 379 (Idaho 1985) (statute upheld that required a psychiatrist's recommendation of release prior to parole for convicted criminal whose crime, history, or conduct indicated he was a sexually dangerous person; "[i]t bears a reasonable relationship to the proper state purpose of ensuring that prisoners released on parole will be likely to successfully serve the remainder of their sentences out of the physical custody of the Board of Corrections"); Harris v. Oklahoma County District Court, 750 P.2d 1129, 1130 (Okla. Crim. App. 1988) (prior to release, trial court required to order psychiatric evaluation of acquittee and make a determination that acquittee not currently mentally ill and dangerous to public peace or safety based on this evaluation).
591. See, e.g., People v. Finkle, 573 N.E.2d 381, 384-85 (Ill. App. Ct. 1991) (permissible to require committed defendant to rely on professionals available at institution where confined; they are experts on sexually dangerous persons in general and are the most knowledgeable about defendant's problems and progress; defendant failed to show examining and treating doctors at institution were unfair or biased).
592. See, e.g., Benham v. Ledbetter, 785 F.2d 1480 (11th Cir. 1986); Williams v. Wallis, 734 F.2d 1440 (11th Cir. 1984) ("We think that the state's interest in preventing the premature release of individuals who have already proven their dangerousness to society by committing a criminal act outweighs the interest in avoiding continued confinement of an acquitted who has already had the benefit of the hospital's nonadversary proceedings."); Canidate v. Strickland,
presumption of continuing insanity at the release hearing,\textsuperscript{593} to require judicial approval of the treating mental hospital’s release decision,\textsuperscript{594} to make release standards more stringent,\textsuperscript{595} to impose a clear and convincing evidentiary standard,\textsuperscript{596} to not require that the release proceedings be adversarial in nature,\textsuperscript{597} to put in place an independent
board to review all release decisions, to limit the frequency of release petitions (e.g., if the MDO was denied release, the court would not hear another release petition until twelve months had elapsed), and to require that the MDO first complete a mandatory one-year period in a local outpatient program. Furthermore, in attempting to prevent release, the State’s failure to satisfy a technical requirement associated with the release proceeding, such as meeting a filing deadline, may be overlooked.

These procedural devices have been approved even though they may not be acceptable for a civil patient that has been involuntarily committed. As noted with regard to procedures implemented for the initial processing of the MDO, justification for this distinction is derived from the MDO’s having committed a criminal act and including (1) mental health system’s institutional goal of transferring patients to a less restrictive environment and eventual release, (2) perennial lack of space and financial resources, and (3) medical professional’s pride in his own treatment; furthermore, frequency of evaluations reduces risk patient will be confined any longer than necessary, probative value of providing adversary hearings slight with potential to be counterproductive as it undermines beneficial institutional goal of finding least restrictive environment appropriate, unnecessarily impose a not insignificant financial burden on the State, and neither judges nor administrative hearing officers, the ultimate decision makers in an adversarial hearing, are better qualified than mental health professionals to render psychiatric judgments).

598. See, e.g., LaDew, 532 A.2d at 1053 (“more stringent” 1986 amendments to Maine statutory scheme “create[d] a State Forensic Service to examine the mental condition of defendants asserting the insanity defense and of [insanity] acquitees seeking release. A report by the legislative subcommittee that proposed the amendments . . . emphasized the public concern that [insanity] acquitees were too quickly being released and too quickly gaining complete discharge.”).

599. See, e.g., Benham v. Ledbetter, 785 F.2d 1480 (11th Cir. 1986) (limiting access to review ensures efficient use of state’s processes).

600. See, e.g., People v. Superior Court (Woods), 268 Cal. Rptr. 379, 380-81 (Ct. App. 1990) (insanity acquittee could not be released even if sanity restored till one-year period as outpatient completed).

601. See, e.g., State v. R.R.E., 470 N.W.2d 283, 284 (Wis. 1991) (insanity acquittee not entitled to release because court failed to abide by statutory time limits for holding a hearing on his petition for reexamination; hearing required within 30 days, but petition lost by court administrators for three months).

602. See, e.g., Benham, 785 F.2d at 1480 (permissible to require judicial approval of treating mental hospital’s release decision, even though civil committee could be released at any time on judgment of a hospital official, and permissible to impose presumption of continuing insanity even though same presumption did not apply to civil committees); Lofin v. State, 349 S.E.2d 777, 779 (Ga. Ct. App. 1986) (trial court free to reject recommendation of staff of institution where acquittee placed even though civil patient could not be involuntarily committed unless team of medical experts so recommended); R.R.E., 470 N.W.2d at 283 (directory versus mandatory time limits for court hearings).

603. See supra part III.A.

604. See, e.g., Benham, 785 F.2d at 1480; Lofin, 349 S.E.2d at 777, 779 (insanity acquitees demonstrate dangerous propensities by committing physical elements of crime, and thus have to bear burden of proving to trial court appropriateness for release).
the need to protect society. Indeed, it has been asserted that such procedural devices have been specifically imposed because of public perception that MDOs were being released too readily. Furthermore, courts have ruled that the inability of mental health professionals to make predictions concerning future mental illness and dangerousness did not foreclose legislatures from imposing additional procedural protections as part of the release process in order to ensure the safety of the community. Interestingly, in cases challenging release procedures, the positions of the MDOs and the State may be reversed from what they were in initial processing cases, although typically the interests of the State still prevail.

Among the State interests that have been identified are: the need to protect society from the MDO's potential dangerousness, the need to ensure that the MDO is ready for release, the need to prevent abuses

605. See, e.g., Benham, 785 F.2d at 1489 (because of potential dangerousness of acquittee upon release, "it may not be inappropriate to ask the insanity acquittee 'to share equally with society the risk of error.'" (quoting Jones v. United States, 463 U.S. 354, 367 (1983)); Williams v. Wallis, 734 F.2d 1434, 1437, 1440 (11th Cir. 1984) (The circuit court wrote that "[r]e leasing someone who has been proven dangerous, when it has not been proved that he has recovered, poses a real threat of danger to society." and also wrote that "[d]ifferences in release procedures based on dangerousness are constitutionally permissible . . . ."); Taylor v. Commissioner of Mental Health & Mental Retardation, 481 A.2d 139, 151 (Me. 1984) (relatively lenient preponderance of evidence standard rejected because inadequate to assure safety of community not endangered by release; "On balance, the public interest in ensuring a correct decision on the eligibility question outweighs the acquittee's private interest . . . ."); R.R.E., 470 N.W.2d at 285 ("The legislature did not intend the release of criminally committed individuals without a court determination that the individual may be safely released."); mandatory time limits for release hearings would place heavy burden on society for even nominal procedural delays).

606. See, e.g., LaDew v. Commissioner of Mental Health & Mental Retardation, 532 A.2d 1051, 1053 (Me. 1987) (discussing 1986 amendments to Maine statutory scheme creating State Forensic Service to examine insanity acquitees seeking release, noted that "A report by the legislative subcommittee that proposed the amendments . . . emphasized the public concern that [insanity] acquittees were too quickly being released and too quickly gaining complete discharge.")

607. See, e.g., Benham, 785 F.2d at 1480 (lack of certainty in the field of mental illness and the insanity defense, combined with indication of dangerousness drawn from having been found beyond a reasonable doubt to have committed a criminal act, justifies reduced, rather than increased procedural protections); State v. Fouche, 563 So. 2d 1138 (La. 1990), rev'd, 112 S. Ct. 1780 (1992); Taylor, 481 A.2d at 146 (reasonable doubt standard inappropriate because (1) requires degree of certainty in diagnosis and treatment seldom attainable in mental health evaluations and (2) critical issues at release hearing (predicting future conduct) inherently less capable of being determined with certainty than issues in most criminal trials).

608. For example, MDOs facing commitment initially have opposed assigning the decision solely to a hospital official without accompanying judicial approval, whereas MDOs seeking release have opposed judicial review and argued that the decision should be left solely in the hands of the treatment staff. See generally Benham, 785 F.2d at 1487 ("[The] relative lack of confidence in scientific diagnoses of mental illness and prediction of dangerousness alters somewhat the traditional due process concern with accuracy, which customarily is meant to protect the individual interest . . . .").
of the criminal process (e.g., discourage false pleas of insanity), and
the need to conserve the financial resources of the State.\textsuperscript{609} The opposing interests of the MDO are generally viewed as diminished. Unlike initiating procedures where the MDO has an interest in avoiding the stigma associated with a finding of mental illness, the stigma is considered to have already attached prior to the release proceeding.\textsuperscript{610} Similarly, the MDO is not considered harmed by continued hospitalization, but thought likely to benefit.\textsuperscript{611} Finally, at least one court has asserted that treatment staff and the treating facility have no interest in retaining the MDO longer than appropriate, and will actively seek to promote the release of the MDO.\textsuperscript{612}

Judicial opinions contemplating the release of the MDO often note the societal pressures placed both upon the MDO’s treatment staff and the judges assigned to the cases, particularly where the MDO previously demonstrated particularly violent behavior, and make it difficult to remain impartial.\textsuperscript{613} The impression is sometimes given that treating mental health professionals actively seek the power to independently make admission or release decisions. At least one opinion noted, however, that treatment staff attempted to manipulate the decision-making process to force the courts to take ultimate responsibility for the decision on whether to release the MDO.\textsuperscript{614} Such efforts

\textsuperscript{609} See, e.g., Benham, 785 F.2d at 1480; Williams, 734 F.2d at 1434; People v. Woods, 268 Cal. Rptr. 374, 379 (Cal. Ct. App. 1990) (mandatory one-year period in outpatient program regardless of current prognosis necessary to provide “crucible” and “testing period” as part of transition back to community).

\textsuperscript{610} See, e.g., Benham, 785 F.2d at 1480.

\textsuperscript{611} See, e.g., Williams, 734 F.2d at 1440 (“On the other hand, the consequences of continued confinement for the individual, although a serious deprivation of liberty, are ameliorated by some countervailing factors. He will benefit from the continued treatment he will receive, and he will be released as soon as the hospital’s trained medical professionals consider that he is no longer mentally ill or dangerous, or as soon as he can prove the same in a habeas corpus proceeding.”).

\textsuperscript{612} See, e.g., id. at 1438 (“Hospitals and their medical professionals certainly have no bias against the patient or against release. Therefore, we can safely assume they are disinterested decision-makers. In fact, the mental health system’s institutional goal—i.e., transfer to a less restrictive environment and eventual release—favors release. Other factors also favor release, including a perennial lack of space and financial resources, . . . and including the medical professional’s pride in his own treatment. The frequency of the evaluations also reduces the risk that the patient will be confined any longer than necessary.”).

\textsuperscript{613} See, e.g., Carlisle v. State, 512 So. 2d 150, 160 (Ala. Crim. App. 1987) (concerned that hospital staff’s reservations about release influenced by letter from attorney for wife of acquittedee’s victim threatening legal action if acquittedee released; “[T]he facts indicate that the hospital staff and the experts who testified for the State were not totally ‘disinterested decisionmakers.’ . . . [C]lear that the letter from the attorney of the widow of the deceased threatening legal action if the appellant is released, entered into the decision not to release the appellant. We cannot allow the liberty interests of the appellant to be abridged by such threats.”).

\textsuperscript{614} Id. at 156 (NGRI acquittedee with long history of mental illness prior to killing his
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may be traced in part to the difficulty of predicting the future behavior of an MDO and concerns over potential liability where such predictions prove wrong.\textsuperscript{615} Courts typically are not eager to assume this decision-making responsibility either.\textsuperscript{616}

7. Post-Release

Although the legal system's immediate control over the MDO may be terminated, the responsibility of the mental health professional may not end with the release or discharge of the MDO. The treatment plan for the MDO often envisions that the MDO will continue to receive services after release. Courts and mental health professionals responsible for the release decision may attempt to attach conditions to the release order that require the MDO to present him or herself to mental health professionals periodically in order that necessary adjustments to the MDO's treatment can be made.\textsuperscript{617} Alternatively, the MDO may voluntarily agree to keep such appointments. These periodic meetings give mental health professionals an opportunity to assess how well the MDO is adjusting to life in the community and fine-tune the treatment provided.

Unfortunately, the transition to community living for the MDO is not always smooth. MDOs on occasion suffer relapses that result in the MDO exhibiting dangerous or injurious behavior. While monitoring the MDO, the mental health professional may have an opportunity to anticipate such behavior and take steps to control or prevent it. Unfortunately, the inherent unpredictability of mental illness, along with other factors, almost inevitably results in some failures to anticipate the MDO's future course of behavior. Nevertheless, since the \textit{Tarasoff} decision was issued in California,\textsuperscript{618} considerable attention has been given to the duty of mental health professionals to take

\begin{footnotes}
\footnotetext{615} See infra part III.C.7.
\footnotetext{616} See, e.g., \textit{Carlisle}, 512 So. 2d at 150.
\footnotetext{618} \textit{Tarasoff v. Regents of University of Cal.}, 551 P.2d 334 (Cal. 1976).
\end{footnotes}
actions that warn or protect third parties from anticipated injurious acts by their clients.\(^6^{19}\)

Related judicial opinions address the issue of who bears the cost of mistakes in predicting the future behavior of an MDO subsequent to release. It could be asserted that because the MDO is treated pursuant to an order of the State, the therapist should not be held liable for any harmful acts the MDO may subsequently commit. As previously noted, judicial opinions have spoken in terms of the necessity of the community sharing the risk of caring for such individuals. Following this train of thought, it could be concluded that mental health professionals who order or recommend the release of the MDO into the community, or subsequently treat them, should be protected by a relatively broad cloak of immunity from liability, similar to that possessed by the judiciary. Alternatively, the argument could be lodged that absent gross misconduct by the professional, the task of predicting the future behavior of the MDO is so arduous the professional should not be found liable for simple mistakes in judgment.

However, recent decisions indicate that some courts are going to take a very close look at the actions of the mental health professional involved in the release or subsequent monitoring of an MDO where the MDO harms a third party following release. Although most judicial decisions addressing this issue involve civil patients,\(^6^{20}\) one can

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\(^{620}\) For examples of judicial opinions addressing civil patients that have expanded the liability of mental health professionals for failing to take adequate steps to warn or protect others in response to the dangerousness of their patients, see Jablonski v. United States, 712 F.2d 391, 397 (9th Cir. 1983) (despite lack of specific threats concerning specific individuals, psychiatrists liable when patient seen on out-patient basis killed his girlfriend); Hamman v. County of Maricopa, 775 P.2d 1122, 1128 (Ariz. 1989) (applied "zone of danger" test in finding psychiatrist owed duty to mother and stepfather to properly control child even though no specific threats made against them by child); Hedlund v. Superior Ct. of Orange County, 669 P.2d 41 (Cal. 1983) (negligent failure to diagnose dangerousness sufficient basis for liability; liability extends to bystanders, particularly those in close relationship with target of threat); Perreira v. State, 768 P.2d 1198, 1201 (Colo. 1989) (rejecting foreseeable zone of danger standard, held that state mental health center and staff psychiatrist could be liable for shooting death of police officer by mentally ill person recently released from involuntary commitment even though mentally ill person made no specific threats against particular persons during period of treatment); Naidu
anticipate arguments that where the patient is an MDO, the therapist has a higher level of knowledge that his or her patient may be violent in the future, and thus a greater duty to warn or protect potential victims.

Traditionally, mental health professionals were not liable for the harm done by clients to third parties because there had been no contractual relationship between the third party and the professional. Usually called privity of contract, this meant that the professional was liable for negligent actions only to the person the professional had contracted to provide with services. However, in line with general developments in tort law, an increasing number of jurisdictions have imposed a duty of care on mental health professionals that extends to third party individuals that the professional could reasonably foresee being harmed by the client. The extent of this duty and the range of harmed third parties the courts have concluded were foreseeable has varied from jurisdiction to jurisdiction. Even though the information indicating risk to a third party typically is obtained in the course of a confidential therapist-client interaction, these cases generally conclude that the need to protect third parties from serious harm out-

v. Laird, 539 A.2d 1064 (Del. 1988); Durflinger v. Artiles, 673 P.2d 86 (Kan. 1983) (state mental hospital may be liable for negligent release of involuntary patient); Evans v. Morehead Clinic, 749 S.W.2d 696 (Ky. Ct. App. 1988); Davis v. Lhım, 335 N.W.2d 481 (Mich. Ct. App. 1983); Schuster v. Altenberg, 424 N.W.2d 159 (Wis. 1988). But see Sellers v. United States, 870 F.2d 1098, 1099-100 (6th Cir. 1989) (psychiatrist does not owe duty to public at large; because of difficulty of predicting behavior of psychiatric patients, liability limited to "readily identifiable" victims); Morton v. Prescott, 564 So. 2d 913 (Ala. 1990) (lack of specific threat of harm to victim or identifiable group of which victim might have been a member); King v. Smith, 539 So. 2d 262 (Ala. 1989) (psychiatrist's minimal personal contacts with outpatient insufficient to show special relationship or circumstances necessary to create duty to protect third persons); Baldwin v. Hospital Auth. of Fulton Cty., 383 S.E.2d 154, 156-57 (Ga. Ct. App. 1989) (defendants never had the “control” of patient that would allow them to claim legal authority to confine or restrain against his will; patient had not expressed threat of harm to anyone other than himself); Eckhardt v. Kirts, 534 N.E.2d 1339 (Ill. App. Ct.) (no evidence of specific threats nor reasonably foreseeable risk of harm), appeal denied, 541 N.E.2d 1105 (Ill. 1989); Wofford v. Eastern State Hosp., 795 P.2d 516, 520-21 (Okla. 1990) (in formulating psychiatrist’s duty to exercise reasonable professional care in discharging mental patient, must take into account uncertainty that accompanies psychiatric analysis; duty extends only to persons foreseeably endangered by patient’s release; patient’s behavior not foreseeable in light of fact that released more than two years prior to incident and hospital not informed during interim of former patient’s “strange” behavior); Dunkle v. Food Service East, Inc., 582 A.2d 1342 (Pa. Super. Ct. 1990) (no duty to warn where patient has not threatened to inflict harm on a particular individual); Rogers v. South Carolina Dept. of Mental Health, 377 S.E.2d 125 (S.C. Ct. App. 1989) (no duty to warn when no prior identifiable threat to victim).

621. See generally REISNER & SLOBOGIN, supra note 379.
622. Id. at 114-53.
623. Id.
weighs any damage to the therapist-client interaction resulting from a breach of confidentiality. In conjunction with cases addressing the potential liability of therapists if a released MDO attacks someone in the community, judges have tended to focus on the scope of the duty of care that is owed and the foreseeability of harm to the particular person. A Washington court, in a case involving the release of a NGRI acquittee, ruled that a "psychiatrist or therapist has a duty to take reasonable precautions to protect any person who might foreseeably be endangered by his patient's mental problems." In reviewing the record, the court noted that its release order, an order that the mental health center responsible for treating the acquittee on an out-patient basis received and placed in its records, stated the substantial danger the acquittee posed for the general public and the conditions of his release. In addition, the center's records showed it was aware that the acquittee had missed several appointments, was not taking his medication, and was exhibiting paranoid behavior. The court argued that these facts had the potential to establish that it was foreseeable that the acquittee would harm a woman who lived across the street from him five-and-one-half months after release. Furthermore, if his acts were foreseeable, it might be shown that the center should have taken certain steps when it became aware that the acquittee was violating the conditions of his court-ordered release. However, the court left open the possibility that a relatively high standard for recovery might be imposed. The court indicated that gross negligence as opposed to ordinary negligence may be the appropriate standard to apply in evaluating whether the steps the center took were deficient. The opinion suggested that this higher standard might be incorporated in recognition of the difficulty in predicting and preventing harmful behavior.

An opinion issued by the Supreme Court of Oregon also extended the liability of mental health professionals treating and releasing an MDO. The MDO was initially found NGRI following a high-speed

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624. Id.
626. Id. at 929.
627. Id. The acquittee did, however, keep one appointment four days before the incident in question and showed no impairment at that time. Id. at 927.
628. Id. at 928.
629. Id. As a potential exonerating factor, the court also noted that there was no indication that the center had any knowledge about the acquittee's victim.
630. Id.
631. Id.
automobile chase with police, during which he hit and seriously damaged two cars. Initially committed to a psychiatric hospital, seven months later he was conditionally released to a private medical center. After two months, the conditional release was revoked and he was recommitted. Six weeks later he was again conditionally released to the medical center. Seven months later the MDO admitted himself to the center's residential program because he was anxious, depressed, and feared loss of control. He was permitted to leave after three days, but the following morning called the center and complained of auditory hallucinations. He kept a scheduled appointment the next day, reiterating problems with visual and color distortions, but missed a scheduled appointment two days later. Two days after the missed appointment, while driving seventy miles per hour in a thirty-five mile-per-hour zone, he ran two red lights and collided with a car, killing the driver. The decedent's estate sued the medical center, among others, for wrongful death. The court ruled that the center, having accepted the MDO as a patient, had a duty of reasonable care in controlling its patients' acts, and that a breach of the duty entailed potential liability to persons foreseeably endangered by the breach. Ultimately, the question of whether the MDO's acts and the risk to the public were foreseeable was a question of fact to be decided by a jury or a court sitting as factfinder.

The court determined that there were four key facts in determining whether the center should have reasonably foreseen the need to take the MDO into custody. The first key fact concerned the amount of contact the center had with the MDO. The court acknowledged the difficulty of foreseeing the actions of an individual only observable a few hours per week. Nonetheless, this did not mean that the individual's acts were unforeseeable. The court noted that a therapist at the center had recently met with the MDO and talked to him on the phone, which provided at least a limited opportunity to evaluate the MDO's mental condition.

The second key fact concerned the identifiability of the victim. The court indicated that ordinarily the fact that the MDO had not threatened to harm anyone nor threatened to drive so as to injure persons would have limited the duty of care to readily identifiable victims. However, in this case, the court noted the center had a statutory duty

633. This case is somewhat unique in that the court found the basis for the medical center's duty of reasonable care in the statutory provision for committing, conditionally releasing, or discharging an acquittee, rather than in the common law doctrine of negligence as set out in Tarasoff and other cases. This statute dictated that the primary concern was to be "the protection of society." Id. at 148.
to control the MDO, not just for the MDO's sake, but "for the peace and safety of the general public." Thus, the fact that the decedent had not been identified in advance did not mean that the MDO's acts in harming the decedent were unforeseeable.

The third key fact was the impact of prior reckless driving by the MDO. Again the court indicated that ordinarily the fact that the MDO had on a prior occasion exhibited reckless driving would not make the collision foreseeable. The court stated that "[c]areless or reckless driving habits are hardly limited to psychiatric outpatients." However, the court noted that it was the previous act of reckless driving that brought the MDO to the center. The court concluded that "reckless driving was a significant risk for [the center] to consider in deciding to allow [the MDO] to remain in the community," and was an appropriate consideration on the issue of foreseeability.

The final key fact was the extent to which the MDO's mental condition had deteriorated. The court ruled that it was appropriate for the factfinder to take into account the MDO's reports to the center that he feared he was losing control, felt out of touch with the outside world, and was suffering auditory hallucinations and visual and color distortions. Furthermore, the factfinder could consider the failure of the center to attempt to take the MDO into custody or notify the agency with authority to recommit the MDO of these changes. The court concluded there was sufficient dispute over these four facts that it must remand the matter to the trial court to resolve.

Such opinions have drawn sharp reactions. It has been argued that they force private mental health care providers to make the protection of society their primary concern, with the needs of the patient

634. Id.
635. Id. at 149.
636. Id.
637. Id.
638. Id.
639. See also Semler v. Psychiatric Inst. of Wash., D.C., 538 F.2d 121 (4th Cir.) (psychiatric institute with custody of convicted felon that it placed on outpatient status without court authorization found liable when felon subsequently killed a girl), cert. denied, 429 U.S. 827 (1976); Tamsen v. Weber, 802 P.2d 1063, 1067 (Ariz. Ct. App. 1990) (in discussing potential liability of therapist who issued unescorted grounds privileges to MDO who subsequently escaped and assaulted passer-by, scope of liability for psychiatrist treating outpatient not as broad as for psychiatrist treating inpatient because outpatient has greater freedom and is more difficult to monitor and control; liability for former limited to identifiable potential victims whom can be warned).
becoming secondary.\textsuperscript{640} It is further predicted that these opinions will lead the prudent professional to have the MDO taken into custody whenever there is doubt over the future acts of the MDO, will limit the use of outpatient treatment and in turn will slow recovery, will encourage custody decisions to be made by treating professionals rather than through a formalized procedure designed to ensure the rights of the acquittee, will force the therapist into an inherently conflicting role of having to choose between protecting society and treating the patient, will require the professional to make decisions that he or she is not adequately trained to exercise, namely protecting society, and will impose on the MDO the "cost" of protecting society.\textsuperscript{641}

It has also been argued that at least some MDOs, because they have been involved in repeated harmful acts, are at a much higher risk to pose a danger to the general public than others who seek mental health services.\textsuperscript{642} This suggests that the therapist treating such individuals may have greater notice of potential harm, and thereby a greater responsibility to take steps to prevent that harm. At the same time, it is argued that these judicial opinions rely inappropriately on the belief that mental health professionals can predict dangerousness.\textsuperscript{643}

Arguably, this "cost" of protecting society will also be borne by mental health professionals who either refuse to constrict their treatment recommendations or, because of the inherent difficulty in predicting the course of mental illness, are unable to respond quickly or sufficiently enough to avert the dangerous behavior of the MDO.


\textsuperscript{641} Sheridan, \textit{supra} note 638.

\textsuperscript{642} Weiner, \textit{supra} note 84, at 325.

\textsuperscript{643} See Paul S. Appelbaum, \textit{The New Preventive Detention: Psychiatry's Problematic Responsibility for the Control of Violence}, 145 AM. J. PSYCHIATRY 779, 781 ("Psychiatric responses to the uncertainty associated with this potential for liability sometimes include extreme measures aimed at lowering the risk. Yet, the intractability of chronic, characterologically based dangerousness often lends an air of desperation and futility to such efforts. ... The nub of the issue ... from a clinical and policy perspective is that dangerousness and mental illness ... are not synonymous. When the potential for violence is long-term and dissociated from any acute disorder that might exist, the current system provides powerful incentives for psychiatrists to prolong hospitalization beyond the term of useful treatment. Persons thought to be dangerous are deprived of freedom for a time but without therapeutic gain. Meanwhile, the long-term threat inevitably remains whenever the patient is discharged."); Mills \& O'Keefe, \textit{supra} note 341, at 38 ("The most troublesome aspect of these lawsuits may be their perpetuation of the belief that dangerousness can be predicted. In the face of overwhelming research documentation to the contrary, and vociferous denials by the mental health professions ... American courts ... continue to assume that such predictions can be made.").
Nevertheless, judicial opinions clearly indicate that courts are seeking and requiring greater assurances that the placement of the MDO back into the community will not result in the recurrence of violent or harmful behavior by the MDO. Furthermore, it has been suggested that these opinions are influencing the release decisions of mental health professionals.

Recognizing perhaps that these judicial opinions may place too great a burden on mental health professionals charged with treating individuals with a mental illness who are released back into the community, some steps have been taken to shield these professionals from liability. For example, several states have enacted statutes that restrict the liability of therapists to third parties (e.g., where there was a specific threat). Similarly, some states grant immunity to institutions or persons that release a patient or prisoner who subsequently injures a third party. Finally, absolute immunity has been

644. See Mills & O’Keefe, supra note 341, at 37 (“Tarasoff appears to exemplify the growing tendency of courts to hold therapists liable for the actions of dangerous patients”); Weiner, supra note 84, at 339 (“The trend in the law appears to be that when a therapist is in a situation where he is aware that his patient is planning to harm another person, who is unlikely to be aware of that harm, he must take some type of action to protect the third person.”).

645. See Appelbaum, supra note 641, at 783 (“Data are in fact beginning to appear indicating the distorting influence that liability concerns can have on admission and release decisions. The surges in commitment reported in Washington State and New York City following widely publicized episodes of violence by mentally ill persons suggest similar phenomena.”); Weiner, supra note 84, at 339 (“Therapists have become aware of an increased obligation to take some actions to protect third parties from their patients.”).

646. See Reisner & Slobogin, supra note 379, at 133. See also Barry v. Turek, 267 Cal. Rptr. 553 (Cal. Ct. App. 1990) (psychiatrist immune under California law since he could not reasonably have known that patient posed a serious threat of violence); Porter v. Maunnnangi, 764 S.W.2d 699 (Mo. Ct. App. 1988) (state-employed psychiatrists statutorily immune from liability for decision to discharge patient who later committed suicide when discharge decision made in good faith and without gross negligence).

647. Reisner & Slobogin, supra note 379, at 120. See, e.g., VanLuchene v. State, 797 P.2d 932 (Mont. 1990) (State not liable for death of child killed by inmate released at expiration of sentence; State does not have duty to rehabilitate prisoners, avoid the release of prisoners whose mental illness renders them dangerous to society, or issue a warning concurrent with release to the general public); Fay v. City of Portland, 782 P.2d 182 (Or. Ct. App. 1989) (county correction’s officials entitled to quasi-judicial immunity after releasing inmate from jail’s psychiatric unit in response to court-order to relieve jail overcrowding and six days later assaulted plaintiffs; in so doing officials had failed to take into account court-ordered release criteria, which if followed would have prevented this release; nevertheless, when performing a judicial function, actor can make a mistake and still be entitled to quasi-judicial immunity); Melville v. State, 793 P.2d 952 (Wash. 1990) (prison officials not liable for not providing mental health treatment to inmate who murdered ex-wife and daughter three months after release). See also Hoffman v. Warden, 457 N.W.2d 367 (Mich. Ct. App. 1990) (police officers and sheriffs deputies entitled to immunity for failing to take plaintiff into custody for purposes of obtaining mental health treatment), appeal denied, 437 Mich. 1005, 1991 Mich. LEXIS 1260 (Ct. App. 1991). But see Nguyen v. State, 788 P.2d 962 (Okla. 1990) (decision to release psychiatric patient not encompassed within statute granting state immunity).
afforded to the professional where he or she is responding to an order of the court or participating in the judicial proceeding with the judge retaining ultimate decision-making authority.\footnote{648}{See, e.g., Walker v. State, 806 P.2d 249 (Wash. Ct. App. 1991) (doctrine of judicial immunity protects state psychiatric hospital from liability for failing to inform court of its conclusion that MDO was dangerous and discharging MDO from hospital; both acts clearly connected to hospital's participation in judicial proceeding; judge retained ultimate decision-making authority over release), review dismissed, 118 Wash. 2d 1014 (1992); Bader v. State, 716 P.2d 925, 927 (Wash. Ct. App. 1986) (Hospital that provided evaluation and recommendations used by court in formulating its release conditions for NGRI acquittee had absolute immunity when acquittee subsequently killed a woman; "When psychiatrists or mental health providers are appointed by the court and render an advisory opinion to the court on a criminal defendant's mental condition, they are acting as an arm of the court and are protected from suit by absolute judicial immunity."); however, opinion would have been different if assailant had been admitted to mental hospital because of crime committed, and hospital either recommended release to court or had been negligent in failing to seek involuntary commitment; since not the case, even if hospital negligent in recommendation of lenient release conditions, it could not be held liable.}

IV. Conclusion

The courts have struggled with the dilemma of balancing humane treatment for MDOs with ensuring public safety. To understand the current judicial attitude towards the MDO, it is necessary to clearly define the particular issue placed before the courts. In the past, courts adopted a relatively monolithic approach regardless of the question posed and left virtually all treatment and administrative decisions to those charged with making them. That is no longer the case. Not only must the specific issue before the court be taken into account, but the particular court, be it state or federal, trial or appellate, may also affect the result.

Current law regarding the treatment of the MDO can best be described as a continuum with two major conflicting interests balanced at either end. At one extreme, MDOs receive special attention by the law, at least in part, because of society's fears regarding their dangerousness. The community, often unable to differentiate among individuals, fears random violence and associates it with MDOs. Society appears to be unwilling to rely on the implicit promises of the 1960s and 1970s that treatment alone will transform MDOs into non-threatening, non-disruptive individuals. Instead, the community insists that such individuals be removed from its midst and placed in a setting where the acts that brought the MDO into the criminal justice system cannot be repeated.

However, the rulings of the 1960s and 1970s do not appear to have been totally abandoned. The concerns that shaped those rulings con-
tinue to influence the judiciary, albeit within a different context. Al-
though perhaps far less willing to grant MDOs their freedom, society,
as reflected through its judiciary, continues to adhere to a belief that
treatment can be beneficial and should accompany the restrictions
imposed on the MDO’s liberty. Indeed, it appears there may be a
rough attempt to balance increased restrictions on the MDO’s liberty
with increased oversight of the treatment provided to ensure that the
MDO is given an optimal opportunity to recover.649

This continuum, however, pays little heed to the mental health
professionals who are given the responsibility of treating the MDO,
or to the dilemmas it poses for them. On the one hand, mental health
professionals are obligated to assure the safety of the community. On
the other hand, they are required to treat and promote the recovery
of the MDO. They are asked to predict which MDOs should be al-
lowed into society and which should not, and may themselves be
"punished" if they are wrong. While their treatment of the MDO
receives increasing scrutiny, the range of treatment options available
to them may be limited by the community’s unwillingness to risk a
premature return to society. At the same time, this may be one of the
most treatment-resistant populations that the mental health profes-
sional will ever face. Finding an effective treatment modality to re-
spond to their treatment needs may be extremely difficult, and may
increase the likelihood of mistakes in diagnosis, medication, and
treatment. In addition, the safety of the individual professional may
occasionally be at risk in the course of interacting with the MDO, a
matter that receives little consideration by the judiciary but which
further complicates the clinical picture.

Despite some fluctuation, the standard of care which the judiciary
expects professionals to meet while caring for MDOs has risen in the
last three decades. While identifying the nature of that standard can
be a bewildering prospect for the mental health professional who per-
ceives the judiciary to be inconsistent in the approach being endorsed,
it is possible to find a mooring for the way in which a mental health
professional should approach an MDO client. That mooring is the
"professional judgment" standard which the courts increasingly have
adopted as an overarching principle in scrutinizing the actions of
mental health professionals.

649. An empirical question left unanswered is whether the increase in treatment is having
any effect on the subsequent behavior of the MDO. Substantial financial outlays are typically
associated with provisions for this treatment. At the same time, to the extent that treatment is
effective, the length of institutionalization can be shortened, and substantial savings incurred.
As a general rule, if the professional can demonstrate that he or she acted according to professional standards, liability will not be imposed. Ascertaining what professional standards apply, however, can be arduous and unsettling. Although beyond the scope of this Article, the professional judgment standard is where most legal analysis of the appropriateness of the professional’s actions begins, tempered by the concerns for individual rights and public safety discussed throughout this Article. In charting judicial developments over the last three decades, the intent of this Article has been to describe the pattern that can be discerned from their opinions and the forces at work upon the judiciary. In turn, it is hoped that this Article will help society (and the judiciary) to better understand and assess the appropriateness of the approaches utilized. In addition, it is also hoped that this Article will enable individuals, such as mental health professionals, charged with interacting with MDOs to better anticipate the reactions of the courts and to shape their behavior accordingly.