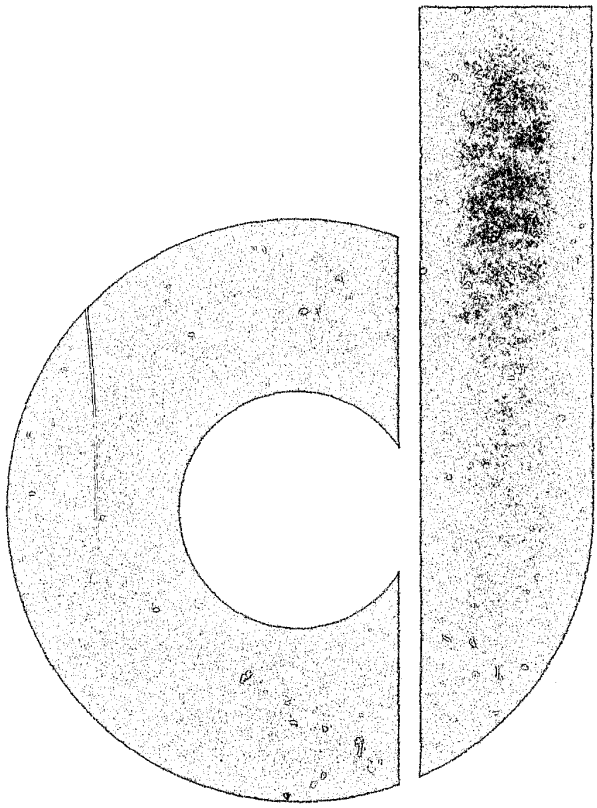
NATIONAL INSTITUTE OF MENTAL HEALTH

CRIMINAL COMMITMENTS AND DANGEROUS MENTAL PATIENTS: Legal Issues of Confinement, Treatment, and Release



Crime and Delinquency Issues

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

CRIME AND DELINQUENCY ISSUES:
A Monograph Series

CRIMINAL COMMITMENTS AND DANGEROUS MENTAL PATIENTS: Legal Issues of Confinement, Treatment, and Release

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Rockville, Maryland 20852

This monograph is one of a series on current issues and directions in the area of crime and delinquency. The series is being sponsored by the Center for Studies of Crime and Delinquency, National Institute of Mental Health, to encourage the exchange of views on issues and to promote indepth analyses and development of insights and recommendations pertaining to them.

This monograph was written under contract number ADM 42-74-29 from the National Institute of Mental Health. The opinions expressed herein are the views of the author and do not necessarily reflect the official position of the National Institute of Mental Health of the Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U.S. Department of Health, Education, and Welfare.

Library of Congress Card Number: 76-28650

DHEW Publication No.(ADM) 76-331
Printed 1976

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.35
Stock No. 017-024-00535-5

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FOREWORD

There has been in recent years considerably increased legal interest and activity with respect to the commitment, treatment, and handling of the mentally ill, including mentally ill persons charged with or convicted of crimes. This interest appears to be part of a broader social and legal trend in our society that has led to greater concerns for safeguarding the rights of various categories of socially deviant individuals (e.g., accused criminals, juvenile delinquents, and the mentally ill) when involuntary deprivations of liberty may be involved. While the full panoply of due process and related safeguards traditionally has been available to persons charged with crimes, such constitutional protections have not, until fairly recently, been viewed as necessary for those being subjected to "remedial" and "therapeutic" efforts under so-called "civil" (as opposed to "criminal") proceedings. The rationale (or perhaps even rationalization) has been that constitutional protections deemed essential when the State exercises its powers for punitive and social control purposes via the criminal process are neither necessary nor appropriate when the stated purposes are benign and concerned with care and remediation.

During the past decade the U.S. Supreme Court and numerous other appellate courts have held repeatedly that, where involuntary deprivations of liberty are involved, the traditional distinctions between "civil" and "criminal" proceedings provide insufficient justification for the denial of certain essential constitutional safeguards. The reasoning and rationale underlying such earlier decisions in the juvenile delinquency areas (e.g., in such landmark cases as *Kent*, *Gault*, and *Winship*) have moved logically and inevitably to confront similar problems involving the mentally ill and other "special" categories of persons such as sexual psychopaths and defective delinquents. Indeed, such cases as *Rouse v. Cameron*, *Wyatt v. Stickney*, *Humphrey v. Cady*, *Dixon v. Attorney General*, *In re Ballay*, *Specht v. Patterson*, *Jackson v. Indiana*, and *O'Connor v. Donaldson* have entered rather prominently into American legal and mental health history. Undoubtedly, these and several other similar decisions of the recent past will be joined by many more in the years to come.

Despite the aforementioned major and promising developments in the area of mental health law, many problems remain. One major area requiring careful conceptual analysis and clarification pertains to the disparate varieties of cases involving mental disabilities and currently

handled via both the "civil" and "criminal" commitment processes. Since these commitment procedures include actions premised on remedial and caregiving (i.e., parens patriae) functions of the State, as well as those concerned essentially and primarily with protection of the community (viz, police power functions), a number of critical public policy, legal, and programmatic issues continue rather thoroughly to be confounded.

This monograph has been developed by the NIMH Center for Studies of Crime and Delinquency to address the specific issues noted above. These topics and concerns relate very directly to the priority concerns of this Center and also of the National Institute of Mental Health in the area of interactions between the legal and mental health systems.

Prof. David B. Wexler notes in this monograph that the numbers and kinds of mentally ill persons considered to be in need of secure confinement in special units or mental hospitals tend to include a veritable "smorgasbord of disparate legal categories" such as sexual psychopaths, defective delinquents, mentally ill persons involuntarily committed because of their presumed "dangerousness" to others, pretrial incompetents, and others. (Just why our societal concerns with regard to the special handling of "dangerous" persons tend to be limited almost solely to persons labeled as mentally ill, and this in the absence of any clear or convincing evidence demonstrating that the mentally ill constitute one of the most "dangerous" groups in our society, poses yet another glaring problem.)

The author further points out that recent legal developments have markedly affected the extent to which the above categories of mentally ill persons may be placed in security institutions for indeterminate periods of time. Yet, there appear to be pressures on legislative and administrative bodies to increase the capacity and number of facilities for the indeterminate confinement of such persons.

Prof. Wexler's monograph is accordingly designed to assist understanding of the implications of some legislative and administrative trends with respect to mentally ill persons that may well be at variance with, or in clear conflict with, developing legal guidelines and constraints. It is hoped that the discussion and explication in this excellent monograph will facilitate more careful consideration of plans to establish expanded facilities for the so-called "dangerous" mentally ill and mentally ill offenders. To the extent that there are continuing pressures to develop such additional facilities, perhaps because of the "Edifice complex" which seems to afflict our society, the ensuing discussion may well help to avoid plans and programs that could turn out to be expensive mistakes.

The author of this monograph is one of the leading authorities in the field of mental health law and related criminal justice concerns. To the task of preparing this monograph he brings the fruits of his many previous writings, as well as considerable legal research and practical experience in the field of mental health law. Especially noteworthy, I believe, is Prof. Wexler's ability to define, conceptualize, and analyze issues that touch on major theoretical legal issues and that also relate to a variety of public policy and programmatic concerns of a very practical nature.

Two key features of this monograph deserve particular notice and commendation. Prof. Wexler has avoided a technical legal style of writing in order to encompass both legal as well as therapeutic and administrative concerns within his analyses, and thereby has made this discussion of relevance and value to a wide audience of interested persons in the legal, correctional, mental health, and related fields. In addition, Prof. Wexler has placed major emphasis on the need to take into account a number of broad philosophical and ideological currents in our society which have influenced the making of new mental health law in recent years. By starting with this general overview and then proceeding to a discussion of more specific legal developments affecting particular categories of mentally ill persons, he establishes a clear rationale for the policy recommendations proposed.

In order to provide the author full freedom to develop the issues he deemed important to the topics being addressed, no detailed specifications or guidelines were set in advance, and no substantive changes have been made in the manuscript submitted. Thus, the views expressed here are those of the author; the National Institute of Mental Health is pleased to make them widely available to facilitate further attention to and discussion of these important topics.

Finally, it should be noted that the initial draft of this monograph was submitted to this Center by Prof. Wexler in May 1975. Although some minor updating has since been made, the bulk of the text should be regarded as being current as of the date of original submission.

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CHAPTER I

Introduction

There is, at the moment, considerable interest, particularly among legislators and administrators of mental health and correctional institutions, in the topic of mentally ill offenders and related categories of mental patients. The interest spans a spectrum of problems, ranging from whether there ought to be special statutes authorizing the indefinite commitment of various types of persons (such as "sexual psychopaths" or "defective delinquents") to where dangerous mental patients and criminally committed patients ought to be confined. In particular, officials in many jurisdictions are now pondering the question whether to construct security or other special facilities for certain groups of mentally ill persons perceived to be particularly dangerous.

This monograph will address those questions and will tender a series of recommended courses of action. At the outset, it is important to note that the above questions actually involve a host of subquestions, many of which are therapeutic and legal in nature. For example, whether separate security or other facilities ought to be constructed will depend at least in part on what types of patients will be legally permitted to be housed in them and for how long a period, and on what those facilities can and cannot accomplish—both therapeutically and legally. Similarly, the group of patients traditionally thought to require secure or special facilities actually constitute a smorgasbord of disparate legal categories—sexual psychopaths, defective delinquents, other "special" varieties of offenders, criminal defendants found incompetent to stand trial, criminal defendants found not guilty by reason of insanity, mentally ill prisoners, civil patients with criminal charges or detainers outstanding, and civilly committed patients who are thought to be particularly dangerous or aggressive.[1] In recent years, legal developments have markedly altered the ease with which certain of those categories may be committed or placed in maximum security quarters.[2]

In short, because of the important recent legal activity, policy questions regarding the confinement of criminally committed mental patients cannot be addressed on a clean slate. Legal constraints are

sufficiently numerous that any proposed solution to the series of pertinent problems will require an understanding not only of modern social movements, but also of legal factors which would render certain possible "solutions" difficult or frequently unconstitutional. Moreover, varying legal requirements affect some of the categories of patients in different ways; in order to achieve a complete understanding of the overall situation, it will be necessary to sort out the legal and constitutional factors and to relate them separately to each group of special patients.

From a distillation of the legal and related considerations, it should be possible to suggest certain legislative and administrative action that ought to be taken to deal with the criminally committed. Legislative proposals made by others will also be evaluated. Administrative procedures that are gaining favor with the courts will similarly be discussed. In some areas, however, because of conflicting legal trends and other factors, firm recommendations will be simply unavailable. In those instances, the conflicts and uncertainties will be noted in order to alert institutional administrators to the problem areas which may at least temporarily place them in a legal "double bind," in order to encourage courts and legal authorities to give further thought to those areas, and in order to encourage psychologists, psychiatrists, and other behavioral scientists to perform needed empirical work to lay a firm foundation on which sensible legal positions can be based.

My overall conclusion, which will be elaborated in—and hopefully justified by—the following sections, is that new, large security and other special institutions ought simply not to be constructed. Instead, security units at State and regional civil mental hospitals ought to be retained or developed through remodeling. Further, administrative (or perhaps legislative) procedures should be developed to permit flexible—but safeguarded—transfer of patients between the general population units and the security units. Finally, mental health services at correctional institutions should be significantly upgraded, and the establishment of small psychiatric units at correctional facilities might also be contemplated in order to house overtly psychotic offenders and voluntary prisoner-patients.

In seeking to justify these conclusions, this monograph will discuss legal developments affecting each type of patient typically associated with confinement in secure or special facilities. Before that is done, however, it will be necessary to explore certain general movements—social, psychological, and legal—with a view toward relating these movements to the specific categories of patients and to the conclusion. The discussion of general developments will constitute

chapter II of the monograph, the discussion of specific categories of patients will be deferred until chapter III, and the monograph will close with chapter IV, which will present the conclusions.[3]

CHAPTER II

General Developments Relevant to Security and Special Institutions

A. Decarceration

All thoughts concerning the possible construction of new security and special institutions must first be placed in the perspective of a clear-cut social movement toward deinstitutionalization or decarceration[4]—a movement which now also boasts a partial constitutional handle.[5] For a variety of reasons, the emerging presumptions—social, psychological, and now even legal—disfavor confinement of patients and prisoners if it is avoidable,[6] disfavor lengthy periods of confinement if shorter periods might suffice,[7] and disfavor confinement in secure facilities if confinement in less secure facilities might be suitable.[8]

The decarceration trend has been spurred on principally by the vastly expanding literature documenting the adverse effects of incarceration,[9] which need not be detailed again here, by the increased awareness that alternatives to institutionalization are often satisfactory,[10] and by the moral view that we ought not to deprive persons of any more liberty than is necessary to achieve legitimate governmental goals. On the legal front, decarceration, broadly defined, is being achieved through several different avenues.[11] Lawyers are arguing, and courts are increasingly accepting, the principle of the "least restrictive alternative"—i.e., that full-scale hospitalization, particularly of civil patients, is not constitutionally warranted where alternatives less restrictive of liberty are preferred by proposed patients and at the same time are deemed medically feasible.[12] Secondly, the legal system is becoming increasingly tolerant of many forms of deviant behavior and is responding by placing certain types of behavior outside the ambit of legal control, either as a matter of policy[13] or as a matter of constitutional law. In the area of mental health law, constitutional constraints are beginning to limit the civil commitment power. Commentators are beginning to assert[14]—and the courts[15] and legislatures[16] are likely to follow suit—that commitment standards in contemporary statutes are vague, overbroad, and in need of streamlining. Commentators are urging that the paternalistic (parens patriae) and the public protection (police power) bases of the commitment power be kept analytically distinct.[16a] For commitment under the former power, it is being urged that a threshold requirement of mental *incapacity* to decide about matters of hospitalization is needed, rather than a mere finding of mental illness and a need for care and treatment. Under the police power, it is asserted that a substantial likelihood of future dangerousness should be found rather than a mere unenlightened psychiatric prediction of future conduct.[17] Tightened commitment standards will preclude the commitment of many persons who would be hospitalized under current standards.[18] Finally, as a later section of this monograph will demonstrate,[19] the notion of a durational limit on the length of confinement is finding increased support among legislators and is gaining favor as a constitutional quid pro quo of the power to confine. Those who are confined will, therefore, be confined for shorter periods of time.

Against the backdrop of the decarceration movement, it would seem to be both legally and economically unwise for officials to plan for the erection of new security or special institutions. Surely, certain patients will require confinement in rather secure facilities, but, as sections will indicate, those patients are far fewer than might be expected, and, legally, serious procedural[20] and substantive[21] obstacles must be overcome before security-type confinement can be constitutionally authorized for many sorts of patients. *It would certainly be shortsighted to plan the construction of secure institutions by contemplating that they will be populated by numerous patients, only to learn later that much of the proposed population will not be able legally to be placed in those institutions.*

Moreover, one dramatic consequence of the decarceration movement should be to reduce the population of civil mental hospitals (State and regional) across the country. As courts insist that patients not be sent to mental hospitals if less restrictive alternatives (outpatient treatment, day treatment, halfway houses, community mental health centers) are suitable, as substantive standards for commitment are narrowed and made more specific, and as procedural protections in the commitment arena are increased, judicial hearings become more meaningful. It can be anticipated that at such hearings lawyers will challenge psychiatric diagnoses and predictions, will argue persuasively about whether refined commitment standards have been met, and will introduce independent experts to testify regarding the suitability of less restrictive alternatives.[22] As a result, it

is likely that far fewer proposed patients will be funneled into State and regional mental hospitals. *As the reduction of population in our civil hospitals becomes a reality, thought will naturally be directed toward how the newly found space in such hospitals ought to be put to use.* Reducing the cramped quarters of the remaining civil patients will be a high priority, perhaps constitutionally mandated by cases requiring that confined patients be accorded some semblance of privacy.[23] But beyond that consideration, *it ought to be possible to convert some of the space into security units.* In economic terms, groups and commentators who have studied the problem of conversion have concluded that the venture need not be very difficult or very costly.[24] Moreover, as will be discussed later, there are numerous administrative and therapeutic advantages that flow from having a security unit as part of a general State or regional mental hospital rather than as a wholly separate institution.[25]

B. Treatment Issues

In formulating policy regarding the construction of special facilities for the dangerously mentally ill, it is relevant to know how effective various modes of therapy are, whether some sort of treatment must be provided to various categories of patients, and whether therapy can be refused by those groups of patients.

Some proponents of special facilities presumably favor the construction and use of such facilities for the forced reformation of mentally ill offenders. They claim that such facilities would go a long way toward reducing the rate of crime. Yet, it is important to recognize that even if the current brands of psychiatric, psychological, biochemical, and neurological treatments were thoroughly efficacious, there is *little evidence that the administration of those therapies would lead to an appreciable or even a noticeable reduction in the general rate of crime.* As one commentator has recently noted, fully two-thirds of all criminal suspects avoid apprehension, and only one-half of the remaining third proceed to judgment in criminal courts.[26] And only a tiny proportion of the remainder will be incarcerated and offered or subjected to the assumedly efficacious institutional programs of treatment or rehabilitation.[27] With figures as small as these, it is evident that, even with phenomenal correctional know-how, we should not expect correctional efforts to make a significant dent in the overall rate of crime.[28] Thus, many decarceration proponents "insist . . . that the amount of crime prevented by the incapacitation

through confinement of a number of convicted felons has little impact on the total amount of crime in a society. . . ."[29] This is not to suggest that treatment ought not to be available to confined offenders or to dangerous mental patients in order to give them an opportunity to improve their lot and their future lives.[30] The suggestion is simply that, in light of apprehension statistics, we should be skeptical of accepting a treatment rationale—even were treatment highly effective—as a panacea for curing the ills of society's crime problem and for substantially increasing the protection of the public.

Moreover, commentators who have thoroughly reviewed the available literature have repeatedly concluded that *there is little evidence indicating therapeutic effectiveness.* For example, a recent review by Ralph Schwitzgebel,[31] a psychologist and a lawyer, concludes that, apart from some of the newer therapies derived from psychological theories of learning,

> The effectiveness of traditional therapies in changing the behaviors which led to the commitment of the patients has yet to be clearly demonstrated. In a sense, those traditional forms of therapy have been living for many years on public faith and "credit" while the public, legislatures, and courts have acted in reliance upon statements of therapists which indicate that treatment can in fact change behaviors.[32]

Likewise, David Rothman, an historian, has argued that the treatment rationale has been invoked to legitimate too much—indeterminate confinement at the Patuxent Institution, aversive treatment of offenders, etc.—particularly since judicial deference is typically bottomed on the mere *promise* of therapeutic effectiveness rather than on its *proof.*[33] Accordingly, both Schwitzgebel and Rothman urge courts and public officials to begin gauging effectiveness by actual outcome or performance measures rather than by conclusory statements of therapists or by objective-sounding but nonetheless deceptive criteria such as patient-staff ratios, etc. In Rothman's words:

> [I]t would be far better to measure confinement standards by accomplishment. Intervention in people's lives must not be allowed if we merely *believe* but are not *certain* that we can accomplish good. To an astonishing degree we operate now on the basis of myths: that confinement in a state mental hospital will produce cures, that five-year-minimum terms for drug offenders will rehabilitate them, or that sentences of five to ten years will prevent or deter a significant amount of crime. Hard data and performance statistics are essential here, even recognizing all the difficulties in gathering and evaluating them.[34]

Since the sorts of patients with which the present monograph deals are actually a hybrid between mental patients and criminal offenders, rehabilitation results of correctional efforts are as important for present purposes as are results of traditional psychotherapeutic methods. Once again, however, the results are hardly encouraging. The Citizens' Inquiry on Parole and Criminal Justice, for example, undertook a comprehensive study of the New York parole system that included a review of literature relating to rehabilitation efforts within correctional institutions as well as in settings of conditional release. The study found no evidence to indicate that the different correctional and treatment programs studied had any appreciable effect on recidivism.[35] The only clear-cut conclusion was that the longer a person is confined, the more likely it is that that person will recidivate.[36]

The sparse evidence relating specifically to the "hybrid" category of patients mentioned above is inconclusive and has sparked heated controversy. A study by Hodges of "defective delinquents" committed by Maryland law to the Patuxent Institution, and indicating a far lower recidivism rate for "fully treated" Patuxent inmates than for "partially treated" or "untreated" groups,[37] was subjected to immediate and vigorous attack by Dr. Alan Stone.[38] Stone noted that the study did not address the crucial problem of false positives in the selection process, that the treatment effectiveness figures were based on a population of persons who enjoyed weekend furloughs and work release programs, and that no identifying characteristics (mean age, etc.) of the fully treated paroled group were provided. With these deficiencies, scientists, Stone claimed, would not be convinced that the *treatment* variable was responsible for the lowered recidivism rate. Stone concluded that the Hodges study had "serious methodological inadequacies, which render its conclusion untenable," and found "no evidence that justifies its overblown conclusions or the existence of Maryland's law."[39]

Superficially impressive statistics released by the Patuxent Institution in its 1973 progress report[40] were similarly taken to task by an ad hoc Legislative Committee of the Maryland Psychological Association. The Patuxent report boasted particularly of the extremely low recidivism rate of the "fully treated" group of prisoners—a group which had been paroled and ultimately released by the Board of Review after successfully serving out a 3-year parole status. The Maryland Psychological Association group, however, in a letter to the House Judiciary Committee of the Maryland Legislature, noted that factors *other* than the program of *treatment* at Patuxent could easily

have led to the low rate of recidivism in the fully treated group.[41] In particular, it was asserted that the favorable recidivism statistics could be attributable to one or more of the following three factors:

(1) *The careful process of screening and selecting inmates to be accorded parole status.* A careful parole selection process can easily lead to a low recidivism rate. But the inmates so selected may be the type who would succeed with or *without* treatment. Thus, the low rate may be attributable to the selection process *itself*, rather than to the treatment provided by Patuxent.

(2) *The program of close parole supervision.* The tight and intense program of parole supervision could, once again, be *itself* responsible for a low rate of recidivism. Regardless of the presence or absence of treatment, institutions adopting such a plan of parole supervision could experience sharp reductions in their rates of recidivism.

(3) *The possible "dropping out" from the statistics of parole failures.* The Patuxent report is unclear regarding what happens to persons who fail during parole supervision and how those persons are treated in the Institution's released statistics.[42]

Accordingly, the Maryland Psychological Association Legislative Committee concluded that, apart from treatment considerations, it could accept the impressively low recidivism rate reported by Patuxent while interpreting it to mean simply that: "When a selected group of treated inmates are carefully supervised and followed for a three year period, and when inmates who are failures along the way are dropped from this group, the outcome indicates a quite low recidivism rate."[43] In light of the persuasive critique of the Patuxent figures provided by Alan Stone and by the Maryland Psychological Association, pronouncements regarding the therapeutic effectiveness of the Patuxent Institution should be received with skepticism. The case for efficacy has yet to be demonstrated.

Right to Treatment

Apart from considerations of efficacy, relevant treatment questions include the constitutional or legal right *to* treatment, and the emerging right of prisoners, patients, and "hybrids" to *refuse* treatment. While both of these issues are of rather recent legal origin, the right-to-treatment area is considerably more developed than the area of the right to refuse treatment. Yet, in terms of Supreme Court pronouncements, the question whether there is a constitutionally prescribed right to treatment remains unresolved. Many observers had expected the question to be resolved by the Court in the recent case of *O'Connor* v. *Donaldson*,[44] but the Court decided the case on

narrow grounds and left open the right to treatment question. The Court ruled simply that it is inappropriate to confine without treatment nondangerous persons capable of adequate community adjustment. But the Court did not consider whether such persons *could* be confined if treatment were forthcoming or whether persons confined because of *dangerousness* have a right to treatment.

Regardless of the Court's ultimate verdict on the existence of a constitutionally grounded right to treatment and its contours, the right—or at least some semblance of it—is now so firmly embedded in lower court decisions,[45] modern statutory enactments,[46] and legal commentary[47] that its continued existence, with or without a constitutional imprimatur, is almost assured. The right may have a different theoretical basis and scope, however, when applied to patients committed pursuant to the State's paternalistic power (parens patriae patients) and when applied to patients committed pursuant to the police power of the State (police power patients).

The "core" recipients of a right to treatment are presumably those parens patriae patients who are committed because they are mentally ill, legally incompetent to make hospitalization and treatment decisions, and *in need of treatment.* To the extent that a need for treatment is part of the rationale for commitment, confinement without treatment would be legally unwarranted.[48]

Some "security-status" patients—the principal concern of this monograph—are committed pursuant to the parens patriae power[49] and are accordingly entitled to treatment. But it must be recognized that many security patients, such as certain dangerous civil patients and patients found not guilty by reason of insanity, are confined pursuant to the State's police power. Police power patients are also generally thought to enjoy a right to treatment, but the scope and theoretical base for this assumption is far shakier than in the case of parens patriae patients.

Courts have often accorded police power patients a right to treatment on the theory that detention is ordinarily appropriate only for a finite period, following a trial with many procedural protections, and after a finding that the subject has committed a specifically defined offense. Since police power commitments deviate substantially from that criminal model, the quid pro quo or "trade-off" for the departure ought to, according to the theory, result in a right to treatment even for police power patients.[50] The theory has, however, been sharply criticized on a number of grounds.[51] Two other bases for a police power right to treatment, less subject to criticism than the quid pro quo rationale, have recently been advanced:

> In order to prove that the societal benefit of the commitment outweighs the detriment to the confined person, the state might introduce evidence concerning the nature and amount of any treatment that could reduce the predicted duration of the detention and which would be available to the patient if he desired it. A police power commitment following the presentation of such evidence is thus justified, in part, by the promise of treatment, and a person committed under these circumstances would have a due process right to its provision. In other cases, the dangerousness of an individual may be so great that potentially permanent confinement would be warranted; thus mere custody under humane conditions would not be arbitrary or irrational. Nevertheless, failure to provide available treatments would violate the constitutional requirement that deprivations of fundamental liberties be the least restrictive necessary to accomplish valid state objectives.[52]

If the above bases of a police power right to treatment for persons committed under a police power rationale are accepted as constitutional doctrine or even as a matter of legislative policy, they ought to have considerable bearing on the question of where security patients are physically confined. For instance, if it is assumed that the failure to provide police power patients with "available" treatment would run afoul of the least restrictive alternative doctrine, mental health policymakers must consider the consequences that would flow from certain judicial interpretations of the term "available":

> The correct meaning of "available" for least restrictive alternative purposes may be difficult for a court to ascertain in a jurisdiction which wishes to segregate *parens patriae* and less dangerous police power patients from very dangerous police power patients. Faithfully observing the right to treatment for *parens patriae* and less dangerous police power patients, the state might desire to commit all such patients to a well-staffed, well-maintained, and well-equipped sanatorium. Very dangerous police power patients, however, would preferably be sent to a detention facility providing a humane environment but no psychiatric treatment; the state's claim would be that no treatment was necessary for such individuals because the state's interest in confining them was greater than the detriment of lifelong institutionalization. A court could, however, order the transfer of some psychiatrists from the treatment center to the detention facility or otherwise attempt to equalize the services provided by these institutions as a precondition to police power commitments. Although one might accuse such a court of "judicial legislation," the minimal additional expenditures which such an order might require would probably be within the scope of previous cases dealing with least restrictive alternatives.[53]

The above analysis seems to cut against the distant and sharp segregation of police power patients from parens patriae patients. According to the analysis, the "less dangerous" police power patients will (or ought to) have a rather clear-cut right to treatment since interests of public protection alone could not warrant their being housed in a nontherapeutic institution. Even the "very dangerous" police power patients, who can perhaps be held on the basis of public protection alone, probably ought as a matter of policy to be offered treatment. Moreover, if such patients are separately housed without treatment, the State will run the risk that a court, on legal least restrictive alternative grounds, may issue some type of therapeutic "equalization order," mandating the diversion of some parens patriae treatment resources to the dangerous police power patients.[54] Such an order would pose cumbersome problems of implementation if the dangerous police power patients were physically isolated from the parens patriae population. Accordingly, *the most appropriate method of insuring that treatment will be available to police power patients*, and of avoiding issuance of hard-to-implement judicial equalization orders, *would probably be to house very dangerous police power patients in secure units on the premises of civil mental institutions.*[55]

Right to Refuse Treatment

Even if treatment must be made available to all types of patients, including police power and security-status patients, it by no means follows, as some psychiatrists and psychologists mistakenly believe, that therapy can be *forced* on unwilling patients and that those patients' rights *to* treatment would be infringed if therapy were not thrust upon them. The legal system—through case law, legislation, and administrative regulations—is steadily defining and refining a right to resist treatment.[56] *In light of this emerging right, legislators and other officials who contemplate building large security and special hospitals in order to force treatment on the residents must recognize that their goal will, for the most part, not be legally available.*

In a handful of recent cases, the courts have addressed the right-to-resist issue. One such case is *Mackey* v. *Procunier*.[57] Mackey, a prisoner at Folsom, was transferred to Vacaville in order to receive electroconvulsive therapy. The transfer for that purpose was apparently agreed to by Mackey. Once at Vacaville, however, Mackey was apparently subjected, without his consent, to a very different procedure: "anectine therapy." Anectine is a muscle relaxant which induces paralysis and respiratory arrest. Its standard use, with an anesthetic, is as an adjunct to electroconvulsive therapy in order to

prevent bone fracture. Mackey claimed, however, that he was administered the drug while he was awake and as part of a program of "aversive therapy." That is, he received anectine injections contingent upon his engaging in inappropriate behavior. When administered to conscious patients, anectine has been described as creating a sensation of drowning, dying, and suffocating. When Mackey's case reached the United States Court of Appeals for the Ninth Circuit, that court ruled that proof of his allegations could raise serious questions under the Eighth Amendment cruel and unusual punishment clause and the emerging First Amendment protection of mental privacy.

A similar problem arose with security patients at the Iowa Security Medical Facility. There, nurses administered injections of apomorphine, a drug which induces incidents of uncontrollable vomiting, to misbehaving patients.[58] The United States Court of Appeals for the Eighth Circuit, in the case of *Knecht* v. *Gillman*,[59] held that the administration of apomorphine without the informed consent of the patient ran afoul of the constitutional proscription against cruel and unusual punishments.

Clearly, then, aversive and punitive programs of behavior control can no longer be resorted to with complete therapeutic freedom. Indeed, forcibly subjecting patients even to schemes of *positive* reinforcement—"reward therapy"—is a process also headed for legal difficulty. Programs of "token economies" in which tokens, earned for appropriate behavior, can later be cashed in to purchase desired items and events, may pose difficulties because patients may begin in such programs at legally unwarranted stages of deprivation. Similar difficulties may be encountered in the "tier systems" in which privileges are dependent upon one's place in a hierarchy and in which one's place, in turn, is dependent upon appropriate behavior.

In many token economies and tier systems, food, beds, privacy, and ground privileges are used as "reinforcers" which are available only if earned by engaging in appropriate behavior. Yet, decisions defining rights of patients, such as *Wyatt* v. *Stickney*,[60] are increasingly suggesting that patients are constitutionally *entitled* to such items and events as part-and-parcel of a humane psychological environment. Considerable doubt is thus cast on the legality of the continued use of such *contingently* available reinforcers.

Elsewhere, this writer has summarized the possible impact of *Wyatt* and related case law and statutory developments on token economies and tier systems:

> According to the *Wyatt* court, a residence unit with screens or curtains to insure privacy, together with "a comfortable bed

> . . . a closet or locker for [the patient's] personal belongings, a chair, and a bedside table are all constitutionally required." Under *Wyatt*, patients are also insured nutritionally adequate meals with a diet that will provide "at a minimum the Recommended Daily Dietary Allowances as developed by the National Academy of Sciences." *Wyatt* further enunciates a general right to have visitors, to attend religious services, to wear one's own clothes (or, for those without adequate clothes, to be provided with a selection of suitable clothing), and to have clothing laundered. With respect to recreation, *Wyatt* speaks of a right to exercise physically several times weekly and to be outdoors regularly and frequently, a right to interact with members of the other sex, and a right to have a television set in the day room. Finally, apparently borrowing from Judge Bazelon's opinion for the District of Columbia Circuit in *Covington* v. *Harris*, Judge Johnson in *Wyatt* recognized that "patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment"—presumably including, if clinically acceptable, ground privileges and an open ward.
>
> Thus, . . . the usual reinforcers will be legally unavailable. The emerging law appears to vindicate the assertions of the patients who, at the inception of the Patton State Hospital token economy, "pointed out to the nurses that the state had an obligation to feed them and that the nurses were acting illegally in denying them entrance to the dining room." Chronic patients at Anna State Hospital who had to work for screens and personal lockers to insure privacy would, under *Wyatt*, have those items provided noncontingently. According to the "least restrictive conditions" rationale of *Covington* and *Wyatt*, it would seemingly be impermissible to house on closed wards those patients clinically capable of exercising ground privileges, such as Richmond State Hospital's admittedly non-psychotic alcoholic patients who, before the onset of the token economy program, would have quickly been placed on an open ward. The identical "least restrictive conditions" rationale would presumably also invalidate programs, such as the one at Anna State Hospital, in which ground privileges or supervised walks are available only by purchase, and programs in which outright release from the institution is conditioned upon the accumulation of a set number of tokens or points.[61]

At the Medical Center for Federal Prisoners at Springfield, Missouri, a tier system established by the Federal Bureau of Prisons, known as the START program (Special Treatment and Rehabilitative Training), was recently subjected to constitutional challenge. Part of the challenge was aimed at the level of deprivation in the lower tiers of the program, where reading materials, exercise opportunities, and

visitation rights were sharply limited. Because the Bureau of Prisons decided, while the litigation was still in process, to terminate the Springfield START program, the Federal court hearing the case dismissed most of the issues as moot, and accordingly did not squarely address the deprivation issue.[62] But the Bureau of Prisons has indicated that it intends to employ positive reinforcement principles in future correctional efforts. If these efforts entail levels of deprivation comparable to START's, further litigation of the issues can be expected. State-run tier systems, such as the one operated by Maryland's Patuxent Institution, may also find themselves targets of START-type lawsuits if their levels of deprivation are sufficiently severe.[63]

As in the case of the right to treatment, the right to resist treatment operates differently with respect to parens patriae and police power patients. According to the emerging view, if a patient or prisoner is mentally competent to decide about matters of therapy and gives informed consent, the therapy can go forward; but if the competent person refuses consent, the State lacks a sufficiently compelling interest to thrust the therapy upon the patient. If, on the other hand, the patient is *incompetent* instead of competent, his acquiescence or refusal is not determinative, and in certain instances a surrogate decisionmaker (guardian, Human Rights Committee, court, etc.) can consent even to intrusive therapies if less restrictive techniques seem unsuitable and if the proposed therapy seems, in a cost-benefit sense, to be in the best interest of the incompetent patient.[64]

Since incompetency is regarded as part-and-parcel of the parens patriae commitment power, parens patriae patients will presumably be eligible for forced treatment if the other important tests—best interest and least restrictive alternative—are also met. Police power commitments, on the other hand, are based on potential dangerousness but do not necessarily require a level of mental disability amounting to incompetency. Police power patients, therefore, may be in a position to refuse intrusive treatment, although the propriety of their continued confinement while dangerous may, for public protection purposes, be constitutionally affirmed.[65] Superficially, it may seem curious that parens patriae patients—by far the more innocuous of the two categories of patients—may be subjected to unwanted intrusive therapies, whereas their dangerous police power counterparts may head off such therapies by their mere say-so. Upon closer analysis, however, the constitutionally created irony seems to dissipate: If parens patriae patients are confined because of their need for treat-

ment and for their mental inability to make competent treatment decisions, it seems reasonable for those patients to be given—or to be subjected to—appropriate treatment. But since police power patients are confined, despite mental competency, because of their dangerousness to society, it seems equally reasonable to allow such patients to submit to therapy if they desire it and believe it will reduce the length of their confinement, but to also respect their competent refusal if they choose to satisfy society's public protection interest by simply remaining confined so long as they continue to pose a serious societal danger.

Since a large number of security-status patients are committed pursuant to a police power rationale, their right to resist intrusive therapeutic procedures will make it clear that institutions cannot reasonably be constructed with the avowed purpose of forcibly reforming those patients. Nonetheless, as noted earlier, police power patients, wherever they are housed, should be accorded a right to seek appropriate treatment if they desire to alter their behavior and if they can thereby shorten their period of compulsory confinement.

Informed Consent

In order to preserve the delicate balance between according police power patients a right to refuse therapy, and at the same time to allow them to submit to therapy to which they give their informed consent, it will be necessary for the courts to come properly to grips with the concept of consent.

One impediment to approaching the consent notion carefully has been the conceptual confusion generated by the case of *Kaimowitz* v. *Department of Mental Health*.[66] *Kaimowitz* was a Michigan trial court decision which, on constitutional grounds, barred the performance of experimental psychosurgery on involuntarily confined patients. The *Kaimowitz* court held that psychosurgery could not be performed without the informed consent of the subject, and held further that even apparently *acquiescing* patients could not submit to the procedure because such persons would be unable to give legally adequate informed consent.

Informed consent, according to *Kaimowitz* and other authorities, can be broken down into the three constituent elements of competence, knowledge, and voluntariness. With respect to confined patients submitting to psychosurgery, the *Kaimowitz* court found each of the required elements unsatisfied. Competence was absent because the court viewed the process of institutionalization as creating a dependence among patients which rendered them cognitively incapable

of making decisions as serious and complex as whether to submit to psychosurgery. Knowledge was found wanting because the risks of psychosurgery were deemed so uncertain that consent to psychosurgery were deemed so uncertain that consent to psychosurgery could not be regarded as truly "informed." And voluntariness was absent largely because the desire for release was regarded as so overpowering that it would coerce patients into submitting to psychosurgery in order to improve their prospects for discharge.

Elsewhere, this writer has criticized the *Kaimowitz* court's loose use of the three informed consent elements, which renders *Kaimowitz* difficult to distinguish analytically from instances where informed consent *ought* to be found.[67] It is clear that the *Kaimowitz* court intended its holding to be confined to the special facts involved in the case—that is, to procedures which are experimental, highly intrusive, dangerous, and irreversible. But such a limitation is not particularly satisfactory in a conceptual sense. In any event, there is a tendency at least among certain advocates to expand the *Kaimowitz* rationale to cover a host of therapeutic situations other than psychosurgery.

Of particular concern is the notion of voluntary consent. If the legal system wishes to preserve the delicate balance mentioned earlier between allowing consensual therapy and disallowing nonconsensual therapy, it must "pierce through the rhetoric, fueled by the *Kaimowitz* case or at least by sloppy readings of that case, that institutions are inherently coercive and that, because the lure of release is so overpowering, voluntary consent is unobtainable in an institutional setting."[68] Should the inherent coercion formula be accepted and applied to a broad spectrum of intrusive therapies, the effect would be to vitiate the right *to* treatment because the following logic would apply: Patients have a right to treatment. They also have a right to resist treatment in the absence of informed consent. But informed consent cannot be given by institutionalized patients because any such consent would be inherently coerced rather than voluntary. Thus, patients cannot be forcibly subjected to therapy, nor can they voluntarily submit to it, for their submission will be equated with forcible subjection.

By such a process of reasoning, our institutions—for security-status patients, for prisoners, and for involuntarily confined civil patients—would be converted, by the force of law, to humane holding facilities and nothing more. And under the label of paternalism, patients would be *deprived* of a treatment option, and some would continue to be confined because of their untreated dangerous behavior. That result seems as unacceptable as the opposite problem—the

traditional position from which we are rapidly moving—of a therapeutic free-for-all, where therapists are allowed to determine the appropriateness of treatment procedures for particular patients and to subject even competent protesting patients to those procedures.

The solution seems to lie in recognizing that pressure to select a particular option, even if the pressure is generated by a desire to avoid or reduce incarceration, should not itself be deemed the legal equivalent of coercion. In other areas of the law, that recognition is readily apparent. Plea bargains are upheld as voluntary even though motivated by a desire to avoid or reduce incarceration. Reasonable conditions of probation and parole are regarded as voluntarily agreed to even though, once again, their acceptance by prospective probationers and parolees is often motivated by a desire to avoid or reduce incarceration. Coercion, therefore, should not be viewed as a doctrine which condemns pressure per se, but rather as a doctrine which guards against *unfair* or *unreasonable* choices.[69] Coercion should more readily be found if a patient is promised benefits for the *mere act* of participating in a program, or is threatened with additional adverse consequences for not participating, than if a patient is merely offered an opportunity to participate (with no benefits or detriments flowing from the participation decision per se) in a program which, *should* it actually alter his behavior and undercut the reason for his detention, may lead to his release.[70]

C. Indeterminate Confinement

A hallmark of most existing or proposed schemes for the commitment of "special" or "security" patients has been confinement for a wholly indeterminate period, justified on the grounds of public protection or therapeutic necessity or both. Increasingly, however, indeterminate sentencing (and even "indefinite" sentencing, where there is a set maximum, but where release can antedate the maximum expiration date) is falling into rather widespread disrepute on policy grounds and, more recently, even on emerging legal and constitutional grounds. Accordingly, as this section will seek to demonstrate, *legislators should not propose commitment statutes for special or security patients with the confidence of being able to confine those patients for an indeterminate period.*

Arguments in Favor of Indeterminate Confinement

There are, of course, several positive arguments that have been advanced in support of indeterminate sentencing. These have been carefully catalogued by E. Barrett Prettyman, Jr., in a recent authoritative study[71] of indeterminate sentencing with particular reference to its operation at the Patuxent Institution:

> (a) It allows the fullest possible implementation of the rehabilitative ideal of correctional reform.
> (b) It offers the best means of motivating involuntarily committed inmates to work for rehabilitation, since they hold the key to their release in their hands, and motivation is a prerequisite for many, although not all, forms of rehabilitative treatment.
> (c) It offers the maximum protection to society from hardcore recidivist and mentally defective offenders, and public safety is a primary concern of the criminal law.
> (d) It helps maintain an orderly environment within the institution.
> (e) It prevents unnecessary incarceration of an offender and thus helps to prevent the correctional system from becoming a factory from which first offenders emerge as hardened criminals.
> (f) It offers a feasible alternative to capital punishment.
> (g) It removes the judgment as to the length of incarceration from the trial court judge and puts it in the hands of a qualified panel of behavioral experts who make their final decision based on considerably more evidence than is available at the post-conviction stage of the trial.
> (h) The decision as to length of incarceration reflects the needs of the offender and not the gravity of the crime, in the best interests of both society and the criminal offender.
> (i) It prevents correctional authorities from being forced to release from custody an offender who is clearly not ready to rejoin society.
> (j) It prevents the problem offender from retreating into a "sick" role during rehabilitation.
> (k) It acts as a deterrent to crime.[72]

Arguments Against Indeterminate Confinement

Despite the advantages, Prettyman himself, joining a chorus of other commentators, concludes that "the indeterminate sentence is self-defeating as a rehabilitative device."[73] Prettyman's conclusion derives in part from his witnessing the practical operation of indeter-

minate confinement at Patuxent and in part from his collecting, by means of a comprehensive review of the literature, the manifold arguments advanced *against* the continuation of indeterminate sentencing schemes:

(a) Treatment is a myth, and vocational training is a fraud. For various reasons ranging from inadequacy of staffs to the difficulty of therapy in a maximum security atmosphere, inmates are neither treated, trained nor rehabilitated. Claims of therapy simply cloak banishment to institutions devoid of treatment processes. And if there is no treatment, has not the entire case for the indeterminate sentence disappeared?
(b) Even if treatment were honestly attempted by adequate staffs, psychotherapy with involuntarily committed patients is generally considered difficult, and indeterminate sentencing may therefore supply only negative motivation which will be insufficient for achieving long term results.
(c) Even if effective therapy were possible with some offenders, it is neither justified nor proper for all offenders, and there should be a right *not* to receive unwanted therapy.
(d) Since the treatment is token and rehabilitation is almost nonexistent, the indeterminate sentence becomes a device to hide society's dehumanizing treatment of criminals, particularly those who are poor and/or members of minority groups.
(e) Similarly, by taking the criminal off the street while at the same time promising rehabilitation, the indeterminate sentence makes it easy for society to ignore the underlying social causes of crime. To put it another way, indeterminate sentencing allows society to isolate the fruits of its inadequate social policies when they are disruptive but simultaneously to ignore the problem as a whole since the most unpleasant results (crime and criminals) are effectively removed.
(f) In most instances, the indeterminate sentence is used as an instrument of inmate control. The staff and the releasing authority simply play God with the offender, wielding the variable sentence as a weapon. Where a system entails so many discretionary decisions, it is fraught with the potential for abuse.
(g) In practice, the psychiatrist becomes more of a jailer than a healer. While he is supposed to treat the inmate, he also knows that he will have to testify in court at various times about his "patient" and that his recommendation to the releasing authority will virtually determine the inmate's release date. This puts the psychiatrist into an inherently untenable role, brings political pressures to bear on his decisions, and restricts his freedom to work for the best interest of his patients.

(h) The designation of some offenders as mentally ill is extremely arbitrary, as is the identification of those who fall within the statutory definitions of "defective delinquent" or "sexual psychopath." As one commentator has implied in regard to the Maryland definition of a "defective delinquent," it could include virtually every offender except an unhelmeted motorcyclist. Another has broadened the definition only slightly: "Apparently, any potential chronic miscreants could be found to be in sufficient emotional imbalance so as to justify invoking the jurisdiction of the statute." Once the defective delinquents reach the institution, they are such a variable lot that it is virtually impossible to devise a single treatment approach that will meet the needs of the entire group.
(i) There is a great danger that the indeterminate sentence will be used to punish political beliefs and unpopular views, especially those which antagonize the staff. The religious and political nonconformist is the type of inmate who is most likely to fight the therapeutic system and thus to foreclose his own release. Even among offenders, there should be the right to be different. There are arguments for and against involuntary behavioral change, but innumerable authorities have warned against unrestricted use of behavioralistic principles to insure social order.
(j) The indeterminate sentence structure encourages the smart or cunning offender and is more favorable to him than to a less intelligent offender, although the more intelligent offender may be the most dangerous to society. This is because of the ease with which a smart offender can play the game and fool his captors.
(k) Despite the fact that courts are supposed to retain some measure of control, there simply is no adequate protection from life imprisonment in the guise of "the indeterminate sentence." Since release authorities are normally more concerned about protecting the public than with releasing the prisoner at the earliest possible date, the practical result is that the institutionalization may stretch on endlessly. To put it another way, if the psychiatrist recommends against release, and the authorities refuse to release for any reason, no one will know that a mistake has been made. On the other hand, if the inmate is released and becomes a recidivist, the mistake is evident to one and all. Because of this uncertainty and of the difficulty of predicting "dangerousness," the sentence contravenes the individual rights of the inmates. Even where the sentence does not ultimately turn out to be for life, the result is a longer confinement than that which would have occurred had the inmate gone to prison. Moreover, in most persistent offender situations society is as well protected by a maximum sentence of, say, 30 years, since that term removes the offender past the age at which recidivism normally occurs.[74]

Shamming

In practice, students of the indeterminate sentence have repeatedly observed that patients and inmates are drawn to game-playing—known colloquially as "shamming," "conning," or, in the parole release context, "programing"—in order to convince their keepers that rehabilitative efforts have been successful and that release is in order. Some inmates develop extraordinary skills in convincing institutional staff and releasing authorities of the appropriateness of discharge. A Patuxent inmate summed up the situation to Prettyman in these words:

> Look, man, most of us are good at shamming. We grew up in the streets surrounded by confidence games. Literature is available to everyone now—hell, we talk as much about the Oedipus complex as about baseball. We know what these cats want to hear. Not the real gory stuff—what you're really thinking—because that scares 'em and makes 'em think you're still dangerous. But you spill your guts in a nice kind of way and act as if you're gaining all these insights. Now that you know yourself and that you killed that girl because you were really killing your mother, you don't have to kill anymore. It doesn't seem to occur to 'em that I might want to kill my mother several times over. Hell, everything I've told 'em is a lie. One big sham.[75]

So pervasive is the shamming phenomenon that at the security hospital at Atascadero, California, the following anonymously drafted tongue-in-cheek but highly revealing document is in widespread circulation:

HOW TO SURVIVE A MULTIDISCIPLINARY MEETING
(particularly if you're an aggressive sexual offender)

Or, do these comments have any implications for helping define what the hospital considers "therapeutic" responses

1. Give an account of your offense which correlates closely, if not exactly, with the Probation Officer's report; particularly with respect to: (a) Whether a weapon was involved; (b) Whether physical violence was involved.
2. Show remorse: e.g. "I'm sorry" "What I did was wrong" plus 25–50 additional words appropriately chosen. Include a reference to the victim, and particularly make a "guess" about how badly they must have felt about your action towards them.

3. Be able to explain, very clearly and convincingly, any discrepancies between your description of your offense and that contained in the Probation Officer's report.
4. Be able to give a nice "insightful" explanation as to why you committed your offense.
5. Be prepared to discuss any personal "beefs" which have accumulated with members of the hospital staff. These disagreements may or may not have anything to do with your presenting problem. You can recognize the beginning of such a discussion by hearing the staff member's voice become high pitched and louder than usual as they ask, e.g. "do you remember what you said to me when . . ." or "is it not true that on the occasion of . . . , you said to me that . . ." At these times the best guideline would be to quietly *agree* with the staff member, *without* offering any alternative view of the situation being described.
6. "Accept" and agree with any semi-punitive homespun observations about your offense, such as "what you did was pretty sick, don't you think!" Headnodding and a quiet "yes" as the statement is being made would be most helpful.
7. Be prepared for irrelevant questions such as, "can you really have children?" or, "didn't your parents really break up your marriage?"
8. Be able to explain how "the program" has helped you, and how it could be improved. (A brief suggestion or two would be sufficient.) Do not suggest in any way that "the program" is at all unclear to you, or that there may not, in fact, be a program.
9. *Never* deny any statement contained in the Probation Officer's report which is unfavorable to you (e.g. a weapon being involved; physical force being involved), and then later admit it. Particularly undesirable would be to claim that the original denial on your part was due to "nervousness" or "being scared" or some other reasonable explanation.
10. Be able to give a convincing description of what you will do if the same set of circumstances recurs which led to the offense for which you are now confined. This description should obviously include the comment that you would not repeat the same offense again. Also, refer to having gained better inner "controls" through treatment in the hospitals, getting more "help" by going to a psychiatrist, immediately.
11. Be a patient here for three years.

12. Make no statements which suggest that you, or others like you, are "entitled to" or "were justified in doing" any of the things which led to your hospitalization.
13. Even though you believe you have made some positive changes, be sure to express doubt as to whether or not you are really "cured." Show concern about recidivating and the need to stay on guard.
14. Be able to explain how you have made constructive use of the hospital's resources.
15. Tell how you have improved relationships with others to tolerate stress and frustration.
16. Tell how you never strike out at others physically or verbally.
17. If you had headache, ulcers of stomach or depressions, tell how you cried in therapy and confessed your wickedness and these physical pains and discomforts healed themselves without medications.
18. Talk about disturbing dreams, especially nightmares or any recurring dream.
19. Claim responsibility for everything in your life to the point where someone tells you it is not really your fault, as they shed a few tears in sympathy.
20. Have a choice of realistic plans for the future and be willing to conform. Prospects for further training and constructive employment are great.
21. Avoid reliance on religion and other "good" things but don't knock them. Plan to attend church to associate with the right kind of people.
22. Be fearful of the use of alcohol in any form and strive to attend AA if alcohol was ever a problem. The same for drugs.
23. Tell how you used to use "words" in group therapy, but then experienced deep feelings of regret for what you have done and a quiet desire to stop using words as a cover up for real feelings took place. Give examples similar to those you read in biographies of great men.[75A]

Release Criteria

To make matters worse, efforts at shamming—and therefore necessarily efforts at genuine rehabilitation as well—are often frustrated by the absence of clear-cut criteria for improvement and discharge.

Hugo Adam Bedau, a philosopher, has described four possible correctional models which vary from one another in terms of the type of sentence and release standards. (1) A fixed sentence where release is contingent simply upon reaching the expiration date; (2) an indeterminate sentence where release is gauged by objective conditions (obtaining a high school equivalency diploma, etc.); (3) an indeterminate sentence where release is gauged by subjective criteria (expressing "socially constructive attitudes," etc.); and (4) an indeterminate sentence where the inmate population is never informed of the release criteria.[76] While most administrators of special and security institutions operating under an indeterminate sentence probably purport to follow model two (objective release criteria), the indeterminate sentence in practice probably conforms most closely to model three (vague and subjective release criteria) and not infrequently to model four (unspecified release criteria).

If indeterminate confinement is to be continued in any form, it ought at least to conform to model two. Models three and four are examples of bad psychology as well as bad law. In a report to the National Prison Project, for example, Bernard Rubin, M.D., criticized on psychological grounds the "Control Unit Treatment Program" at the United States Penitentiary at Marion,[77] a program which is somewhat analogous to an indeterminate sentence scheme. The Marion control unit program placed hostile prisoners in indefinite special confinement (with progressive tiers of increasing privileges) in order to alter their behavior and attitudes so that they might eventually re-enter the general prison population. Rubin found that the program had to operate capriciously, for the stated release criterion was simply one which "reflects the committee's confidence that the offender has matured beyond the point of being a probable danger to other persons."[78] The absence of objective criteria for entering or exiting the program and for range progression within the program led Rubin to conclude that the Marion control unit system could not even be rightfully termed a "program."[79] Moreover, in Rubin's view the "program" worked actual harm: On the one hand, it corrupted the inmates by encouraging dishonest game-playing and shamming; on the other, the lack of specified objective criteria was demeaning to the inmates and led to feelings of helplessness, frustration, and outright rage.[80]

Many observers agree with Rubin's assessment of programs which do not clearly specify behaviors necessary to trigger the valued contingency of release. Ralph Wetzel, for example, has noted that the success and efficiency of contingency management programs can be greatly facilitated by the utilization of cues, prompts, and models

relating to expected behavior patterns.[81] And Albert Bandura, in a recent provocative piece,[82] notes that contingencies function to motivate and to impart information. Contingencies operate best, then, "after individuals discern the instrumental relation between action and outcome,"[83] and "behavior is not much affected by its consequences without awareness of what is being reinforced."[84] Bandura concludes that

> Not surprisingly, people change more rapidly if told what behaviors are rewardable and punishable than if they have to discover it from observing the consequences of their actions. Competencies that are not already within their repertoires can be developed with greater ease through the aid of instruction and modeling than by relying solely on the successes and failures of unguided performance.[85]

These principles are, as Bandura admits, hardly surprising. Their intuitive sense is reflected in the anecdote about a father who, disturbed by his young son's propensity for foul language, went to a psychologist for advice on how to handle the problem. "Use principles of behavior modification," the psychologist suggested. "Punish your son contingent upon his use of nasty language." Armed with that advice, the father the next morning asked his son what he would like for breakfast. The son replied (expletives have been deleted), "I think I'll have some of those ——— cornflakes." The father promptly spanked the boy and sent him to his room for an hour of "time-out." At the expiration of that hour, the father brought the boy back to the table and said, "Now, let me ask you again, what do you want for breakfast?" "Well," the boy responded, "I sure as ——— don't want any of those ——— cornflakes!"

If we are to expect patients and inmates to alter behaviors in ways that will gain release from indeterminate confinement without resort to game-playing and shamming, objective and clearly specified performance criteria must be provided. But even if this step is taken, successful legal challenges may still be leveled on constitutional grounds against the concept of confinement for wholly indeterminate durations.

Durational Limits

Legal commentators and recent cases have urged the creation of durational limits on confinement with respect to both the criminal system and the system of civil commitment. In terms of the criminal

law, for example, Norval Morris, concerned about therapeutic excesses and about our total inability to predict dangerousness, has in a recent article urged that criminal punishment should be justified by retribution and deterrence, should not have an independent goal of preventive detention, and ought not to have a reformative goal other than to make rehabilitative programs available to willing participants who are confined for periods set solely by retributive and deterrent considerations.[86] In his article, Morris suggests intricate interplays between the deterrent and retributive variables to determine whether incarceration is justified, but in determining the *maximal length* of permissible incarceration—the question of key concern for present purposes—considerations of deterrence fall out of Morris' scheme, leaving retribution to reign supreme.

According to Morris, deterrence should drop out of the maximum length of incarceration determination because of the following process of reasoning:

> To use the innocent as a vehicle for general deterrence would be seen by all as unjust . . . Punishment in excess of what the community feels is the maximum suffering justly related to the harm the criminal has inflicted is, *to the extent of the excess*, a punishment of the innocent, notwithstanding its effectiveness for a variety of purposes.[87]

With deterrence thereby removed from the picture, Morris proposes that maximum lengths of incarceration be determined by the principle of retribution or "desert:" "no sanction greater than that 'deserved' by the last crime or bout of crimes for which the offender is being sentenced should be imposed."[88] Morris has, therefore, actually converted retribution into a *protective* principle by urging, in essence, that a "retributive lid" be clamped on the length of permissible incarceration.

Case law is beginning to accept the principle that a period of criminal confinement ought to be confined by a retributive lid—or at least by a "rough" retributive lid—and that considerations of reformation, deterrence, and preventive detention ought not to play a major role in creating constitutionally permissible maximum periods of incarceration. Actually, the statement of the principle, as opposed to its accepted application, goes back as far as 1910, when the Supreme Court in *Weems* v. *United States*[89] announced a constitutionally grounded mandate to the effect that "it is a precept of justice that punishment for crime should be graduated and proportioned to offense."[90] In recent years, the courts have begun to invoke the *Weems* "proportionality" rule, which is considered to be part-and-par-

cel of the Eighth Amendment proscription against cruel and unusual punishments, to set aside at least those dispositions and sentences which are grossly disproportionate to the moral blameworthiness or seriousness of the triggering offense.[91]

Three recent judicial decisions are worthy of special attention. The earliest is the 1968 case of *Watson* v. *United States*,[92] a decision of a three-judge panel of the District of Columbia Circuit later vacated on other grounds by the court sitting as a whole (*en banc*).[93] Watson, an addict, was prosecuted in effect for the possession of narcotics, quite possibly for personal use, and upon conviction was given a mandatory 10-year prison sentence without the possibility of probation or parole. The appellate court panel, reviewing the sentence, recognized that, when dealing with narcotic addicts, stiff punishment might be required to reform offenders or to deter other addicts from pursuing the narcotic habit,[94] but considered those justifications for punishment to be dwarfed by considerations of proportionality. In adopting a "rough retributive lid" principle to serve as a ceiling on punishment, the panel stated:

> The only plausible justification for punishing such possession more severely is that, though less serious, it is harder to deter. But that rationale, while entitled to consideration, cannot support a penalty "out of all proportion to the offense" or to the culpability of the offender.[95]

Another significant proportionality decision is the Fourth Circuit case of *Hart* v. *Coiner*.[96] There, the court, on Eighth Amendment cruel and unusual punishment grounds, overturned a mandatory life sentence, imposed pursuant to a three-time habitual offender law, as applied to the petitioner, whose "priors" consisted of a perjury conviction, a conviction for drawing a check in the amount of $50 when his account contained insufficient funds, and a conviction for transporting forged checks in the amount of $140.

To the State's argument that the sentence was necessary—and therefore arguably not cruel and unusual—to deter others and to protect society from habitual criminals,[97] the court responded:

> Is it a rational exercise of state police power to put a man away for life—at tremendous expense to the state—because over a 20-year period he passed or transported three bad checks and might do it again? Life imprisonment is the penultimate punishment. Tradition, custom, and common sense reserve it for those violent persons who are dangerous to others. It is not a practical solution to petty crime in America.[98]

It is important to emphasize that the rejection of the State's argument indicates that the *Hart* court would condemn punitive excess even if it were demonstrated that the absence of a heavy penalty would lead to others in the community committing similar crimes, and even if habitual committers of such crimes could be identified with ease. The *Hart* court, in other words, would prefer a legal system where rather minor crimes are punished proportionately after the fact to a system which authorizes life imprisonment as preventive medicine against property crimes.

Another proportionality decision that is even more pertinent for our purposes concerned an explicitly *indeterminate* sentence (rather than a mandatory sentence for life or for a long number of years) that was given to a criminal sex offender of a type clinically indistinguishable from sexual psychopaths[99] who often find themselves under indeterminate commitment to security mental hospitals. The case in question is the 1972 California case of *In re Lynch*.[100] Lynch, upon his second conviction for indecent exposure, was given a wholly indeterminate sentence (which might therefore theoretically entail lifetime confinement). Invoking the proportionality language of *Weems*,[101] coupled with the California constitutional proscription against cruel and unusual punishments, the *Lynch* court found the indeterminate sentence imposed by the trial court to be without satisfactory legal support.

Like the courts which decided the two other recent cases discussed above, the *Lynch* court was unimpressed with State assertions that the interest of general deterrence and the need for sex offender isolation were sufficient to sustain the heavy penalty. Thus, the Attorney General's argument that the indeterminate sentence was necessary for deterrence was rejected—although perhaps only on the limited ground that compelling evidence of the validity of the premise was not presented.[102] Moreover, the State's assertion of a need for isolation did not carry the day even though the court recognized that, with respect to the sexual conduct at issue, the prospect for recidivism is very real. The prospect of recidivism in the context of indecent exposure, real as it may be, simply does not, in the words of the *Lynch* court, "justify the greatly enhanced punishment"[103] of indeterminate confinement.

Although *Watson*, *Hart*, and *Lynch* were decided in the context of the criminally *convicted*, their carryover to the category of special offenders who are criminally *committed* (and, by a somewhat different line of reasoning, to the category of the civilly committed) is rather compelling. If, for example, one accepts the *Lynch* principle that indeterminate confinement of at least certain convicted sex offenders

must be legally replaced by a rough retributive lid, and if one accepts the research findings that convicted sex offenders are clinically comparable to committed sexual psychopaths,[104] it is difficult to justify on due process and equal protection grounds—and surely on grounds of sound social policy—the propriety of wholly indeterminate confinement for the category of sexual psychopaths. *From a constitutional and public policy standpoint, it is therefore important to recognize that, if two sexually deviate groups are in fact virtually indistinguishable, the decision whether a sexual deviate will serve a determinate term as a convicted criminal or an indeterminate term as a committed patient must in actuality rest on prosecutive, psychiatric, or judicial whim. The constitutional and policy objection can be reduced, of course, if the emerging requirement of a ceiling on convicted sex offender confinement is carried over to the category of committed sexual psychopaths.*

Several of the legal and philosophical factors discussed above could also be marshaled to condemn the indeterminate confinement at the Patuxent Institution of so-called "defective delinquents." According to a recent Patuxent Institution progress report, the legislative intent in enacting an indeterminate sentence was based upon the following policies, to which the Institution faithfully subscribes: "The idea was coming to prevail that punishment meted out in proportion to the seriousness of the offense is not the only answer to the problem of crime, but that treatment of the offender and protection of society are also important and suggest an indeterminate sentence."[105] But in light of *Lynch* and related rulings, and in light of the views of commentators such as Norval Morris, "the idea is now coming to prevail" that proportionality is the essence of the maximum length of confinement. The treatment rationale offered by the Patuxent report is undercut by the disappointing outcomes of therapy and, even more importantly, by the emerging right of competent inmates to refuse treatment. The public protection rationale offered to justify confinement beyond limits set by retributive standards is undercut by documentation that future dangerousness is virtually beyond our current predictive capacities. And, although not offered by the Patuxent report, a justification based on considerations of general deterrence would be undercut by the point made earlier that confinement for deterrent purposes in excess of retributive limits is, to the extent of the excess, the equivalent of the concededly objectionable device of punishing the innocent for the utilitarian purpose of deterring possible criminal activity by others.[106] Consequently, if Patuxent's confinement period is to be brought into conformity with *presently* prevailing (or at least emerging) legal and philosophical notions of sentencing, incarcerative ceilings should be set which are proportional to the "last crime or bout of crimes for which the offender is being sentenced."[107]

The argument for constitutional limits on the length of confinement in therapeutic and noncriminal contexts was given a recent boost by important and much quoted language in the United States Supreme Court case of *Jackson* v. *Indiana*.[108] In the course of setting a constitutional clamp on the period that a defendant may be committed as incompetent to stand trial, the *Jackson* Court stated broadly that, "at the least, due process requires that the nature *and duration* of commitment bear some reasonable relation to the purpose for which the individual is committed."[109]

The *Jackson* due process durational limit language indicates that, even outside the criminal context, where retribution is inappropriate and where it may be sometimes inappropriate to use retributive lids as guides to setting ceilings on civil confinement,[110] incarcerative limits can and will be set, under a substantive due process rationale, according to the *purpose* of the commitment.[111] Invoking the pertinent language of *Jackson*, for example, a recent law review article has argued that, as part of constitutional due process, durational limits are required on civil commitments.[112] The article argues persuasively:

> Statutes which provide for indefinite confinement assume that following the initial commitment order, the state retains authority to detain the individual until its authority is challenged and shown no longer to exist. However, since the state's authority to confine an individual depends on his present status, the original commitment determination would seem to establish only that the individual is committable at the time of the hearing and for the period during which that status is unlikely to change. Upon the expiration of that period, the state should be required to release the patient or to demonstrate that further confinement is justified.[113]

The article suggests that for parens patriae patients, a 3-6 month commitment period would be appropriate,[114] and that for civilly committed patients confined under the police power, a longer period could be constitutionally justified, although not a wholly indeterminate one.[115] The distinction with respect to maximum durational limits between parens patriae and police power patients is a theoretically and practically important one. *Given the difference in the purpose of commitment between those two categories, it is important to recognize*

that different durational limits for those categories could be constitutionally supportable. If it is mistakenly assumed that *all* civilly committed patients must be treated with complete equivalence, even with respect to duration and release standards, legislatures might well refuse to reform commitment laws for the benefit of parens patriae patients because, they might improperly believe, any such duration and release standard benefits would also have to be applied to the very different and dangerous category of police power patients.

CHAPTER III

Specific Categories of Patients

A. "Special" Offenders

Many of the problems associated with such "special" offenders[115A] as sexual psychopaths and defective delinquents have already been discussed in the preceding portion dealing with general issues of concern. However, special attention should be given to the point that selection criteria for commitment under special offender statutes are typically (and perhaps inherently) vague and rely on assessments of future dangerousness. The hazards in—or virtual impossibility of—predicting dangerousness have been so well documented in recent careful studies that little need be said of the matter here other than to underscore their crucial findings.[116] *Equally important,* but less discussed in the literature, *is the matter of vague commitment criteria and the related matter of how such vague standards result in arbitrary decisionmaking by mental health professionals and commitment courts.*[117]

Often, a person accused of a crime and also considered mentally disturbed can be legally processed in a number of alternative ways,[118] and the choice of a particular alternative may depend on arbitrary and nonclinical criteria. The problem is particularly compounded if the conditions and terms of confinement vary considerably among the alternative avenues. In jurisdictions in which special offender laws are in operation, these arbitrary selection problems are especially evident.

The operation of Maryland's defective delinquency law is a case in point. The fluidity of the defective delinquency concept is reflected by the change over time in the types of offenders (property offenders versus violent offenders) referred by the courts to the Patuxent Institution for defective delinquency evaluations. As noted in a recent Patuxent progress report:

> The crimes resulting in referral to Patuxent Institution (to be referred to as "last crime"), have shifted emphasis from 41 percent for murder, robbery, assault, and rape (1955-1959), to 71 percent being convicted for murder, robbery, assault and rape (1970-1972). The proportion for whom the "last crime" was a

so-called property offense (burglary and larceny), has decreased from 59 percent in 1955–1959, to 29 percent during the time period 1970–1972.[119]

Startling evidence of arbitrariness in the administration of the since repealed Michigan sexual psychopath Goodrich Act is provided in a relatively recent article by Professor Grant Morris.[120] Morris quotes a report to the Michigan legislature by a Special Committee on Mental Health Legislation which had studied the discrepant treatment of sexual deviates at the Ionia security hospital and at the Jackson State Prison:

> [P]ersons committed to mental hospitals under this Act were for the most part minor or nuisance sex offenders, while sex criminals of the violent and dangerous variety were generally sent to prison.
>
> * * * * *
>
> Yet ironically, . . . the sex offender sent to Jackson was nearly twice as likely to be paroled, within any given number of years, as his counterpart who ended up in Ionia.
>
> Case histories of minor offenders subjected to incredibly long terms of confinement after being "Goodriched" into Ionia, although presenting no real danger to the public, could be cited but have already been repeatedly considered by former study committees and commissions.[121]

Legal Reform Options

Now that the most important problems facing "special" offenders have, in this section and earlier, been brought to the surface, it is appropriate to discuss possible legal reforms that might reduce or eliminate the major problems. *One legal avenue*, which would satisfactorily address the problem of indeterminacy, *would be to apply the criminal law maximum sentence even to offenders committed pursuant to special statutes for sexual psychopaths, defective delinquents, and other categories.* If such a lid were established, it is conceivable that courts would view the process of placing an offender in a special treatment program as constituting a mere "sentencing alternative," not requiring elaborate due process trappings.[122] On the other hand, it is at least equally conceivable that, despite the ceiling on confinement, courts might focus on the need for flushing out additional pertinent facts (regarding mental illness, receptivity of the subject to treatment, and the like) before "sentencing" an offender to a special treatment program, and might regard the special stigma of special confinement and the consequences of mistaken placement to

be matters of particular importance. If that is the judicial perception of the problem, the courts might require, on due process or equal protection grounds, a full-blown hearing, with procedural protections similar to a civil commitment hearing, before an offender could constitutionally be placed, even for a determinate period, in a special treatment program or facility.[123]

If a hearing is not required before a defendant is sentenced to a determinate term as a special sort of offender, the indeterminate sentence problem will of course disappear, but other problems—such as the arbitrariness of the selection system—will not. Indeed, even if a prior hearing is required constitutionally or is granted as a matter of legislative policy, the selection problems, although they may be somewhat reduced, will be far from eliminated. To the extent that involuntary selection will rely on clinical judgments, predictions of dangerousness, and perhaps inherently vague criteria of commitment, problems of arbitrariness will remain even though they may be concealed under a guise of procedural protections.

Another legal approach, which would be aimed at selection problems as well as at problems of indeterminate confinement, would be to abolish special offender commitments, as Michigan did when it recently repealed its sexual psychopath statute. If that is done, sexual deviates may still be civilly committed if they are given the procedural protections of a civil commitment hearing and if they meet the substantive criteria for civil commitment. Alternatively, they may be criminally convicted and sentenced to probation or to a determinate term of imprisonment. If the conviction-imprisonment route is followed, it will underscore the need for increased psychiatric and psychological services at correctional institutions.[124] Further, because greater numbers of persons with emotional problems will, under the conviction-confinement approach, find themselves in prison, more prisoners than at present are likely to require transfer from the prison to a psychiatric unit at the prison or to a mental hospital. Greater use would be made of transfer statutes, which are the subject of a later discussion in this monograph. Finally, because mentally disturbed persons—and sexual offenders and child molesters (known in the prison community as "baby rapists") in particular—are often brutally treated in a prison environment, it may at times be advisable, as the later discussion proposes, to allow, under certain circumstances, a mentally disturbed prisoner to transfer *voluntarily* to a mental facility even if the prisoner does not meet the standards for involuntary commitment and transfer.

A third alternative, which seems to overcome indeterminate sentence problems and most selection problems without totally abolishing special treatment programs, was recently submitted in draft form to the Minnesota Legislature and is based upon a sex offender report prepared by an interdisciplinary group of faculty members at the University of Minnesota.[125] Portions of the interesting and noteworthy legislative proposal, which deals exclusively with the sexual offender category of "special" offenders, are set out below:

> Section 1. [CREATION OF THE CENTER FOR RESEARCH ON SEXUAL OFFENDERS.] There is hereby created the center for research on sexual offenders for the purpose of investigating the nature of sexual offenses, studying the prevention, control and correction of antisocial sexual behavior, evaluating sex offender treatment programs operated or utilized by the state, and examining convicted sex offenders. The center shall conduct presentence examinations of convicted sex offenders and report the results of each examination to the court. The center shall also periodically examine each offender while he serves his sentence and report its conclusions to the Minnesota corrections authority to assist that agency in determining the individual offender's eligibility for parole, and shall periodically examine these offenders placed on probation or parole and report their conclusions to the department of corrections.
>
> . . .
>
> Subd. 3. [APPOINTMENT OF A DIRECTOR AND HIRING OF STAFF.] The board shall appoint a director, chosen on the basis of competence in either psychiatry, psychology, corrections or other related social science profession. The director shall hire staff competent in the areas of criminal law, psychiatry, psychology, social welfare, corrections and medicine and such clerical staff as are needed to fulfill the center's duties in accordance with this act. . . .
>
> Sec. 2. [CONVICTION OF A SEX OFFENSE; PRESENTENCE REPORT.] Subdivision 1. Any person convicted of a sex crime shall be committed for no longer than the maximum sentence time provided by law for that particular crime.
>
> Subd. 2. If a person who is 18 years of age or older at the time of his apprehension is convicted [of committing or attempting to commit a sex crime], the court shall commit him to the commissioner of corrections who shall cause him to be studied and examined by staff from the center for research on sexual offenders for a presentence social, physical, and mental examination. The court and all public officials shall make available to the center's staff conducting the examination, the commissioner, and the offender, all pertinent data in their possession in respect to the case.
>
> Subd. 3. If the court commits a person to the commissioner for securing an examination by the center's staff, the commissioner shall order the offender detained at a place he has designated for that purpose.
>
> Subd. 4. Upon completion of the examination, but not later than 60 days after the date of the commitment order, a report of the examination and the recommendations made by the center staff shall be sent to the commissioner and the court.
>
> The report shall include the examining staff's determination as to whether the offender is dangerous to the public, whether he should be placed on probation, and whether the offender will respond to treatment.
>
> Subd. 5. [DISPOSITION WHERE TREATMENT IS NOT RECOMMENDED.] If it appears from the report that the center's examining staff has determined that the offender would not at this time respond favorably to treatment and therefore that the offender should not at this time receive treatment, and that the offender should not be placed on probation, the court shall sentence the offender to imprisonment for a term no longer than the maximum provided for that crime by law.
>
> Any offender sentenced to imprisonment under this subdivision has the right to petition the commissioner for annual review of his case to determine whether he would at the time of review respond to treatment.
>
> Subd. 6. [DISPOSITION WHERE TREATMENT IS RECOMMENDED.] If it appears from the report that the center examining staff has recommended that the offender receive treatment and that the offender should not be placed on probation, the court shall allow the offender to choose either to agree to receive treatment in a secure treatment facility, or to refuse treatment and serve his sentence in a prison facility.
>
> An offender committed under this subdivision may petition the commissioner for transfer between the two types of facilities described in this subdivision, but in no case shall an offender be allowed more than two transfers at his own request.
>
> If the center examining staff has recommended that the offender be sentenced according to this subdivision, and the offender agrees to receive treatment, the offender shall be immediately transferred to a secure treatment facility to begin serving his sentence.
>
> If the center examining staff has determined that the offender is not dangerous to the public and should be sentenced to probation, the court shall place the offender on probation, subject to the condition that the offender participate in an outpatient

program approved by the commissioner. Successful participation in such an outpatient program is required for successful completion of probation.

If the offender is on probation, he shall be periodically examined by staff from the center which shall report its conclusions to the commissioner.

. . .

Sec. 3. Subd. 2. [PAROLE.] Any person under the commissioner's custody pursuant to this section may be paroled if it appears to the satisfaction of the Minnesota corrections authority that he is capable of making an acceptable adjustment in society. The center's examining staff shall examine each offender and shall make a written report to the corrections authority concerning the staff's conclusions with regard to parole eligibility.

Although there are several weaknesses in the Minnesota draft,[126] the statutory proposal presents several unique advantages. Indeterminate confinement problems are overcome by the requirement that the criminal law sentencing lid apply to both correctional and therapeutic confinement. Problems of arbitrary selection are largely overcome by giving the *offender* the option of therapeutic or penal placement.[127] The ability of the offender to request, on two occasions, transfer from one type of facility to the other insures him an opportunity to make a decision that is truly informed (based on personal experience of the conditions at the two institutions) and that takes into account his perception of his physical security at the respective facilities.

B. Defendants Found Incompetent to Stand Trial

Traditionally, security mental hospitals have been populated in large part by defendants found incompetent to stand trial (IST) or by defendants being evaluated to determine their competency to stand trial.[128] Until very recently, the typical situation involving IST defendants could have been portrayed as follows: defendants alleged to be IST would be automatically confined, often in a maximum security institution, for a rather lengthy (30-90 day) period of evaluation;[129] ultimately, a court hearing would be held, and those persons judicially found IST ("IST's") would be automatically committed to a security hospital for an indefinite period (until competent to stand trial),[130] perhaps to last a lifetime.[131]

Because of a highly significant Supreme Court decision and certain other developments, the IST legal confinement situation is now undergoing a radical alteration. Invoking equal protection and due

process considerations, the Court, in the 1972 case of *Jackson* v. *Indiana*,[132] ruled unconstitutional the *indefinite* confinement of IST's pursuant to procedures and substantive standards which fall below the standards employed for the civil commitment of the mentally ill. Accordingly, the mere filing of criminal charges and a determination that a defendant is incompetent to stand trial cannot authorize long-term hospitalization of IST's unless there has also been a civil commitment hearing, a showing of dangerousness, etc. The *Jackson* Court did, however, approve a *limited* commitment of persons holding IST status:

> We hold, consequently, that a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal.[133]

Jackson has considerable bearing on the question of the security status of persons who formerly fell within the IST category, for one likely result of *Jackson* is to shift and shuffle patients from the IST category—where secure confinement has typically been the case [134]—to the category of the civilly committed—where secure confinement is clearly the exception. Moreover, patients who have been declared IST, and who are thereafter released from IST status and converted to a civil commitment classification, are by no means necessarily dangerous enough to require secure confinement despite their civil label. Many IST's are charged with only minor or property offenses. Their incompetence to stand trial can result from a mental condition which does not pose a serious threat to others, such as psychotic depression, benign hallucinations, etc. Accordingly, if and when such persons are civilly committed, they may well need to be confined pursuant to the State's parens patriae power rather than pursuant to its protective police power.

In light of *Jackson*, then, it can be expected that *there will be fewer long-term IST patients, and fewer candidates for confinement in security institutions.* A related development which should curtail the population of security facilities is a growing awareness that IST

evaluations need not consume a lengthy period of time, and that most of them do not have to be conducted in secure facilities. *While IST evaluations have usually been conducted in secure institutions over a 30 to 90 day period, recent studies have concluded that fully 70 percent of those evaluations can adequately be conducted on an outpatient basis.*[135] It is true that *Jackson* is silent on this matter and requires simply that IST evaluations be conducted within a "reasonable" time.[136] But Professors Burt and Morris, cognizant of the fact that the rights to bail and to a speedy trial are at stake, are hopeful that *Jackson* will not be interpreted to sustain existing practice, especially since, "with a sufficient number of psychiatrists and psychologists, diagnosis could usually be performed in a few days and always in the defendant's home community." [137]

Moreover, when consideration is given to the right to bail, to the previously addressed concept of the least restrictive alternative, and to the fact that an IST adjudication need not involve a showing of dangerousness, it becomes evident that mandatory secure confinement of all defendants found IST is bad policy, bad psychology, and perhaps bad law. It does not seem justifiable to confine at a maximum security institution, even for a finite and limited period, "a defendant charged with car theft who, following an automobile accident shortly after the alleged theft, has developed a condition of amnesia sufficient to render him incompetent to stand trial." [138] The asserted justification for mandatorily confining such nondangerous IST's at maximum security facilities or on locked wards at regional hospitals is the prevention of escapes which might be motivated by pending criminal charges.[139] Yet, although the legal responsibility of mental health facilities to prevent such escapes is a matter of substantial ambiguity,[140] it seems preferable for the legal system to place fewer constraints on the operations of those institutions and to relieve them of a function which more properly rests with the judicial bailing authority. After all, if a court deems a defendant to be a sufficiently safe risk with respect to eventually appearing at trial and accordingly sets a reasonable bail or releases the defendant on his own recognizance (with or without attaching specific conditions to the release), such a defendant would, absent a mental condition affecting his ability to stand trial, be released to his home community. If, because of incapacity to stand trial, that same defendant is in need of psychiatric treatment, there seems little reason to require his confinement if outpatient psychiatric treatment would be clinically adequate or even preferable. Further, if effective treatment were to require his confinement, that alone does not seem to provide sufficient reason to regard him automatically as being also an escape risk in need of security status. More attention needs to be given, then, to transferring the supposed security problems relating to nondangerous IST's to the judicial authority which sets bail and which tailors and sets appropriate conditions of pretrial release. In addition, attention ought to be paid to the possibility of deterring or dealing with escapes by invoking or creating criminal penalties for escaping—or attempting to escape—from mental institutions.[141]

In sum, modern IST proposals, some antedating *Jackson* and some responsive to or fueled by that ruling, *suggest a substantial decrease in the number of IST patients at maximum security facilities. Many patients thought to be IST can and will be evaluated as outpatients or as patients in local facilities; those adjudicated IST will remain so for only a short while, after which they will be released or civilly committed (usually to civil facilities). During the brief period when the patients are technically IST, they may be treated as outpatients in a civil facility, or, if security is required, at secure units of civil facilities. There is little indication that placement at a separate secure institution is necessary or proper.*

It should be noted, however, that if there is a prohibition against bringing to criminal trial a person who is IST, and if a person who is IST can be treated on an outpatient basis in his home community, there are certain potential antitherapeutic implications which might flow from that incentive system. Because of the "contingency structure," a patient may receive "secondary gain" by staying in the IST role indefinitely. For, by *remaining* clinically IST while at large in the community, a patient may *indefinitely* postpone "pending" criminal proceedings without sacrificing liberty. Although it is not specifically addressed to overcoming the secondary gain advantages attached to outpatient IST status, the interesting Burt and Morris proposal to abolish the incompetency plea—and to criminally try defendants despite their incompetence [142]—would deal a crippling blow to any antitherapeutic aspects of the above-described incentive structure.

Burt and Morris have also expressed concern that because of the durational limit placed by *Jackson* on IST commitments, States will be reluctant to release IST patients after the expiration of the limit. States may instead be tempted, at the expiration of the IST commitment period, to shoehorn former IST's into the civil commitment process.[143] Further, while *Jackson* requires that incompetency commitments be limited in duration, it does not specifically mandate that pending criminal charges be dismissed when the incompetency com-

mitment period terminates.[144] Accordingly, if former IST's are civilly committed, the civil commitments can be accompanied by criminal detainers or hold orders. That would lead to a situation which often entails confinement under onerous security conditions similar to the conditions of confinement under which IST's have often been held.[145]

Burt and Morris fear, therefore, that the pre-*Jackson* situation of indefinite, long-term security confinement of IST's may in practice remain relatively unaffected by the *Jackson* ruling. They are particularly concerned that State officials, State courts, and State legislatures will be so intent on confining IST's beyond the *Jackson* durational limit that States will be reluctant to introduce needed reforms in their civil commitment statutes that could also make the continued confinement of one-time IST's more difficult. As Burt and Morris put it, "States may well be drawn to greater abuse of the mad in order to be sure of ensnaring the bad." [146] Their full explanation is well stated:

> If state officials cannot bring to trial an incompetent person whom they believe to be a criminal, and cannot hold him simply because he is incompetent, it is far from unlikely that the civil commitment statute will be stretched to fit his case.
>
> Most civil commitment statutes lend themselves readily to this purpose: substantive standards are vague; fact-finding processes are haphazard; and no effective time limits on commitment are assured. While reform efforts have had useful impact in some states, *Jackson* invites the states to preserve the worst elements of their civil commitment laws in order to confine the "criminally insane" who, under the *Baxstrom-Jackson* principle, can no longer be indefinitely confined as incompetent.[147]

Abolition?

The solution proposed by Burt and Morris, a solution blocked only by rather easily discardable dictum in *Pate* v. *Robinson*[148] to the effect that "the conviction of an accused person while he is legally incompetent violates due process,"[149] is to abolish the incompetency plea per se. In its place, they would substitute a trial continuance not to exceed 6 months, during which time the State must commit resources to help the accused attain competence. If competence is not attained within the 6-month period, the State must either dismiss criminal charges or, if appropriate, bring the accused to trial with increased defense discovery rights and a heightened prosecutive burden of proof, protections that will compensate in part for the accused's continued incompetence. The authors have embodied their proposal in a useful set of proposed rules of court:

PROPOSED RULES OF COURT GOVERNING TRIAL CONTINUANCES FOR MENTAL DISABILITY

(1) A motion for trial continuance may be filed by the defendant or by the prosecuting attorney alleging that the defendant's competency to stand trial is impaired by mental disability; that is, that the defendant lacks sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and/or that he lacks sufficient understanding of the proceedings against him.

(2) Upon the filing of such a motion, or upon the court's independent determination that there is a question regarding the defendant's competency to stand trial, the court shall conduct a hearing. If, at the hearing, the court determines that there is sufficient reason to believe that further examination of the defendant by licensed psychiatrists is necessary to determine the defendant's trial competency and his prognosis for greater competency, the court may adjourn the hearing for this purpose for a period of no more than three weeks.

(3) The court shall determine, at the hearing if adjournment is unnecessary, or at a subsequent hearing no more than three weeks after the initial hearing if adjournment was necessary, (a) whether the defendant is incompetent to stand trial because of mental disability and, if so, (b) whether there is substantial probability that the defendant will become competent to stand trial within six months. If the court finds that psychotherapy[149A] is required to remedy the defendant's disability, the court shall determine whether an adequate individual plan for the defendant's treatment has been prepared. An adequate plan will specify the program and facilities available for treatment of the defendant and the prior treatment experiences with comparably disabled persons upon which is based the claim of a substantial probability that the defendant will become competent to stand trial within six months.

(4) If the court makes affirmative determinations under sections (3) (a) and (3) (b), the court shall grant a trial continuance of no more than three months. If the defendant requires psychotherapy to remedy his disability but is unable to afford such treatment from his own resources, the court shall order that the state provide psychotherapy services to the defendant on an out-patient basis unless it is clearly necessary that treatment be provided on an in-patient basis to make him competent. If in-patient treatment is clearly necessary, the court may order the defendant confined for psychotherapy in an appropriate state facility.

(5) No more than three months following the grant of the trial continuance authorized by section (4), the court shall conduct a hearing to determine (a) whether the defendant remains incompetent to stand trial because of mental disability and, if so, (b) whether, on the basis of the defendant's progress toward remedying his disability, there is a substantial probability that the defendant will become competent to stand trial within three months. If the court makes affirmative determinations under subsections (a) and (b) of this section, the court may grant a further trial continuance for no more than three months. The court may order, or continue its previous order, that the defendant be confined for psychotherapy in an appropriate state facility as provided in section (4).

(6) A motion for trial continuance shall not be granted solely because tranquilizing drugs or other medications have been or are being administered to the defendant under medical direction, unless the court finds that there is substantial probability that the defendant will not require the drugs or medication to be competent for trial within the appropriate time limit prescribed by section (3) or (5).

(7) If, under the procedures set out in sections (3) or (5), the court determines that a defendant is incompetent to stand trial because of mental disability but that there is no substantial probability that such incompetency will be remedied within the appropriate time limit, or that such incompetency has not been remedied within the time prescribed by section (5), the court shall grant no trial continuance on the ground of the defendant's incompetence. If the prosecuting attorney indicates an intention to bring the defendant to trial, the court shall determine at a pretrial hearing whether fundamental fairness to the defendant requires that special trial or pretrial procedures be used in order to redress his disabilities. The court may prescribe any or all of the special pretrial and trial procedures set out below, or such other procedures as it deems necessary:

(a) Prior to trial, the court shall review all the evidence that the prosecution intends to offer at trial and shall order pretrial disclosure of evidence that would materially assist the defendant in overcoming the disabilities under which he labors. Disclosure of evidence that may endanger the lives of witnesses, or in any way promote substantial injustice, shall not be ordered.

(b) On motion for directed verdict, either before or after jury deliberation, the court shall demand from the prosecution a higher burden of proof than would obtain in an ordinary criminal prosecution, and the court shall insist on extensive corroboration of the prosecution's case with respect to issues on which the defendant is likely to be prevented by his disability from effective rebuttal.

(c) If the trial is before a jury, the court shall instruct the jury that in weighing the evidence against the defendant, it should take into account, in the defendant's favor, the disabilities under which he went to trial. If trial is before the judge sitting alone, he shall take account of those disabilities.

(8) Any conviction shall be set aside if evidence that was not available for trial because of the defendant's incompetence subsequently becomes available and might have led at trial to a reasonable doubt regarding the defendant's guilt.[150]

In terms of the need for security mental health facilities, it should be evident that patients who in the past have largely contributed to the population of secure institutions would, under the Burt and Morris proposal, be funneled into the correctional system. Implementation of their proposal, therefore, would require less emphasis on the construction of secure institutions and more emphasis on extending psychiatric and psychological services to the correctional community.

The Burt and Morris proposal is an important and interesting one, deserving of serious consideration. It should be realized, however, that their fears regarding impediments to needed reforms of civil commitment statutes touch on only part of the problem and deal with only one of the impediments. They recognize that needed civil commitment law reforms are unlikely to be realized unless and until certain IST patients can somehow be funneled into some other type of relatively long-term confinement. What they do not specifically address, however, is the extent to which the current civil commitment system *itself*—with its propensity for treating identically parens patriae and police power patients—is a major obstacle to commitment law reform. If it is believed that commitment law revision must take the form of providing *equivalent* treatment for these two disparate categories of patients, the "states may well be drawn to greater abuse of the mad [parens patriae patients] in order to be sure of ensnaring the bad [police power patients]."[151]

Establishing short durational limits on commitment, and vesting the power to release committed patients before that time in the unilateral hands of the hospital, may be wise and important goals for parens patriae commitment law reform. But if legislatures are under the impression that such reforms must *also* accrue to the benefit of police power patients, it is unlikely that those reforms would make their way into the statute books. As was indicated earlier in the discussion on indeterminate confinement, however, differences in durational confinement limits for parens patriae and police power patients *can* probably be established in a constitutionally inoffensive

manner. And as a later section notes, some differences between the two patient categories can probably be established with respect to the extent of scrutiny attached to a hospital decision to release a patient prior to the expiration of the durational limit. It may also be permissible to draw distinctions between the two patient categories with regard to living quarters, e.g., less restrictive conditions for parens patriae patients as opposed to more secure confinement (such as in the security unit of a civil hospital) for police power patients.[152]

C. Civilly Committed Patients With Criminal Detainers

A seldom discussed category of so-called security patients is the group of civil patients against whom there are filed criminal detainers (hold orders). A detainer is simply a notification by law enforcement authorities to an institution that criminal charges are pending against a particular patient or inmate, coupled with a request that the institution notify the appropriate law enforcement authority shortly before the person is to be released. Law enforcement agents can then take custody of the person for purposes of criminal prosecution.[153] The detainer problem is a considerable one in prisons, where perhaps 30 percent of the population is under detainer,[154] but it also exists to some extent in mental hospital settings.

Whether in a correctional or a mental health context, there is a tendency to view persons against whom detainers have been filed as exceptional escape risks. Such persons accordingly tend to be viewed as candidates for mandatory maximum security classification.[155] Furthermore, rehabilitative or therapeutic efforts are often frustrated by the existence of detainers. Persons subject to detainers are often unwilling or unable to engage in self-improvement efforts when their futures are so much in doubt.

There is good reason for substantial concern for undue hardships that can be caused by the detainer system in view of the fact that:

> the filing of a detainer by a law enforcement agency by no means reflects a considered professional judgment that prosecution is warranted. Often, detainers are filed routinely, and the actual exercise of prosecutive discretion is deferred until the prosecutor is notified by the incarcerating institution of the inmate's impending release. And sometimes detainers are seemingly filed solely for their nuisance or harassment value. In any case, of all the detainers filed, . . . "it is estimated that less than half . . . are exercised or even filed with any intention of being exercised." Finally, those detainers which are eventually exercised often raise serious speedy trial questions.[156]

> *Especially because of the infrequency with which detainers are exercised, civil patients with detainers should not be sent automatically to security institutions. Security should be individualized according to an assessment of the history and clinical condition of the particular patient, the severity of the outstanding charge, the existence in the jurisdiction of effective criminal escape statutes, and, if it can be ascertained, the likelihood of the outstanding criminal charge eventually being pressed. Even where security is warranted, it can generally be attained by confining such patients in closed civil wards or, in extreme instances, in a security unit of a civil hospital.*

Simply because a civilly committed patient is under detainer does not justify a conclusion that the patient is incompetent to stand trial.[157] And since the Supreme Court, in *Smith* v. *Hooey*,[158] has held that a person does not forfeit his Sixth Amendment right to a speedy trial simply because he is confined with a pending detainer, legal or paralegal assistance should be provided to enable patients under detainer to invoke their Sixth Amendment rights and remedies. If a speedy trial is held and the patient is convicted, the uncertain state of his future will at least be resolved. But it is also possible that a patient's demand for a speedy trial may prompt the prosecuting authorities to dismiss the criminal charges, or the demand may result in a trial that ends in an acquittal. If either of the last two outcomes are forthcoming, the patient will no longer be viewed as an exceptional escape risk and may then be treated as an ordinary civil patient.[159]

Legal or paralegal assistance should likewise be provided to civil patients with criminal detainers who were previously committed as IST's and who subsequently, after failure to regain competency, were civilly committed with the original criminal charges still outstanding. *Jackson*, it will be recalled, ruled that IST commitments could last for only a reasonable period, but the case did not specifically address the question whether criminal charges could remain outstanding indefinitely at the expiration of the IST commitment. Consequently, certain patients who in the past were confined for long periods as IST may, after *Jackson*, fall within the category of civilly committed patients with criminal detainers. Even if the Sixth Amendment speedy trial guarantees do not apply to such civilly committed patients while they remain clinically incompetent to stand trial, legal assistance for such patients would be helpful in assuring that the issue of their competency is continually scrutinized. Such legal assistance could also take the form of negotiating with prosecuting authorities for dismissal of the charges. In addition, it should be

noted that the *Jackson* Court did at least recognize the *possibility* that constitutional questions could arise with respect to the indefinite continuation of criminal charges after the expiration of the IST commitment period. Constitutional infirmities might be present, the Court suggested, on grounds of the Sixth-Fourteenth Amendment speedy trial guarantee or on the "denial of due process inherent in holding pending criminal charges indefinitely over the head of one who will never have a chance to prove his innocence." [160] Thus, even for civilly committed detainer patients who are clinically incompetent to stand trial, legal resources could be helpful and could lead to extinguishing whatever legal basis exists for treating those patients as escape-prone security risks.

Finally, whether a civilly committed detainer patient is competent to stand trial or not, it is crucial to note that, especially because detainers are filed without much consideration, a prosecutor can often be persuaded to dismiss a detainer, particularly if the outstanding charge is not serious and if a compelling case can be made, as it often can be, that the existence of the detainer is antitherapeutic. Therapists and social workers could substantiate such contentions in appropriate instances and, acting on their own or preferably with legal assistance, could request the appropriate authorities to dismiss the detainers and charges. If institutions are properly equipped to deal with detainers, and approach the problem from the proper perspective, many of the custodial and countertherapeutic aspects of the detainer system can be overcome.

D. Defendants Found Not Guilty by Reason of Insanity

Traditionally, persons who have been found not guilty by reason of insanity (NGRI) have been subsequently committed to institutions. Typically, however, NGRI patients have been rather few in number, a fact explained by the relative rarity of cases in which the insanity defense has even been raised, let alone raised successfully. Traditionally, there have been strong legal disincentives to the assertion of the insanity defense. Until rather recently, the "successful" invocation of the insanity defense would often lead to *automatic* and *indefinite* confinement in a secure mental institution. Under such legal contingencies, the practice of criminal defense lawyers was to recommend raising the defense only to clients charged with the most serious offenses, such as those carrying a possible penalty of capital punishment or lifelong confinement.

Recent years have witnessed a diminishing of legal disincentives to assertion of the insanity defense. With the realization that an NGRI verdict simply establishes a *reasonable doubt* about sanity at the time of the crime, or at the most a proof of insanity at that *prior time*, courts have, on due process and equal protection grounds, begun to find unconstitutional those statutes which authorize *automatic commitment* of persons found NGRI.[161] Since commitment should be premised on a finding of *present* mental illness and dangerousness, these courts have asserted that due process requires a post-NGRI verdict hearing relating to present mental status, and that equal protection requires that the hearing conform roughly to procedural and substantive standards set by law for civilly committed patients.[162] Further, with the emergence of statutory and constitutional limits on lengths of commitment, defendants who raise the insanity defense are becoming less concerned with the possibility of *indefinite* hospital confinement.[163] Accordingly, it is likely that the NGRI defense will be raised more often in the future, and that there will be an increase in the number of "NGRI commitments"—a matter of considerable significance for the present study. *It is also important to recognize that, as disincentives to the invoking of the NGRI defense decrease, and as more defendants invoke it, persons committed after an NGRI verdict may no longer fall almost exclusively within a class of persons charged with the most serious of criminal offenses.* The need for *secure* confinement for all persons committed following NGRI verdicts, may, therefore, be open to serious question.

Insanity Defense Issues

In the past when the insanity defense was rarely raised, it drew much academic attention (perhaps over-attention) but was not of great practical concern. Now that it appears likely that the defense will be increasingly asserted, however, questions regarding its scope, and even its abolition,[164] have gained in importance. One of the strong arguments in favor of abolition of the defense (and presumably applicable also to the narrowing or nonexpansion of the scope of the defense) is premised on the notion that "it is therapeutically desirable to treat behavioral deviants as responsible for their conduct rather than as involuntary victims playing a sick role." [165]

In a provocative recent article, however, John Monahan argued that there is little evidence one way or other to suggest whether society in general (composed principally of average, nondeviant citizens) "needs" the insanity defense: [166]

> While there is no empirical evidence to support this presumption, neither is there any to refute it.
>
> . . .

> The defenders of the insanity defense assume that its invocation affects the attitudes of the populace through the psychological process of contrast. Citizens are exposed to the bizarre behavior of those labeled irresponsible through the ascription of insanity, and contrast their own "normal" behavior with that of the defendant. They reason: "He is irresponsible. I am not like him. Therefore, I must be responsible."
>
> It can also be argued, however, that the psychological process evoked by the insanity defense is more likely to be assimilation. If individuals frequently hear that some people are not being held responsible for their behavior, they may begin to wonder, "Maybe sometimes I, too, am not responsible for my behavior."
>
> . . .
>
> The insanity defense, however, affects the citizen's perception of responsibility in an unknown direction, if it affects that perception at all. The argument that the citizen needs the insanity defense is, therefore, weak.[167]

Even accepting all of Monahan's well-presented arguments, there is no compelling reason to accept his conclusion. That is, even though there is no evidence to suggest whether the *average* citizen would be better or worse off with the existence of an insanity defense, there is a plausible argument that persons *labeled nonresponsible* by virtue of the defense (or at least by an expansive defense) may be in a *worse* position by virtue of the attribution of that label than they would be if they had been labeled *responsible*. Those labeled nonresponsible might come to perceive themselves as lacking in self-control, which may in turn induce an *increase* in their antisocial behavior. If that is so, society in general, which is obviously interested in keeping lawbreaking behavior at a minimum, *may* be advantaged by the elimination or at least nonexpansive treatment of the defense.

Elsewhere, the significance of the label-attribution problem has been explained as follows:

> Of particular pertinence to the impact of labeling under the therapeutic [or nonresponsible] model is that the therapeutic premise attributes deviancy to causes other than individual responsibility. Consequently, it is not uncommon for deviants, borrowing from the language of psychiatry and related disciplines, to develop a "vocabulary of motives" for lawless behavior that includes a denial of personal responsibility and an attribution of their aberrant behavior to causes beyond their control. More important, perhaps, is the fact that the denial of personal responsibility is accompanied by a self-concept that accepts a lack of self-control, and the altered self-image can in turn lead to *increased deviance.*
>
> Rotter has performed some interesting research on behavioral correlates of "perceptions of causality." He has developed a scheme for classifying individuals as believing in "internal" control or in "external" control. In short, internals believe they control their own destinies, whereas externals attribute causation to outside forces. . . . Most significant, in connection with the emerging therapeutic model, is Rotter's finding that internals really *are* more effective than are externals in altering their environments and in controlling themselves. For instance, "internal inmates in a reformatory learned more than external inmates did about the reformatory rules, parole laws, and the long-range economic facts that would help one get along in the outside world." A related finding—with possible significance for the field of addiction—is that, after the release of the Surgeon General's report regarding the hazards of tobacco, internals were apparently better able than were externals to give up smoking.
>
> . . .
>
> What all of this suggests for present purposes is that even if individual responsibility is an illusion, it may be dysfunctional for us to "cease to regard people as agents of dignity and responsibility who are capable of being blameworthy for what they do." [168]

Monahan, drawing on a vast body of psychological literature, comes to a very similar conclusion:

> The convergence of conclusions drawn from research on theories of locus of control, cognitive dissonance, attribution, achievement motivation, personal causation, reactance, and perceived control among others, strongly suggests that the individual who perceives himself as free and responsible behaves very differently than the individual who believes that he lacks choice and responsibility. In general, the direction of this difference is toward a higher level of awareness, initiative, achievement, independence and complexity for those who perceive themselves as freely choosing to behave in certain ways and as responsible for their behavior. The quality of life associated with these attributes is not lightly tampered with or casually disparaged.[169]

There is no evidence regarding the impact of the insanity defense on average (nondeviant) citizens, but there is a powerful argument that persons successfully invoking the defense may come to regard themselves (and behave) as lacking in control. Contrary to Monahan, this is reason enough for average citizens and for society to consider

abolition of or contraction of the defense. *If legislatures pursue that course, many persons who are now committed as NGRI will find themselves in a prison setting.*[170] Although that group has not been large, *the placement of those persons in correctional institutions will again highlight the need for upgrading psychological services in prisons.* Moreover, the offer of psychological services to those and other prisoners need not inherently contradict the emphasis on "internality" and personal responsibility rather than on "externality" and passive sick-role status. For instance, "reality therapy"—which focuses on *what* the offender has done rather than *why* he has done it—and a "problems of living" approach to personal difficulties, are rather far removed from the "medical model" approach which is often thought to induce sick-role self-concepts.[171]

The foregoing discussion, however, is premised on the notion that modern legislatures will seek to abolish or constrict the insanity defense. For a variety of reasons, however, legislatures may choose not to follow that course of action. If they do not, and if—as is expected—assertions and successful assertions of the insanity defense begin to rise considerably, more attention will have to be paid to procedures relating to the commitment and release of NGRI acquittees.

Release Structures

Typically, State procedures relating to NGRI's have been different from civil commitment procedures. Usually, NGRI acquittees have had an easier route into and a more difficult route out of institutions than have their civilly committed counterparts. As earlier indicated, NGRI acquittees have often been *automatically* committed, without a separate civil commitment type hearing relating to present mental condition and dangerousness. Furthermore, NGRI release procedures have often been extremely cumbersome. In Arizona, for example, where civilly committed patients have always been releasable by unilateral action of the Superintendent of the State mental hospital, a now defunct 1968 law formerly provided that an NGRI could not be released simply at the discretion of the hospital director, but only after two psychiatrists had certified the patient to be no longer dangerous, and only after a *jury*, presumably drawn from the county where the crime occurred, found, with the patient bearing the burden of persuasion, that release was warranted.[172] Compared to civilly committed patients, NGRI's had to bear a tremendously heavy release burden, and "the potential for meting out community vengeance by an unforgiving jury"[173] was apparent. For example, in one Arizona case reported in a field study,

> the patient, charged with assault with a deadly weapon, had originally been found NGRI on October 9, 1969 and was committed to the Arizona State Hospital. On July 30, 1970, two psychiatrists filed certificates to the effect that the patient was no longer a danger to herself or others. The release trial occurred on December 7-9, 1970, but the patient failed to meet her burden of proof, and the jury hung six-six. Thus, despite being hospitalized for fourteen months, being certified as recovered by two staff psychiatrists, and obtaining the favorable votes of half the jurors, she was retained at the hospital.[174]

Disparities such as these in procedural treatment between NGRI's and civilly committed patients have recently led courts to hold, principally as a matter of equal protection, that NGRI's are entitled to admission and release procedures that are *closely comparable* (though not necessarily identical) to admission and release procedures for the civilly committed.[175] State legislatures have responded by according to NGRI's procedures that are comparable to or identical with civil commitment procedures. Thus, spurred on by cases such as *Bolton* v. *Harris*,[176] many jurisdictions are doing away with automatic commitment of NGRI's and are instead funneling those persons through the ordinary civil commitment process. Similarly, many jurisdictions, now including Arizona, currently release NGRI's according to the same release procedures that apply to civilly committed patients—and typically at the unilateral discretionary action of the hospital director.

There may be, however, an adverse latent consequence of releasing NGRI's according to procedures *identical* to civil commitment release procedures. According to hospital officials and staff interviewed by this writer in Arizona, where previously existing disparate release procedures have been replaced by completely equivalent procedures, the State hospital is fearful that adverse publicity and public reaction may ensue if an NGRI patient is released "too soon" or, worse yet, if a released NGRI patient soon commits another violent act. The hospital is thus reluctant to release, *completely on its own say-so*, NGRI's whom hospital staff view as clinically capable of adequately adjusting to the community following discharge. Although the matter is one for empirical investigation, it is possible that, because of the reluctance stemming from sole responsibility for release decisions, the average length of time that NGRI's are now held prior to release in Arizona may actually *exceed* the average period of time that, under prior law, comparable NGRI's were held before being "certified" by the hospital as ready for referral to a jury charged with making the ultimate release decision. The new procedure, therefore, may not have eliminated the nonclinical, extra-legal, and probably unconstitutional[177] factors that were potentially operative in the jury-release

structure. Instead, these sorts of factors may again be operative (albeit less visibly than before) in the new decisionmaking structure of unilateral hospital discharge.

Despite the awareness that such release-inhibiting factors can and do operate, it is difficult to structure a legal system that will remove or lessen their impact. *The establishment of durational limits on commitment will of course help, for those limits will at least insure that unwarranted delays in release will not continue indefinitely.* A durational limit, however, will only lessen the problem, not solve it, since establishment of such a limit will not address the question of unwarranted confinement of a patient who deserves release *before* the expiration of the period of commitment.

Further remedial action is accordingly in order. To the extent that hospitals or therapists might delay or prevent release of particular patients on nonclinical grounds, because of fears of financial liability that might be incurred should such released patients commit violent acts in the community, *statutes could—and should—be enacted immunizing institutions and therapeutic staff from liability for release decisions made in the good faith exercise of professional discretion.*[178]

The attendant problems and fears, however, run deeper than the question of legal liability. Seemingly, the main concern is with taking full responsibility (in a nonlegal sense) for making difficult decisions about future dangerousness in an area where accurate predictive tools are absent and where, when an "incorrect" decision is made, adverse public and press reaction can be very severe. *Psychological studies suggest that if a legal decisionmaking structure could be designed in which NGRI release responsibility is shared or diffused, the decision to release might be made with fewer inhibitions.*[179]

Ordinarily, strong policy objections exist with respect to taking advantage of the psychological consequences of diffusing responsibility, for under certain circumstances diffusion can rather easily lead to the relatively uninhibited making of *culpable* decisions.[180] But diffusion can more readily be justified where the decisions to be made are difficult, and where diffusion is needed to weaken or eliminate the contaminating, and even paralyzing, impacts of nonclinical, extra-legal, and unconstitutional factors.

If a legitimate case for diffusion can be made with respect to hospital release decisions concerning NGRI patients, the next concern would be the type of body that should be designated to share release decisionmaking authority and responsibility with the hospital. A release jury system, such as was operative until recently in Arizona,[181] would relieve hospital staff of unwarranted inhibitions but

would itself be subject, far more patently than the hospital staff, to similar inhibitions. A court, however, might be an acceptable authority-sharing institution, since courts hopefully will be less influenced than juries by community vindictiveness and other extra-legal concerns. If hospitals were required to secure judicial approval prior to releasing NGRI patients, the hospitals would presumably refer to the courts without inhibition those patients deemed by the hospital to be clinically ready for release.[182] In most instances, the courts could be expected to read and rely upon the hospital psychiatric reports and to approve the hospital release decision without holding a full-blown hearing. In selected instances of troublesome cases, the courts might hold hearings and either accept or disapprove the hospital's release recommendation. In any event, the sharing of release responsibility might well have the effect of lessening improper inhibitions. The hospital will know that a court will scrutinize its release recommendation and will serve as an additional safety valve in the release process. The court, on the other hand, will know that the hospital's release recommendation is based upon the evaluative judgment of therapeutic professionals who have had a considerable amount of time in which to observe a patient proposed for release.

If court approval, rather than purely unilateral hospital action, is regarded as appropriate with respect to NGRI patients, the question remains whether the principle of equal protection would authorize a release procedure for NGRI's that differs from the procedure employed for other civilly committed patients. If equal protection were offended by the distinction, it might be necessary to require court approval for the release of *all* committed patients. Such a course would avoid unequal treatment of the NGRI group, but perhaps at the cost of creating a release mechanism more cumbersome than is really desirable. It is unlikely, however, that equal protection would be read to require the *identical* procedural handling of NGRI and other patients. Equal protection may require close comparability of procedural treatment, but it ought not to be read to require complete equivalency. Thus, even *Bolton* v. *Harris*,[183] the liberal District of Columbia Circuit decision which has spoken most forcefully about according NGRI patients procedural rights that compare closely to civilly committed patients, requires only "reasonable" rather than "rigid" application of the equal protection clause.[184] *Bolton* recognized that some differences in procedural treatment between NGRI's and civil patients could be warranted. And the propriety of court-approved release can, according to *Bolton*, be one of those warranted distinctions:

> We uphold the release provisions of §24-301(e) even though they differ from civil commitment procedures by authorizing court review of the hospital's decision to release a patient. We do not think equal protection is offended by allowing the Government or the court the opportunity to insure that the standards for the release of civilly committed patients are faithfully applied to Subsection (d) [NGRI] patients.[185]

A system of court-approved release may thus be advantageous both to NGRI patients (by reducing a hospital's nonclinical inhibitions regarding release) and to society (by insuring that release standards have been "faithfully applied" to patients who escaped criminal conviction only by the successful operation of the insanity defense). If the system is advantageous both to society and to patients with a history of dangerous behavior, however, it seems curious that it should be employed only with NGRI's and with no other patient categories. It would seem that the crucial distinction, for release-structure purposes, ought not to be between NGRI patients and all others, but ought instead to be between *dangerous* and *nondangerous* patient categories or, in more technical legal language, between police power patients and parens patriae patients. Serious legislative consideration should be given, in other words, to permitting unilateral hospital release of parens patriae patients, but to requiring (for the sake of society and the affected patients) court approval of hospital release recommendations before discharging patients committed pursuant to the State's police power.

E. Prison-to-Hospital Transferees

As earlier indicated, psychiatric and psychological services generally have been next to nonexistent in prison settings. The deficiency will become even more acute if, as seems possible, certain additional categories of patients are funneled into correctional settings—as they would be if "special" offender categories were abolished, if the insanity defense were eliminated, or if the Burt and Morris proposal regarding persons found incompetent to stand trial were accepted. The presence in prison of even greater numbers of behaviorally and emotionally disturbed offenders will highlight the need for increased therapeutic services in correctional institutions[186] and the need for workable systems of transferring mentally ill prisoners to mental institutions.

The need of certain prisoners for treatment, a need which may soon be recognized as a legal or constitutional right[187] analogous to the right to treatment guaranteed mental patients, can be fulfilled by various avenues. *One of the most promising methods is the establishment of "minimum mental health standards" for the correctional system, including personnel requirements and appropriate ratios of prisoners to professional and paraprofessional staff.*[188] But even if correctional institutions were to adopt and adhere to minimum mental health standards, there will be a number of instances where, for psychiatric reasons, it would be more appropriate for a mentally ill offender to be removed from the general prison population and to be housed instead in a mental hospital or perhaps a psychiatric unit of a penal institution. The removal issue, however, involves a number of serious constitutional considerations.

Involuntary Removal Procedures

Removal can occur in a variety of legal and factual contexts. A prisoner may be involuntarily committed to a mental hospital, may be involuntarily transferred to a mental hospital for a period not to exceed the criminal sentence, may be involuntarily transferred during his term to a prison psychiatric unit, or may be voluntarily transferred to a mental hospital or to a prison psychiatric unit. Depending upon the form of removal action, differing constitutional concerns may be triggered.

In the past, prison and hospital officials sought to justify removals as simply "administrative placement" decisions, hoping thereby to exempt the procedures from constitutional scrutiny by the judiciary. But the courts, recognizing that removals were often far different from ordinary classification and placement decisions, have easily rejected those assertions. It is now quite clear that the involuntary *commitment* of a prisoner to a mental hospital, perhaps for an indefinite or lifelong stay, is a procedure warranting constitutional safeguards. The courts, invoking equal protection principles, have accordingly required that such prisoner commitment proceedings conform generally to proceedings used for the civil commitment of the (nonprisoner) mentally ill.[189]

The courts have also held that the involuntary *transfer* of a prisoner to a mental hospital must conform to civil commitment safeguards if, because of such factors as parole board policies against releasing prisoner patients or the unavailability of good time allowances to prisoners in mental hospitals, mental patient status is likely to lead to a longer period of confinement than would be the case if the prisoner remained in a correctional institution.[190] Even if parole board and good time practices were such that a prisoner would

not be prejudiced time-wise by an involuntary transfer to a mental hospital, there is a substantial argument that, because of the additional stigma attached to mental hospitalization, the different conditions of confinement entailed in hospitalization, and the drastic consequences of mistaken transfer, the transfer should not be viewed as simply an administrative placement, and the civil commitment safeguards should once again be constitutionally required.[191]

A similar development seems possible in the case of involuntary transfer to a psychiatric unit located in a prison setting. Because of the major change in the conditions of confinement that would result, along with the possibility of stigma and the adverse consequences of mistake, it is possible that the due process clause will be read to require some sort of hearing before such an involuntary transfer can occur.[192]

Voluntary Transfers

Voluntary transfers to mental hospitals or prison psychiatric units do not, of course, require the procedural trappings mandated for involuntary commitment or transfer. Nonetheless, the voluntary transfer area is often riddled with problems and is in considerable need of reform. In many (though not all) jurisdictions, for example, voluntary hospital admission, even with the approval of both the prison and the hospital, is simply not a legally available option insofar as prison inmates are concerned: Involuntary commitment is the only permissible route.[193] That in itself constitutes a legal disincentive to seeking transfer, for if transfer can be effectuated only through commitment, a prisoner who seeks commitment will, at least in the bulk of jurisdictions which do not yet have durational limits on the length of civil confinement, be exchanging his definite sentence expiration date for an indefinite therapeutic release date.[194] Add to that the confusing situation regarding good time allotments in mental hospitals, parole board policies disfavoring conditional release of prisoner-patients, and policies in some States mandating maximum security confinement of transferred prisoners (even of those who have served in prison as responsible outside trusties), and virtually all incentive for an emotionally disturbed offender to seek treatment is undercut by the contingencies of the legal system.[195]

All of those adverse legal contingencies deserve reconsideration. *Surely, there should be no problem regarding the authorization of voluntary admission for prison inmates, as long as the proposed admission is screened by prison and hospital officials to insure that the applicant is not simply seeking to avoid a term of penal incarceration.*[196] Good time credits—both "ordinary" credits and, under some circumstances, "extra" credits—should be made available to prisoner-patients, whether those prisoner-patients have been voluntarily or involuntarily transferred.

Good Time Credit

Since "ordinary" credits are typically earned by a prisoner not only while he is physically in a given State prison, but are earned also while he is standing trial on an out-of-State detainer[197] and while he is serving a given State sentence out-of-State concurrently with the sentence of another jurisdiction,[198] there seems little reason to deny such credits to a prisoner serving his sentence in a State mental hospital.[199] The availability of "extra" credits is slightly more difficult, for most States reserve those credits for inmates who perform certain assignments or who hold positions of confidence and trust. Nonetheless, some such positions are already available in a mental hospital setting and others could easily be made available.[200] Transferred prisoners holding such positions should accordingly be entitled to earn those credits. Moreover, if a prisoner was holding such a position—and earning "extra" credits—prior to the worsening of his mental condition that triggered his transfer to a hospital, he should presumably be permitted to continue earning those extra credits at the hospital even if, because of his mental condition, he is now unable to perform the required activities. In that connection, it is significant that the policy of many prisons is such that "prisoners who undergo treatment for *physical* problems are not deprived of ['extra'] credits for the period of time they spend at the county general hospital."[201] In fact, a recent Federal case found an equal protection violation in the denial of certain credits to a prisoner medically unable to perform prison labor.[202]

Parole

The parole problem is easily as troubling to prisoner-patients as is the problem of good time allowances. Parole boards often have a blanket policy against authorizing the conditional release of prisoners who are confined in mental hospitals.[203] Such rigidity, however, seems unwarranted. Especially in the context of *committed* prisoner-patients, it is important to recognize that

> granting the prisoner-patient parole would not in this setting be equivalent to setting him free. Rather, the parole from his penal sentence would signify simply that, *when* he is discharged

> by the hospital, he will be released rather than returned to the prison—a fact that should surely provide a powerful incentive for the patient to take full advantage of the psychiatric care available and thus to regain his liberty.[204]

Indeed, even with respect to *voluntary* prisoner-patients, where the hospital traditionally has no control over the patient's decision to leave, the parole preclusion policy is unpersuasive. The parole board, if it deems a further period of hospitalization to be necessary prior to the patient's discharge to the community, could parole the patient *to the hospital*, and leave to the hospital the ultimate decision whether to release the patient prior to the expiration of his "parole" status.[205]

The above observations have been underscored by a lower New York court which, on equal protection grounds, declared unconstitutional that State's blanket policy against conditionally releasing prisoner-patients, and which ordered parole to a civil hospital of a Dannemora State Hospital inmate who had been denied parole solely because of his mental patient status.[206] The record in that case contained the testimony of the director of Dannemora State Hospital who claimed that a substantial number of prisoner-patients at the facility could be paroled safely to a civil mental hospital or, in some cases, to outpatient treatment in their home communities. He thought, too, that such action would greatly enhance the patients' chances for complete psychiatric recovery.[207] The court, noting that no flat parole prohibition exists with respect to persons suffering from *physical* disabilities, and noting further that physically disabled prisoners are often paroled to general hospitals for treatment, ruled that, whether dealing with the physically or mentally disabled, "self sufficiency is not a requirement of parole."[208]

Statutory Reform

Recent statutes in States such as Massachusetts, Michigan, and Arizona have addressed, to varying degrees, the legal problems associated with prison-to-hospital transferees. The Arizona statute specifically addresses the issues of voluntary hospital admission, good time credits (both "ordinary" and "extra"), and parole. The pertinent provisions are set out below:

> E. A prisoner may apply for voluntary admission to the state hospital under the provisions of section 36-531. His application, when submitted to the prison physician, shall be forwarded to the superintendent of the state hospital by the prison physician together with the report of the prison physician and such material, if any, provided by the prisoner in support or in explanation of his application. A prisoner hospitalized in the state hospital as a voluntary patient shall be in the legal custody of the superintendent of the prison.
> F. All prisoners transferred to the Arizona State Hospital pursuant to this section [relating to commitments and to voluntary admissions] shall remain eligible to accrue [ordinary] good time credits pursuant to section 31-251. Double-time deductions pursuant to section 31-252 shall be allowed any prisoner who was earning the deductions immediately prior to transfer to the state hospital, and to any prisoner performing any assignment of confidence or trust at the State hospital.
> G. No prisoner otherwise eligible shall be denied parole solely because he is confined at the State hospital pursuant to this section.[209]

F. Civil Patients in Need of Security

Security mental hospitals and secure units of civil hospitals typically house certain civil patients who have been deemed to pose special problems of security. There are serious legal questions related to processes involved in classifying civil patients as being in need of security and in transferring those patients to more secure wards or to secure institutions. The importance of these questions is likely to be heightened as more and more categories of traditionally "criminal" patients become committable, if at all, only via the *civil* commitment route. For example, IST's must now, after a reasonable time, be either *civilly* committed or released; persons found NGRI are no longer automatically committable solely by virtue of the verdict, but must now be *civilly* committed or released; mentally ill prisoners can no longer be "administratively placed" in mental hospitals, and can be involuntarily placed in such institutions only pursuant to the *civil* commitment process.

Just as legal safeguards have emerged to counteract abuses that might otherwise take place at the point of *initial* commitment, so too legal safeguards are emerging to protect committed civil patients from the abuses that might occur if involuntary transfers to secure institutions or wards were permitted to occur in a freewheeling and unscrutinized manner.

Before the recent emergence of legal safeguards regarding security transfers of civil patients, the process was indeed a freewheeling one, highly susceptible to abuse. In an article published in 1971, Professor Grant Morris described the Michigan law and practice of transferring

civil patients from regional hospitals to Ionia State Hospital, a separate, maximum security mental institution.[210] Upon a unilateral determination by a regional hospital director that a given patient was "unmistakably dangerous," the director could on his own order the patient transferred to Ionia. Based on evidence from an analogous situation in New York, Morris came to the conclusion that the Michigan practice was capable of producing massive abuse. Hospital officials are very likely to overpredict dangerousness and in any event may well be tempted to use this means of ridding themselves of troublesome patients. Availability of summary transfer to a security institution may thus lead to a far greater number of transfers than is in fact necessary. Once transferred, and in the absence of legal constraints, such patients are also likely to remain at the receiving institution indefinitely, never to return to the civil sending institution. Those patients who are eventually released to their home communities would probably be released directly from the security hospital.

Because of the problems associated with summary security transfers, there is growing consensus on the need to upgrade both the substantive and the procedural aspects of the security transfer process. Substantively, certain standards or criteria for increasing security have been suggested, the "least restrictive alternative" test has been applied in the context of in-hospital confinement, and durational limits on secure confinement have been proposed. Procedurally, some sort of hearing prior to (or, in emergency cases, soon after) transfer is emerging as a requirement of due process, although the precise form the hearing should take is still a matter of uncertainty, and there is as yet no agreement on whether the hearing ought to be held before an administrative or a judicial body.

Substantive Criteria

In terms of substantive criteria for the transfer of a civil patient to Ionia State Hospital, Grant Morris proposed a strict standard of proof beyond a reasonable doubt that "the patient, while confined in the regional hospital, committed an act or acts which have resulted in, or if continued will necessarily result in serious bodily injury or death to other patients or hospital personnel and that there was no justification for such behavior."[211] Morris' standard, which was proposed to deal with transfers to Ionia only,[212] seems too strict to warrant general acceptance. As Morris himself notes,[213] his proposal does not accept other possibly legitimate sources of security concern, such as the manifestation of suicidal tendencies or a high risk of escape.

Morris' proposal also seems unduly narrow insofar as it restricts grounds for removal to overt acts of extreme danger committed by a patient "*while confined in the regional hospital*," thereby excluding from permissible consideration recent dangerous overt acts which may have *formed the basis* of a patient's police power commitment. If, for security transfer purposes, all civil patients are to be lumped by the law into a single category entitled to minimal security unless and until the State proves, in an individualized sense, that particular patients are in need of greater security,[214] then the law ought to at least permit the security decisionmaker to dip back into patients' recent precommitment pasts in order to ascertain meaningful differences in their dangerousness and their security needs. If hospital administrators are not permitted to look to clear-cut indicia of security needs that were manifested in the immediate precommitment period, those administrators will in a sense be placed in a legal "double bind." By being required to assume that all patients are low security risks unless and until such patients commit posthospitalization overt acts of extreme dangerousness, administrators may place police power patients in a very advantageous position. The administrators, however, will at the same time fall down on their constitutional obligation to guarantee parens patriae patients a meaningful right to treatment,[215] and will fall down on their tort[216] and constitutional[217] obligations to protect patients from the risk of foreseeable harm by dangerous fellow inmates. In the analogous area of prisons, for example, negligence and Civil Rights Act suits based on a failure-to-protect theory are coming into vogue; wardens are being charged with a duty of reasonable classification, and have been found liable for improperly classifying and securing prisoners who have demonstrated mental instability and violence.[218]

In designing substantive criteria for security classification and transfer, it thus seems foolish and counterproductive to ignore, for example, the fact that a particular civil patient has been committed pursuant to the police power because of his demonstrated and predicted dangerousness. To consider, rather than ignore, a patient's precommitment violence does not automatically necessitate secure confinement for all such patients. Rather, what is needed is a decisionmaking process for ascertaining whether particular civil patients (be they parens patriae or police power) warrant confinement over and above ordinary limits, and a concomitant authorization for such decisionmakers to consider both recent precommitment behavior as well as postcommitment instances of violent or other security-relevant behavior.[219]

If certain precommitment or postcommitment facts point to the need for increased security, the pertinent court cases seem quite consistently to require that imposed security measures not exceed those that are in fact required. Put another way, the "least restrictive alternative" doctrine has been judicially applied to in-hospital security determinations.[220] The doctrine suggests that *even if security is needed, a patient ought not to be transferred to a secure unit (and surely not to a security institution) unless and until it is ascertained that less restrictive measures would be unsatisfactory in meeting the perceived security need.* Such less restrictive measures might entail increasing the size of the front-line supervisory staff, decreasing crowded and other aggression-triggering conditions in the institution, increasing doses of tranquilizing medication (if preferred by the patient as an alternative to a transfer), removing ground privileges, and confining the patient to a closed ward of general civil patients.

Procedural Requirements

To insure that whatever substantive security standards are established are actually adhered to, due process is likely to require that security transfers be accompanied by some fair factfinding procedure. Recent judicial decisions have begun to flush out some guidelines regarding the particulars of such a procedure.

The first major case to address the question was the District of Columbia Circuit decision in *Jones* v. *Robinson*.[221] In comprehensive and almost statutory fashion, *Jones* laid down a set of due process minima (detailed below) which must be complied with when a civil patient accused of crime is transferred to maximum security. The case has generated some confusion since it indicated that greater discretion and fewer protections might be appropriate if the transfer were made for purely *medical* reasons.[222] But since *Jones* also noted that procedures equivalent to the due process minima it was enunciating might be required to resolve factual disputes in other serious situations as well,[223] it is likely that the court would not apply very different standards to transfers labeled as medically motivated. In addition, subsequent cases in other jurisdictions seem unimpressed with arguments that transfers denominated as "therapeutic" ought to be accompanied with fewer procedural trappings than transfers denominated as "disciplinary."[224] The *Jones* standards are therefore worthy of complete quotation:[225]

> 1. That the officer conducting the inquiry be neutral, in the sense that where possible he have no prior connection with the accused patient, his alleged victim, or the incident under investigation. A doctor, an administrative assistant to the superintendent or similar personnel of the hospital could serve in this capacity.
> 2. That the investigating officer interview all the witnesses himself, including those suggested by the accused patient, and make a written memorandum of each interview. In this way the same fact finder can judge the credibility of all witnesses.
> 3. That copies of these memoranda be made available to the accused patient and that he be given an opportunity to respond to the allegations contained therein.
> 4. Where the hospital authorities believe that confrontation and cross-examination will not adversely affect the patients involved, including the witnesses, confrontation and cross-examination to the extent indicated should be permitted.
> 5. That a lawyer to represent the accused patient is not required, but the hospital authorities may conclude that a lay representative assigned to the accused patient may be in the interest of justice.
> 6. No court reporter or transcript of the proceedings would ordinarily be necessary, but detailed informal memoranda should be kept by the investigating officer who shall also make findings and give reasons for his decision. These memoranda, together with his findings and reasons, should become a part of the permanent records of the hospital.
> 7. That while the investigating officer may determine whether the evidence is sufficient to justify a transfer of the accused patient to John Howard, to be effective that judgment must be affirmed by the superintendent of the hospital after a review of the record.

Last year, the United States Supreme Court in *Wolff* v. *McDonnell*[226] handed down a decision relating to due process in prison disciplinary proceedings which is at least relevant by way of analogy to the area of mental hospital security transfers. *Wolff* held that where a "major change in the conditions of confinement" is at stake—e.g., good time forfeiture or placement in solitary confinement—due process requires that the inmate be given advance (at least 24 hours) written notice of the charges, be given the right to make a personal appearance and tender an explanation, and be given a written statement of the facts found, the evidence relied upon, and the reasons for the action taken.

To a limited extent, the *Wolff* requirements exceed those of *Jones*. If applied to the security transfer of a civil mental patient, *Wolff* would mandate that the patient be given at least 24-hour advance notice of the alleged facts ("charges") supporting transfer, and would make it clear that in all cases the patient would be entitled to give a *personal* explanation.[227]

In other respects, such as the right to confrontation, the *Jones* requirements exceed those of *Wolff*. The *Wolff* Court leaves the availability of cross-examination to the complete discretion of the prison authorities.[228] *Jones*, on the other hand, provides a slightly greater confrontation right by holding that cross-examination should be permitted in those cases where hospital authorities believe confrontation will not adversely affect the patients involved. The *Wolff* Court gives prison officials complete discretion over whether an inmate can be permitted to call his own witnesses, whereas *Jones* requires that the investigating officer interview all witnesses suggested by the patient proposed for transfer. *Wolff* holds that inmates are not entitled to counsel at the proceedings, but does suggest that illiterate inmates be provided with counsel-substitute (paraprofessionals). *Jones* hints, though it does not hold, that justice may best be served by appointing a lay representative to assist the subject-patient.

To the extent that *Jones* exceeds *Wolff*, the differences can perhaps best be explained by the differences in atmosphere in prisons and hospitals and by the differences between prisoners and patients. The tensions and hostilities of prison life, of utmost concern to the *Wolff* Court with respect to calling and cross-examining witnesses, were obviously not viewed by *Jones* as overwhelming problems in a hospital setting. And the capability of convicts to serve generally as their own counsel would obviously have less weight in the context of a mentally disabled population. Indeed, *Jones* should have been stronger than it was on the need of mental patients for legal or paralegal assistance, and should have mandated the appointment of counsel-substitute in hospital security transfer situations.

In the wake of *Wolff*, one Federal court has already applied the *Wolff* standards to a context somewhat similar to that of *Jones*: the involuntary transfer of prison inmates to a behavior modification program at Springfield, Missouri, that involved a major change in the conditions of those inmates' confinement.[229] Although the transfer in *Clonce* was supposedly for medical or therapeutic reasons rather than for disciplinary ones, the *Clonce* court held the *Wolff* protections applicable. So long as what is involved is a substantially adverse alteration in liberty or custody—a major change in the conditions of confinement—protections are essential. Presumably, the *Clonce* rationale would therefore apply also to intra-institution changes in conditions of confinement, and to transfers for purposes of security. Moreover, *Clonce*, which itself involved a transfer of *prisoners*, naturally relied on the standards of *Wolff*. But had the *Clonce* court confronted a

situation involving a transfer of *mental patients*, where the hostile atmosphere problems of prisons would be less apparent, it might well have mandated instead that the requirements of *Jones* (perhaps embellished by certain protections specified in *Wolff*), rather than the more minimal protections of *Wolff*, govern the transfer procedure.[230]

Administrative Hearings

If, as seems likely, due process considerations will be read to require a *Jones*-type hearing—or something closely resembling it—for mental hospital security transfers, the next inquiry should relate to the most appropriate *forum* for such a hearing. Grant Morris, in his article proposing mental health statutory reforms for Michigan, suggests that security transfers be available only in accordance with a court order issued after a *judicial* hearing.[231] It is important to recognize, however, that while the due process clause probably requires a transfer hearing, the clause does not command that the hearing be judicial as opposed to administrative, and the administrative adjudication route was the one taken by *Jones*, *Wolff*, and *Clonce*.

The administrative route seems in many respects to be the practically preferable one. First of all, if jurisdiction is to be conferred upon a court to handle transfer hearings, legislative action would presumably be required to authorize the proposed judicial activity. Yet, if due process requires some sort of transfer hearing, hospitals will have an immediate need for a workable transfer procedure, and the institutions will be in a constitutionally uncomfortable position if they are expected to await legislative action. If, however, an *administrative* hearing would comport with constitutional standards (as it would), hospitals could easily and rapidly devise, through rules and regulations or internal policy guides, an acceptable machinery of transfer. Further, as the law develops in this new and changing area, and as subsequent court interpretations of *Jones* and *Wolff* embellish the constitutional procedural requirements, necessary responsive action could best be accomplished by the flexible and simple process of administrative regulation, rather than the more cumbersome and time-consuming process of legislative revision.

Moreover, an administrative—rather than a judicial—approach to adjudicating the merits of security transfers seems to have a host of advantages. What I have recently written about the administrative advantages of adjudicating matters of behavior control seems to carry over to the area of patient transfers:

> First of all, if the analogue of the judicial handling of civil commitment hearings for the mentally ill is to have any relevance at all, there is every indication that the courts will not be at all eager to involve themselves in the day-to-day business of behavior control. Empirical studies firmly conclude that courts have permitted—indeed encouraged—remarkably perfunctory procedures in civil commitment hearings and that they effortlessly and routinely rubberstamp the recommendations of the testifying psychiatrists. A lay body such as a Committee on Legal and Ethical Protection, on the other hand, has at least a genuine potential for bringing together a broad-based group of persons carefully selected on the basis of concern and other factors, and of giving them a chance to perform with skill and vigor.[232]

Ideally, then, security transfers should be handled by administrative hearing, with the decisionmaker being not simply a hospital staff member uninvolved in the incident triggering the proposed transfer (which would satisfy *Jones*), but being instead a group of concerned local citizens unaffiliated with the hospital and appointed, by an administratively sanctioned process, by a respected outside organization—such as a local or State affiliate of the National Association for Mental Health.[233]

The key to a workable scheme of security transfers seems to be flexibility—to insure appropriate security when it is needed and to insure that secure confinement terminates when it is no longer necessary. *Flexibility would be fostered by a system in which security determinations are individualized, where security determinations are arrived at by an administrative body* (sparing doctors and staff members time-consuming trips to court), *where durational limits are set on secure confinement* (necessitating that secure confinement for a patient cease after a given term absent a new administrative hearing and determination that continued secure confinement is warranted), *and where security patients are housed on a secure unit of a civil hospital* (promoting the ebb and flow of security as needed) *rather than at a wholly separate (and perhaps distant) secure institution.*

CHAPTER IV

Conclusion and Summary of Policy Implications

This monograph has indicated that security mental hospitals may, because of legal and other developments, lose some categories of their traditional patient residents (e.g., IST's). Some of these patients may, under actual or proposed legal schemes, find themselves in correctional institutions. Others may be civilly committed to State and regional mental hospitals. Even so, civil mental hospitals, because of the decarceration trend and the community mental health movement, can be expected to continue to decrease in total population.

In light of these and other trends enumerated in the monograph, there seems little need for construction of new secure mental institutions. Instead, secure units at civil facilities should be improved through remodeling, and prison psychiatric services should be substantially upgraded.

Recent developments in the law, as indicated in previous sections, also suggest that improved procedures are needed in many jurisdictions for the transfer, in needed instances, of prisoners to mental hospitals and for the individualized placement of certain civil patients in quarters of increased security, such as the secure unit.

Secure units, as contrasted with secure institutions, will help to insure needed flexibility. They can help to prevent patients from getting lost in the security shuffle, decrease their isolation, decrease the stigma of their confinement, and facilitate their re-integration, when indicated, with general patients. No less importantly, a secure unit arrangement is much more likely than a secure institution arrangement to lead to genuine therapeutic opportunities for security patients. An integration of clinical services could result in a sharing of professional staff between secure unit patients and general population patients. A facility which houses general patients as well as security patients is also likely to attract a significantly better professional staff than an institution which houses (often in a remote area) exclusively security patients. After all, many therapeutic professionals shun a steady diet of dealing with the most difficult and dangerous of

patients. On the other hand, many highly competent and energetic psychiatrists, psychologists, and social workers crave variety in their work and might well enjoy spending part of their time with security patients. Civil mental hospitals may thus find it easier to attract an excellent professional staff if they house security patients as well as general patients, rather than exclusively the latter. The secure unit concept, then, would not only assist in developing more manageable security transfer procedures, but could also result in a generally improved condition for security patients and for their general patient counterparts.

Additional Recommendations

Of the many recommendations previously tendered in this monograph, several have important public policy implications and have therefore been collected for reiteration in this concluding section.

"Special" Offenders

- There are two principal problems that typify current laws regarding the commitment of "special" offenders such as sexual psychopaths and defective delinquents. These are (1) indeterminate length of confinement, and (2) vague criteria for commitment which foster a system of arbitrary selection.
- Three basic law-reform options have been proposed to deal with these problems. *One* of them is to apply the criminal law maximum sentences even to offenders committed pursuant to special statutes. That option would solve the length-of-confinement problem but would not address the arbitrary selection problem. A *second* option would be to abolish such special offender commitments. That step would, of course, address both problems and was recently taken in Michigan with regard to sexual psychopaths. A *third* option has recently been proposed to the legislature of Minnesota in connection with sexual offenders. That option would overcome indeterminate sentence problems and most selection problems without totally abolishing special treatment programs. It would involve a requirement that the criminal law sentencing lid apply both to correctional and therapeutic confinements. Problems of arbitrary selection would be largely overcome by giving the *offender* the option of therapeutic or penal placement.

Defendants Found Incompetent to Stand Trial

- Traditionally, defendants thought to be incompetent to stand trial (IST) were confined for a significant time in order to undergo mental evaluation. If they were then judicially found IST, they were typically confined in a secure institution for an indefinite period.
- Recent legal and psychological developments have radically altered the traditional picture. It is becoming widely recognized that the bulk of IST evaluations can be conducted in a short time and on an outpatient basis. Further, a recent Supreme Court ruling prohibits the *indefinite confinement* of IST defendants. Finally, even those defendants judically found IST can often be confined without special security, and, in some cases, can be treated as outpatients.
- Current law bars trying defendants found IST. If, however, a substantial number of IST defendants are required to undergo outpatient treatment, those defendants may be encouraged to postpone criminal proceedings indefinitely by playing a psychiatric "sick" role. In that connection, a recent proposal to abolish the incompetency plea—and to try defendants despite their incompetence—takes on added significance.

Civil Patients With Criminal Detainers

- When a criminal detainer (hold order) is placed against a civil patient because of an outstanding criminal charge, the patient is often perceived as an exceptional escape risk and is placed in maximum security confinement. Efforts at therapy are often frustrated with detainer patients because those patients are frequently unwilling or unable to plan for their improvement and release when their futures are so much in doubt.
- Though detainers are often filed, they are rarely exercised by prosecuting authorities. Especially because of the infrequency with which detainers are in fact exercised, patients with detainers should not be placed automatically in secure quarters. Security should be individualized according to an assessment of the history and clinical condition of the particular patient, the severity of the outstanding charge, and, if it can be ascertained, the likelihood of the outstanding criminal charge eventually being pressed.
- Patients subject to detainers should be provided with legal or paralegal assistance. A legally trained person could assist a detainer patient in making an appropriate demand for a speedy trial on an outstanding criminal charge, or could, in appropriate cases, negotiate with prosecuting authorities to dismiss pending charges. Dismissal is

common if the outstanding charge is not serious and if the existence of the detainer can be shown to be antitherapeutic.

Defendants Found Not Guilty by Reason of Insanity

- Traditionally, the "successful" invocation of the insanity defense resulted in automatic and indefinite mental hospital confinement, often in a secure facility. Because of such legal disincentives to its assertion, the insanity defense was typically invoked only by persons accused of serious offenses who faced severe sentences (such as capital punishment or lifelong imprisonment).
- Gradually, however, because of recent judicial and legislative activity, the provisions for automatic and indefinite confinement of those found not guilty by reason of insanity (NGRI) are beginning to wither away. It is therefore expected that larger numbers of defendants will begin to assert the defense. To the extent that defendants charged with less serious offenses now begin to invoke the defense, institutions should reconsider the presumption favoring automatic secure confinement for persons committed after a finding of NGRI.
- Placing the release authority for NGRI patients in the unilateral discretion of hospital officials may result in timidity in the exercise of that release authority. Unwarranted retention of such patients could be remedied by establishing durational limits on confinement, by passing legislation immunizing the hospital and staff for acts committed by released patients, and by passing legislation requiring court approval of a hospital's decision to release an NGRI patient (as well as other types of dangerous patients).

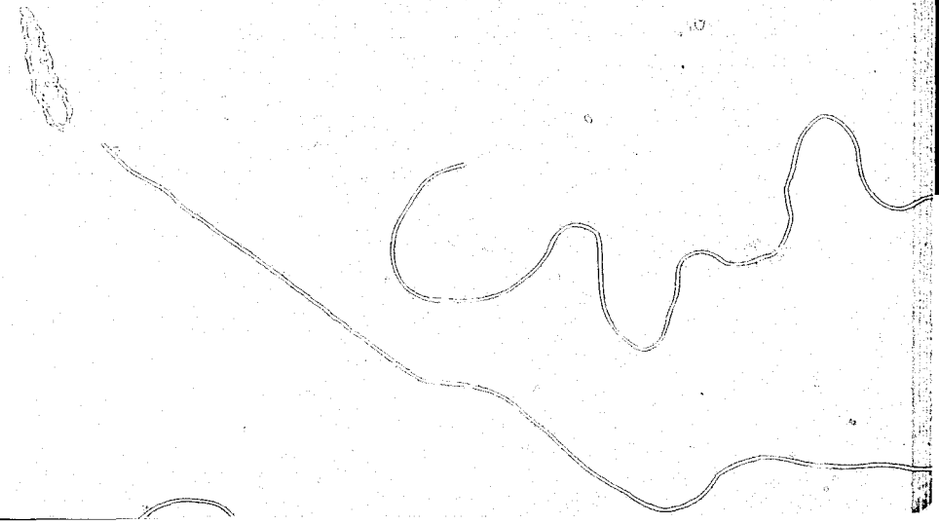
Prison-to-Hospital Transferees

- There has long been a need for improved mental health services in a correctional context. The need may become even greater if legislators abolish special offender laws (such as sexual psychopath statutes) or if they abolish or constrict the insanity defense, since either of those actions would result in an increase of emotionally troubled persons entering the penal system. Attention should be directed toward establishing minimum mental health standards for correctional institutions.
- Even if mental health services at correctional facilities are substantially upgraded, situations will arise when hospital placement of a prisoner will seem warranted. In recent years, policymakers have given increased attention to involuntary prison-to-hospital transfers, and to constitutional and procedural requisites for such transfers, but have largely ignored the area of voluntary hospital admission.

- Legislators should provide for voluntary hospital admission of prisoners under carefully delineated circumstances. Provision should also be made for awarding good time credits during a prisoner's stay at a hospital, and for insuring that parole be available, in appropriate cases, for transferred inmates.

Civil Patients in Need of Security

- Regulations should be drafted specifying substantive criteria which, if met, would warrant increasing the security of civil patients. Those criteria should contain a provision to the effect that security be increased only if less restrictive devices are unavailable to reduce the perceived security risk.
- In addition to specifying substantive criteria required for increased security, the regulations should provide an adequate procedure for resolving factual controversies. An administrative—as opposed to a judicial—security hearing would probably be the most efficient and effective means of achieving that goal.



FOOTNOTES

1. These categories of patients are typically confined in special or secure facilities, or, as at the Arizona State Hospital, are placed on a "special classification status" which requires that, unlike ordinary civil patients, any proposed reduction in their security or increase in their privileges be approved by a Special Classification Committee. See generally Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, pp. 218-219.

2. *E.g.*, Jackson v. Indiana, 406 U.S. 715 (1972) (incompetence to stand trial); Humphrey v. Cady, 405 U.S. 504 (1972) (sexual psychopaths); Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968) (not guilty by reason of insanity); United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969) (prison-to-hospital transfer); Matthews v. Hardy, 420 F.2d 607 (D.C. Cir. 1969) (same); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973) (transfer of civil patient to maximum security); Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969) (transfer of maximum security civil patient to less secure ward). The principal cases and areas of legal activity will be discussed in detail in later sections of the monograph.

3. One organizational caveat is in order: Although, as stated in the text, the various specific categories of committed patients deserve and will receive separate attention, several of the pertinent problem areas overlap one or more categories. These overlapping areas will be discussed principally in the section deemed by the author to be most appropriate, and will be "incorporated by reference" in the sections of subsidiary concern.

4. See, *e.g.*, Rothman, D. Decarcerating prisoners and patients. *The Civil Liberties Review*, Fall, 1973:8-30.

5. See generally Chambers, D. Alternatives to civil commitment of the mentally ill: Practical guides and constitutional imperatives. *Michigan Law Review*, 70:1107-1200, 1972.

6. Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1969) (mental patients); Singer, R. Sending men to prison: Constitutional aspects of the burden of proof and the doctrine of the least restrictive alternative as applied to sentencing determinations. *Cornell Law Review*, 58:51-89, 1972 (prisoners).

7. Jackson v. Indiana, 406 U.S. 715 (1972); Morris, N. The future of imprisonment: Toward a punitive philosophy. *Michigan Law Review*, 72:1161-1180, 1974.

8. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973).

9 *E.g.*, Goffman, E. *Asylums*. Garden City, New York: Doubleday and Company, 1961. 386 pp. See also Rothman, D. *The Discovery of the Asylum: Social Order and Disorder in the New Republic*. Boston: Little, Brown and Company, 1971. 376 pp.

10. *E.g.*, Pasamanick, B., Scarpitti, F., and Dinitz, S. *Schizophrenics in the Community*. New York: Appleton-Century-Crofts, 1967. 448 pp.

11. One careful observer of the decarceration movement has noted, however, that many mental health and prison reform lawyers have not clearly articulated or thought

through their reform strategies. Some seek to bring to the institutions true efforts at rehabilitation. Others, desirous of emptying institutions but reluctant to argue that goal in explicit terms, urge courts to accept a right to treatment or rehabilitation with an underlying hope that such a right will be too expensive to enforce, will create a crisis situation, and will result in massive decarceration. Rothman, D. Decarcerating prisoners and patients. *The Civil Liberties Review*, Fall, 1973:8-30.

12. Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala 1972); Chambers, D. Alternatives to civil commitment of the mentally ill: Practical guides and constitutional imperatives. *Michigan Law Review*, 70:1107-1200, 1972; Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, pp. 1245-1252. *Cf.* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (statutory rather than constitutional base).

The *Harvard Law Review* Note suggests that while the "less restrictive alternative" doctrine will *decrease* the number of *hospitalized* patients, it will *increase* the *total* number of persons subjected to the coercive mental health power of the State, perhaps by requiring certain persons to undergo outpatient therapy whereas, under a system which provided only for full-blown hospitalization or for total release, they would be totally released. Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, p. 1250. It is important to recognize, however, that while the system might so respond, it need not inevitably do so. Commitment courts could ask in the *abstract* whether a proposed patient, *if wholly free*, would meet the rigorous tests of involuntary commitment. If the answer is in the affirmative, courts could then commit to an institution if other alternatives are unavailable, or else dispose of the case through referral to a less restrictive alternative. But if the answer to the question were in the *negative*, courts could simply dismiss the case, thereby releasing the patient from all types of coercive control, without reaching the question of the propriety or desirability of less restrictive alternatives.

13. Geis, G. *Not the Law's Business? An Examination of Homosexuality, Abortion, Prostitution, Narcotics, and Gambling in the United States*. DHEW Pub. No. 72-9132. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1972.

14. *E.g.*, Ennis, B.J., and Litwack, T.R. Psychiatry and the presumption of expertise: Flipping coins in the courtroom. *California Law Review*, 62:693-752, 1974, pp. 749-750.

15. Murel v. Baltimore City Criminal Court, 407 U.S. 355 (1972) (Writ of certiorari dismissed by the Court as improvidently granted, but case presented issues of the vagueness of commitment standards and the necessity, for commitment purposes, of proof beyond a reasonable doubt).

16. See, for example, the tight commitment standards mandated by California's Lanterman-Petris-Short Act, California Welfare and Institutions Code 5000 *et seq* (West 1972).

16A. In the past, there has been a blurring of the two separate bases of the commitment power, but the modern tendency is to recognize their distinct qualities. First, commitment can be justified as an exercise of the State's paternalistic (parens patriae) power. In the exercise of its paternalistic power, the State is presumably authorized to hospitalize and treat those persons who, because of mental illness, are unable to make appropriate personal decisions about hospitalization and treatment. In contrast, when the State commits an individual pursuant to its police power (rather than pursuant to its paternalistic power), it does so not necessarily for the good of that individual, but rather to protect the public from an individual who is mentally ill and dangerous to others.

17. Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87, 1190-1406, 1974, pp. 1201-1244. See also Wexler, D.B. Therapeutic justice. *Minnesota Law Review*, 57:289-338, 1972, pp. 318-326.

18. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, pp. 111-117.

19. See Section II(c), *infra*.

20 Jones V. Robinson, 440 F.2d 249 (D.C. Cir. 1971); *cf.* Wolff v McDonnell, 94 S. Ct. 2963 (1974).

21. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969).

22. On the role of lawyers and independent experts (psychiatrists and psychologists) at civil commitment proceedings, see generally Ennis, B.J., and Litwack, T.R. Psychiatry and the presumption of expertise: Flipping coins in the courtroom. *California Law Review*, 62:693-752, 1974; Litwack, T.R. The role of counsel in civil commitment proceedings: Emerging problems. *California Law Review*, 62:816-839, 1974; Andalman, E., and Chambers, D. Effective counsel for persons facing civil commitment: A survey, a polemic, and a proposal. *Mississippi Law Journal*, 45:43-91, 1974; Cohen, F. The function of the attorney and the commitment of the mentally ill. *Texas Law Review*, 44:424-469, 1966.

23. Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

24. Morris, G. Mental illness and criminal commitment in Michigan. *University of Michigan Journal of Law Reform*, 5:1-66, 1971, p. 56 (Discusses alternatives to the Ionia maximum security institution in Michigan and relates conclusions of a study conducted by the Association of the Bar of the City of New York).

25. See generally *id.* at 56-57.

26. de Grazia, E. Diversion from the criminal process: The 'mental-health' experiment. *Connecticut Law Review*, 6:432-528, 1974.

27. With respect to the area of juvenile delinquency, it has been estimated that only 2 percent of all juvenile offenders are apprehended, and only 10 percent of the apprehended group are confined. Remarks of Dr. David Bordua, Florida State University Colloquium on Law and Social Control, Tallahassee, Florida, May, 1974.

28. A dent in the crime rate could be expected, through confinement or through correctional efforts, only if a small number of persons—who happened to be apprehended—were responsible for an inordinate amount of criminal activity. If crime is prevalent but criminals are rare—so that crime happens to cluster in certain offenders—isolation or efficacious behavior control could reduce the crime rate. But if crime is prevalent and if criminal activity is spread among a large group of offenders, anything short of massive apprehension and confinement could not noticeably influence the general rate of crime.

29. Rothman, D. Decarcerating prisoners and patients. *The Civil Liberties Review*, Fall, 1973:8-30 p. 20.

30. The required provision of treatment for that purpose is, as discussed *infra*, emerging as a rationale for the right to treatment for police power patients.

31. Schwitzgebel, R.K. The right to effective mental treatment. *California Law Review*, 62:936-956, 1974.

32. *Id.* at 947-948.

33. Rothman, D. Decarcerating prisoners and patients. *The Civil Liberties Review*, Fall, 1973:8-30 pp. 24-28.

34. *Id.* at 28.

35. Citizens' Inquiry on Parole and Criminal Justice, Inc. "Summary Report on New York Parole," March, 1974, 47 pp., p. 36 (Mineo).

36. *Id*, at 36.

37. Hodges, E.F. Crime prevention by the indeterminate sentence law. *American Journal of Psychiatry*, 128:291-295, 1971.

38. Stone, A. Discussion. *American Journal of Psychiatry*, 128:295, 1971.

39. *Id.*

40. Patuxent Institution. "Maryland's Defective Delinquent Statute: A Progress Report." January, 1973, 42 pp. (Mimeo).

41. Letter from James E. Olsson, Ph.D., Chairman, Maryland Psychological Association Legislative Committee, to Delegate Martin A. Kircher, Chairman, Judiciary Committee, House of Delegates, Maryland General Assembly, January 23, 1973.

42. *Id.* at 2.

43. *Id.* at 3.

44. O'Connor v. Donaldson, 95 S.Ct. 2486 (1975).

45. *E.g.*, Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

46. *E.g.*, Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) (construing a Congressional statute applicable in the District of Columbia).

47. *E.g.*, Symposium. The right to treatment. *Georgetown Law Journal*, 57:673-922, 1969; Symposium. The mentally ill and the right to treatment. *University of Chicago Law Review*, 36:742-801, 1969.

48. Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, pp. 1326-1327. Apparently the only instance in which a parens patriae patient could be retained without treatment is where an "untreatable" patient is committed because of the need for *humane custodial care*, rather than for treatment. *Id.* at 1327. The *Harvard Note* argues, however, that even with regard to parens patriae patients committed because of a clear-cut need for treatment, "due process does not require that the treatment given be effective," for "the possibility that treatments actually given will not benefit a patient are to be taken into consideration in the initial commitment hearing." *Id.* at n. 43. If the Note is suggesting that need-for-treatment patients may be continually confined even after it is ascertained that efficacious treatment cannot be provided them, the Note's reasoning is faulty. It is of course proper at the initial commitment hearing, in order to balance competing interests and to decide whether commitment is in the patient's best interest, to take testimony regarding estimates of therapeutic success. But while that estimate, even if incorrect, may legitimate the initial act of commitment, it should not, at least if the need for humane custodial care is not present, legitimate continued confinement after therapy proves ineffective and firmly undercuts the validity of the original estimate of therapeutic efficacy.

49. These might include some mentally ill prisoners and civil parens patriae patients held subject to criminal detainers.

50. See discussion in Note. Developments in the law: Civil Commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, p. 1325 n. 39.

51. First, it has been contended that, contrary to the implications of the theory, there perhaps ought to be a constitutional right to treatment *even if* full-blown procedural protections are adopted in the commitment process. Furthermore, the theory might allow for the acceptance of an argument to the effect that since treatment is available, there is no constitutional need for procedural protections. Finally, police power commitments ought, in theory at least, to be available on a finding

of future dangerousness, regardless of whether the subject has manifested his dangerousness through the commission of a specific overt act. *Id.*

52. *Id.* at 1327-1328. Reproduced with permission. Copyright 1974 by The Harvard Law Review Association.

53. *Id.* at 1328 n. 48 (citations omitted). Reproduced with permission. Copyright 1974 by The Harvard Law Review Association.

54. One recurrent and perhaps | inevitable | problem | of | increasingly | equalizing | the treatment of police power patients and the criminally committed with the treatment of parens patriae patients is that the former group may be advantaged at the expense of the latter group. Other instances of this phenomenon will be addressed in later portions of this monograph.

55. By such an arrangement, the institution can have its professional staff shared among all patients. Were the parens patriae and police power patients housed at separate institutions, the police power patients might well be denied treatment on the ground that it is "unavailable" at that institution. If the "unavailability" argument were to fail, the police power institution might have to try to attract staff, which could be a problem of considerable difficulty if its location is in a remote area and if mental health clinicians find it professionally unrewarding to deal exclusively with dangerous patients. And if a court were to order "equalization" of treatment, the parens patriae institution could find itself in a position of having to transfer staff—or of having staff members commute—to the police power facility.

56. Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973); Shapiro, M.H. Legislating the control of behavior control: Autonomy and the coercive use of organic therapies. *Southern California Law Review*, 47:237-356, 1974; Wexler, D.B. Token and Taboo: Behavior modification, token economies, and the law. *California Law Review*, 61:81-109, 1973; Wexler, D.B. Of rights and reinforcers. *San Diego Law Review*, 11:957-971, 1974; Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, pp. 1345-1358.

57. 477 F.2d 877 (9th Cir. 1973).

58. At the Iowa facility, misbehavior as innocuous as swearing was sufficient to trigger an apomorphine injection.

59. 488 F.2d 1136 (8th Cir. 1973).

60. 344 F. Supp. 373 (M.D. Ala. 1972).

61. Wexler, D.B. Token and taboo: Behavior modification, token economies, and the law. *California Law Review*, 61:81-109, 1973, pp. 94-95. Reproduced with permission.

62. Clonce v. Richardson, No. 73 CV. 373-S (W.D. Mo. 1974). The court, however, did not find the "procedural" aspects of the case moot, and ruled that due process requires that a hearing be held prior to the transfer of a prisoner to a behavioral program—such as START—which involves a considerable change in the conditions of the prisoner's confinement. The procedural requirements of the case will be addressed more fully in a subsequent section of this monograph.

63. The privileges allocated according to tier position at the Patuxent Institution are in general not likely to raise constitutional difficulties: the opportunity to play cards, to have paintings on the walls, etc. The only Patuxent privileges which might be regarded as constitutionally suspect involve visitation rights, mail, and mandatory maximum security status for inmates at the first two tiers of the program. Information regarding the Patuxent system was obtained by a visit to the institution made by this writer on May 31, 1974.

64. This constitutional analysis conforms generally to the approach taken in recent comprehensive and thoughtful works. See Shapiro, M.H. Legislating the control of behavior control: Autonomy and the coercive use of organic therapies. *Southern California Law Review*, 47:237-356, 1974; Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974; Note. Conditioning and other technologies used to "treat?" "rehabilitate?" "demolish?" prisoners and mental patients. *Southern California Law Review*, 45:616-681, 1972.

65. Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, pp. 1344-1358.

66. Civ. No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., July 10, 1973).

67. Wexler, D.B. Foreword: Mental health law and the movement toward voluntary treatment. *California Law Review*, 62:671-692, 1974.

68. Wexler, D.B. "Behavior Modification and Other Behavior Change Procedures: A Look at the Emerging Law and the Proposed Florida Guidelines." Unpublished manuscript, 1975. 28 pp., p. 11.

69. Wexler, D.B. Foreword: Mental health law and the movement toward voluntary treatment. *California Law Review*, 62:671-692, 1974, p. 679.

70. Goldiamond, I. Toward a constructional approach to social problems: Ethical and constitutional issues raised by applied behavior analysis. *Behaviorism*, 2(1):1-84, Spring, 1974, p. 60.

71. Prettyman, E.B., Jr. The indeterminate sentence and the right to treatment. *American Criminal Law Review*, 11:7-37, 1972.

72. *Id.* at 15-17. Reproduced by permission of the American Bar Association 1969. Further reproduction prohibited without permission of copyright holder.

73. *Id.* at 37.

74. *Id.* at 17-21. Reproduced by permission of the American Bar Association 1969. Further reproduction prohibited without permission of copyright holder.

75. *Id.* at 26.

75A. A very recent empirical investigation of the release criteria employed by the Atascadero therapeutic staff indicates that the patient shamming sheet conforms remarkably well to reality. Dix, G.E. Determining the continued dangerousness of psychologically abnormal sex offenders. *Journal of Psychiatry and Law*, Fall 1975, pp. 327-344.

76. Bedau, H.A. "Behavior Modification in Prison from the Moral Point of View." Unpublished manuscript, 1974. 20 pp., p. 7.

77. The program was also condemned on constitutional grounds by Federal court action in Adams v. Carlson, Civ. No. 72-153 (E.D. Ill., Dec. 6, 1973).

78. Rubin, B. "Report of Visit to Control Unit Treatment Program." Unpublished report, November 25, 1973. 10 pp., p. 6.

79. *Id.* at 9.

80. *Id.* at 9-10.

81. Wetzel, R.J. "Behavior Modification in the Social Learning Environment." Unpublished, undated manuscript. 18 pp. See *id.* at 3-4: "Cues in learning need to be clear and should specify behavior. When we say to a child 'I want you to be good and behave yourself' we are not giving a very specific behavioral cue. What are the behaviors of 'being good' and 'behaving one's self?' The ability to give clear, specific non-critical and non-provocative cues for behavior is a quality of a good trainer."

82. Bandura, A. Behavior theory and the models of man. *American Psychologist*, 29:859-869, 1974.

83. *Id.* at 860.

84. *Id.*

85. *Id.* at 862.

86. Morris, N. The future of imprisonment: Toward a punitive philosophy. *Michigan Law Review*, 72:1161-1180, 1974.

87. *Id.* at 1173 (italics supplied).

88. *Id.* at 1162.

89. 217 U.S. 349 (1910).

90. *Id.* at 367.

91. See, *e.g.*, Ralph v. Warden, 438 F.2d 786 (4th Cir. 1970), where the Fourth Circuit found a trial court's imposition of the death penalty in a rape case (where the defendant neither took nor endangered his victim's life) to run afoul of the cruel and unusual punishment clause. See also Fulwood v. Clemmer, 206 F. Supp. 370 (D.D.C. 1962), where the court found disproportionate and unconstitutional a prison disciplinary punishment of 2 years segregation for an inmate who violated a prison recreation field rule.

92. 439 F.2d 464 (D.C. Cir. 1968), *vacated on other grounds*, 439 F.2d 442 (D.C. Cir. 1970) (en banc).

93. See note 92, *supra.*

94. See note 95 *infra.*

95. 439 F.2d at 474. It is not clear whether the *Watson* panel employed the term "deter" in its general or special sense. It might have been employed to refer to punishment designed to deter *others* (general), or to punishment designed to dissuade the particular offender from repeating (special), or to both of those asserted justifications for punishment.

96. 483 F.2d 136 (4th Cir. 1973), *cert. denied*, 94 S. Ct. 1454 (1974).

97. *Id.* at 141.

98. *Id.*

99. Morrow, W.R., and Peterson, D.B. Follow-up of discharged psychiatric offenders—"Not guilty by reason of insanity" and "criminal sexual psychopaths." *Journal of Criminal Law, Criminology, and Police Science*, 57:31-34, 1966.

100. 105 Cal. Rptr. 217, 503 P.2d 921 (1972).

101. Weems v. United States, 217 U.S. 349, 367 (1910).

102. 503 P.2d at 936.

103. *Id.*

104. Morrow, W.R., and Peterson, D.B. Follow-up of discharged psychiatric offenders—"Not guilty by reason of insanity" and "criminal sexual psychopaths." *Journal of Criminal Law, Criminology, and Police Science*, 57:31-34, 1966.

105. Patuxent Institution. "Maryland's Defective Delinquency Statute: A Progress Report." January, 1973, 42 pp., p. 2 (mimeo).

106. Morris, N. The future of imprisonment: Toward a punitive philosophy. *Michigan Law Review*, 72:1161-1180, 1974, p. 1173.

107. *Id.* at 1162.

108. 406 U.S. 715 (1972).

109. *Id.* at 738 (italics supplied). See also McNeil v. Director, 407 U.S. 245 (1972), decided soon after *Jackson*, which applies *Jackson's* due process durational limit test to the context of commitments for observation at the Patuxent Institution.

110. *But see* the text accompanying note 104, where it is argued that, especially if the group of convicted sex offenders is clinically similar to the group of committed sexual psychopaths, any confinement lid established for the former group should, on various constitutional and policy grounds, be carried over to the latter group. Similarly, in discussing a confinement ceiling for a group of patients highly relevant to the present study—persons previously found not guilty by reason of insanity—Professors Robert Burt and Norval Morris make the following observation of *Jackson's* impact:

> While community protection may justify longer confinement of defendants acquitted by reason of insanity than of civil committees, these defendants do not pose a threat demonstrably greater than do convicted defendants. *Baxstrom-Jackson*, therefore, requires that confinement of defendants acquitted by reason of insanity be authorized for a period no longer than the term of imprisonment to which defendants convicted of the same offense could be subjected.

Burt, R., and Morris, N. A proposal for the abolition of the incompetency plea, *University of Chicago Law Review*, 40:66-95, 1972, p. 74 n. 30 (Of course, if the insanity defense is abolished, a consideration discussed in a later section of this monograph, the present group of insanity acquittees would, if convicted, serve a term limited by the criminal maximum).

The Burt and Morris proposal makes considerable empirical as well as theoretical sense, for insanity acquittees seem clinically similar to convicted prisoners, just as committed sexual psychopaths seem clinically similar to convicted sex offenders. Morrow, W.R., and Peterson, D.B. Follow-up of discharged psychiatric offenders—"Not guilty by reason of insanity" and "criminal sexual psychopaths." *Journal of Criminal Law, Criminology, and Police Science*, 57:31-34, 1966. If future research were to indicate that insanity acquittees and sexual psychopaths *do* pose a threat "demonstrably greater" than their convicted counterparts, due process and equal protection objections to the longer confinement of the former categories might evaporate. But if the threat posed by those groups were found to be only slightly but not considerably greater than the threat posed by the convicted categories, then, even though due process and equal protection considerations might permit a somewhat lengthier maximum term of confinement for the nonconvict groups, it would probably behoove legislatures to set equivalent lids for the convict and nonconvict groups. That is because, if the criminal maximum is departed from, the legislature will be left to grope around for another, unclear maximum for the nonconvict group. In terms of practicality and convenience, it seems sensible to avoid a groping process, particularly since, if a legislature sets a nonconvict confinement period which substantially exceeds the convict lid, a court might find that "substantial" differentiation unwarranted in the treatment of groups which differ from each other only "slightly," and constitutional problems might then again surface.

111. Thus, *if* commitments to the Ionia maximum security institution in Michigan were ordered for the purpose of treatment (as contrasted with a public protection rationale), *Jackson* might be read to strike down lengthy and indeterminate periods of confinement in light of evidence, provided in an article by Professor Grant Morris, that after 2 or 3 years at Ionia, patients lose interest and motivation and begin to regress instead of progress. Morris, G. Mental illness and criminal commitment in Michigan. *University of Michigan Journel of Law Reform*, 5:1-66, 1971, p. 44 & n. 117. Similarly, in light of evidence that the bulk of patients at the maximum

security hospital at Atascadero, California, are released after a relatively short stay, it might not be therapeutically disadvantageous to substitute a 3-year ceiling for the current indeterminate sentence operative at Atascadero. Interview with Professor George Dix, July 2, 1974 (Professor Dix spent a period of time during 1974 at Atascadero studying legal aspects of the Atascadero program).

112. Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974, pp. 1389-1394.

113. *Id.* at 1391.

114. *Id.* at 1393.

115. *Id.* at 1394 & n. 104.

115A. The term "offender" is used loosely in this section and is not necessarily restricted to individuals who have been criminally *convicted*. Some of the special "offender" statutes involve a *civil* commitment triggered only by a criminal *charge*.

116. The reader is referred to the following excellent articles which marshall the latest evidence and discuss in detail the problems of predicting dangerousness: Shah, S.A. Dangerousness and civil commitment of the mentally ill: Some public policy considerations. *American Journal of Psychiatry*, 132:501-505, 1975. Ennis, B.J., and Litwack, T.R. Psychiatry and the presumption of expertise: Flipping coins in the courtroom. *California Law Review*, 62:693-752, 1974; Shah, S.A. Some interactions of law and mental health in the handling of social deviance. *Catholic University Law Review*, 23:674-719, 1974 (especially pp. 700-712); Morris, N. The future of imprisonment: Toward a punitive philosophy. *Michigan Law Review*, 72:1161-1180, 1974 (especially pp. 1164-1173); Note. Developments in the law: Civil commitment of the mentally ill. *Harvard Law Review*, 87:1190-1406, 1974 (especially pp. 1236-1245). The above articles discuss not only our present incapacity to predict dangerousness with any accuracy, but also the point that dangerousness is largely overpredicted. Even the best efforts at prediction lead to a tremendous number of "false positives," each of which represents a person wrongfully confined because of a mistaken prediction of dangerous behavior.

117. A recent constitutional challenge to the Maryland defective delinquency law, based in part on vagueness of its commitment criteria, was taken to the Supreme Court but was dismissed by the Court without a ruling on the merits of the constitutional claim. Murel v. Baltimore City Criminal Court, 407 U.S. 355 (1972) (certiorari dismissed as improvidently granted).

118. Thus, a mentally ill person who has committed a sex offense might be civilly committed as a mental patient, might be committed as a sexual psychopath, or might be criminally convicted. *Cf.* Humphrey v. Cady, 405 U.S. 504 (1972). Similarly, a mentally deficient person involved in criminal activity could conceivably be committed as mentally ill, committed as mentally retarded, convicted criminally, or be found incompetent to stand trial. *Cf.* Jackson v. Indiana, 406 U.S. 715 (1972).

119. Patuxent Institution. "Maryland's Defective Delinquency Statute: A Progress Report." January, 1973, 42 pp., pp. 14-15 (mimeo).

120. Morris, G. Mental illness and criminal commitment in Michigan. *University of Michigan Journal of Law Reform*, 5:1-66, 1971.

121. *Id.* at 46. There is some evidence that suggests that when "special" institutions share in the commitment decision by themselves conducting the psychiatric evaluations, such institutions may, on nonclinical grounds, reject patients who are potential management problems in favor of more innocuous commitment candidates. For a description of the problem under a system formerly in operation at Atascadero, see Nasatir, M., Dezzani, D., and Silbert, M. Atascadero: Ramifications of a maximum security

treatment institution. *Issues in Criminology*, 2:29-46. 1966, p. 40. Where, however, admission criteria are vague and a *sending* institution has power to decide who shall be sent to a *receiving* institution, one can expect the problem to flow in the other direction. *Cf.* Rubin, B. "Report of Visit to Control Unit Treatment Program." Unpublished report, November 25, 1973. 10 pp., p. 4 ("troublemakers" sent to Control Unit Treatment Program). For a discussion of research needed on structural arrangements in hospital admission decisionmaking processes generally, see Wexler, D.B. Foreword: Mental health law and the movement toward voluntary treatment. *California Law Review*, 62:671-692, 1974, pp. 672-673.

122. Davy v. Sullivan, 354 F. Supp. 1320, 1326 (M.D. Ala. 1973) (Discussing the constitutionality of Alabama's sexual psychopath statute).

123. *Cf.* Specht v. Patterson, 386 U.S. 605 (1967); Humphrey v. Cady, 405 U.S. 504 (1972); Matthews v. Hardy, 420 F.2d 607 (D.C. Cir. 1969); United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969).

The lack of legal clarity in this area is attributable to the particular fact situations present in the above cases. In *Specht*, for example, an offender convicted of indecent liberties was not sentenced to a determinate 10-year prison term as he might have been, but was instead committed, without notice and hearing, to an indeterminate term pursuant to a special sex offender act. The Court found Specht's sentencing procedure to violate due process because an *additional* fact (relating to the propriety of special sex offender treatment), over and above that required for ordinary criminal sentencing, was present and necessitated a due process hearing. It is unclear from the *Specht* opinion, however, whether the "additional issue" itself required a hearing, or whether it did so only when coupled with a magnified sentence exceeding the traditional maximum criminal term. Similarly, in *Humphrey*, the Court expressed constitutional concern over a procedure whereby a defendant convicted of contributing to the delinquency of a minor—a misdemeanor punishable by a 1-year sentence—was, instead of being sentenced, committed under a sex offender law for the maximum 1-year period and *then* for a 5-year renewal period. The Court was called upon to address the propriety of the renewal and, concluding that the renewal could in no way be deemed a mere sentencing alternative, the Court expressed equal protection concern over the absence of a hearing procedure, for the period of renewal, comparable to the hearing procedure that prevails in the civil commitment area. 405 U.S. at 56. But the Court did not squarely address the question whether a hearing would be required for the *initial* commitment. Although it noted that the initial commitment, since limited in time to the maximum criminal sentence, might arguably be viewed simply as a sentencing alternative, *id.* at 510, the Court took no position on that constitutional question.

The lower court decisions are equally ambiguous. In *Schuster*, for example, the Second Circuit ruled that equal protection required a civil commitment hearing before a prisoner could be involuntarily *transferred* (not even indefinitely committed), during the course of a criminal sentence, to a mental health facility. In part, the *Schuster* court was concerned with the indignities of being transferred and with the different conditions of confinement operative at the mental institution. If those were the only facts in *Schuster*—if, for example, the *length* of confinement would not be magnified by a transfer from a correctional facility to a mental health facility—the case could perhaps be read comfortably to support the need for a hearing before one is sentenced to *treatment*, even for a term not exceeding the criminal maximum, rather than to criminal confinement. But *Schuster* is clouded by the important fact, emphasized by the court, that the parole board was known not to grant parole to transferred "patients" even if those persons would have been parole eligible had they remained in prison. Hence, *Schuster's* hearing requirement may also be limited to instances

where one is involuntarily subjected to treatment for a period possibly in *excess* of the criminal maximum.

Matthews involved facts and a legal holding substantially similar to *Schuster*, but the *Matthews* court seemed to emphasize less the possible prejudice to a transferred prisoner attributable to parole board policy and to emphasize more the additional stigma attached to mental institution confinement, the different routines and restrictions of mental facilities, and, above all, the severe psychic and emotional harm that can ensue from a person being mistakenly placed in a mental hospital. 420 F.2d at 610-611. Because of the emphasis on stigma and mistake, it is likely that the *Matthews* court would have rendered a similar ruling (requiring a hearing prior to transfer from prison to hospital) even were the term of possible confinement not subject to potential magnification by the transfer from a correctional to a mental hospital setting. Thus, *Matthews* can probably be read as a precedent from a closely analogous area supporting the right of a defendant to a hearing prior to being sentenced, even for a determinate period, as a "special" category of offender.

124. At some State prisons, no psychiatrists or psychologists are on the staff. A study which dealt in part with the lack of psychiatric services at the Arizona State Prison captured the inmate's perspective of the psychiatric void by reprinting a letter by an inmate sex offender to the University of Arizona Post-Conviction Legal Assistance Clinic, an organization which at the time was assisting the inmate in the preparation of a habeas corpus petition unrelated to the issue of psychiatric treatment. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, pp. 175-176 n. 136:

> You mentioned in your letter that you were about to complete the Writ of Habeas Corpus that you and the other students have been working on for me. I have been looking for you almost every day in regard to this, and I hope that you will soon be bringing it down.
>
> There is something that I would like to bring up, and it is this: I have been locked up now almost continually since 1957 for offenses of this nature and I would like to do something while I am incarcerated this time to help cure me of this sickness. It would be a terrible wrong to get me out of here on any kind of legal loophole if I were to just go and repeat my crimes. That would not be fair to society or to me. While I have been here I have done everything possible I know of to get mental help, but to no avail.
>
> I have had some talks with———[a nondegree prison psychologist] and he told me he thought I was in fine shape but I would like to be surer than that. It is one thing to have a few pleasant talks with an extremely overworked prison official and it is quite a different matter to go up to the State Hospital and get some kind of treatment. If it takes a couple of years so what? It would be far better to be sure than sorry. I have never, since I first got into this kind of trouble had any kind of treatment for it. All I have had were a few psychological tests to see if I was sane enough to stand trial or not. Do you think that the school could help me in this problem? I want help for this problem and I am willing to go to any length to get it. (Copyright (c) 1971 by the Arizona Board of Regents. Reprinted by permission.)

125. Professor Joseph Livermore, Law School (now Dean, University of Arizona College of Law), Professor David A. Ward, Criminal Justice Studies, Carl P. Malinquist, M.D., Department of Psychiatry, David Lykken, Ph.D., Professor of Psychology and Psychiatric Research, Department of Psychiatry, William Hausman, M.D., Department of Psychiatry.

126. For example, sex crimes are not defined with sufficient precision, the evaluation should not necessarily be conducted on an inpatient basis, the 60-day evaluation period seems rather long, the evaluating agency is given too much power with respect to the probation determination and with respect to the determination of dangerousness (which is left undefined), and the requirement that all sex offenders opting for treatment be mandatorily placed in a security facility seems too rigid. Further, unlike confined offenders, probationers are not given a choice with regard to accepting or rejecting therapy.

127. Under the Minnesota proposal, however, since the center staff is charged with conducting eligibility evaluations, there remains the possibility that an offender desiring treatment will be rejected, for nonclinical reasons, by a center staff unwilling to assume the burden of a potential management problem. See the discussion in note 121, *supra*.

128. It has been stated that incompetency to stand trial is "by far the most frequent issue leading to the hospitalization of persons in the criminal justice system." Rosenberg, A.H. Competency for trial—Who knows best?, *Criminal Law Bulletin*, 6:577-589, 1970.

129. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, p. 165; de Grazia, E. Diversion from the criminal process: The 'mental-health' experiment. *Connecticut Law Review*, 6:432-528, 1974, p. 436 n. 14.

130. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona law Review*, 13:1-259, 1971, pp. 166-167.

131. A 1965 study of patients at the Matteawan State Hospital in New York revealed that 645 of the 1,062 IST committees had been hospitalized for longer than 5 years, and one-fifth of the total had been "awaiting trial" for over 20 years. Matthews, A. *Mental Disability and the Criminal Law: A Field Study*. Chicago: American Bar Foundation, 1970. 209 pp., pp. 214-215.

132. 406 U.S. 715 (1972).

133. *Id.* at 738.

134. Though it has typically been the case, the automatic security classification of IST's is, as will be seen later, questionable and controversial.

135. de Grazia, E. Diversion from the criminal process: The 'mental-health' experiment. *Connecticut Law Review*, 6:432-528, 1974, p. 436 n. 14.

136. 406 U.S. at 738.

137. Burt, R., and Morris, N. A proposal for the abolition of the incompetency plea. *University of Chicago Law Review*, 40:66-95, 1972, p. 88.

138. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, p. 167. For a discussion of when amnesia can constitute incompetence, see *id.* at n. 105.

139. Morris, G. Mental illness and criminal commitment in Michigan. *University of Michigan Journal of Law Reform*, 5:1-66, 1971, p. 26.

140. *Id.*

141. There may be legal difficulties—although not necessarily full-blown obstacles—to the criminal prosecution of IST elopers. First of all, simply because a patient is IST does not necessarily mean that such a patient cannot be held legally responsible or that he cannot form the necessary *mens rea* for knowingly escaping or attempting to escape from an institution. *Cf.* McNeil v. Director, Patuxent Institution, 407 U.S. 245, 250-251 (1972) (patient refusing defective delinquency evaluation cannot be held

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in contempt in the absence of a due process hearing to determine whether his refusal is in fact willful and contemptuous or whether it is instead a manifestation of his mental illness for which he cannot properly be held accountable). More troubling is the problem that, even if an IST eloper can be found criminally culpable for his escape, since he is IST vis-a-vis the charge underlying his commitment, he is seemingly also IST vis-a-vis the alleged criminal escape. But his incompetence to stand trial on both those charges, it must be recalled, is hopefully only *temporary*. Under *Jackson*, he would presumably never have been committed as IST unless it appeared that, after a reasonable time, he would *regain* his competence to stand trial. And when his competence is regained and he is able to stand trial on the underlying charge, he will then also be able to be tried for his allegedly culpable escape or attempted escape.

142. Burt, R., and Morris, N. A proposal for the abolition of the incompetency plea. *University of Chicago Law Review*, 40:66-95, 1972.

143. *Id.* at 67.

144. 406 U.S. at 739-740.

145. Burt, R., and Morris, N. A proposal for the abolition of the incompetency plea. *University of Chicago Law Review*, 40:66-95, 1972, p. 78.

146. *Id.* at 70.

147. *Id.* at 71.

148. 383 U.S. 375 (1966).

149. *Id.* at 378. The discardability of the *Pate* dictum is evidenced by language in *Jackson*, where the Court, citing *Pate*, stated: "We do not read this Court's previous decisions to preclude the States from allowing, *at a minimum*, an incompetent defendant to raise certain defenses such as insufficiency of the indictment, or make certain pretrial motions through counsel." 406 U.S. at 741 (emphasis supplied).

149A. The use of the term "psychotherapy" in this and subsequent sections is unduly restrictive. Surely, therapeutic procedures beyond those of a psychotherapeutic nature might be employed to restore an incompetent defendant to competency.

150. Burt, R., and Morris, N. A proposal for the abolition of the incompetency plea. *University of Chicago Law Review*, 40:66-95, 1972, pp. 93-95. Reproduced with permission. Further reproduction prohibited without permission of copyright holder.

151. *Id.* at 70.

152. A segregation in living quarters between the two groups actually involves a trade-off between what is best for the police power patients (who presumably would, in a clinical sense, be somewhat disadvantaged by secure confinement and who might benefit from mingling with the parens patriae patients) and what is best for the parens patriae patients (who presumably would be physically and psychologically more secure by living somewhat apart from their police power counterparts).

153. See generally Wexler, D.B., and Hershey, R.A. Criminal detainers in a nutshell. *Criminal Law Bulletin*, 7:753-776, 1971.

154. Wexler, D.B., and Hershey, R.A. Criminal detainers in a nutshell. *Criminal Law Bulletin*, 7:753-776, 1971, p. 754.

155. *Id.* at 753.

156. *Id.* at 754.

157. *E.g.*, State v. Sheriff of Pima County, 97 Ariz. 42, 396 P.2d 613 (1964).

158. 393 U.S. 374 (1969).

159. The prosecuting authority might also choose simply to ignore the patient's demand for a speedy trial. In such a case, a lawyer might be able to seek a court order dismissing the outstanding charges or at least relieving the patient from the disabilities (such as special security status) attached to the detainer. Wexler, D.B., and Hershey, R.A. Criminal detainers in a nutshell. *Criminal Law Bulletin*, 7:753-776, 1971.

160 Jackson v. Indiana, 406 U.S. 715, 740 (1972).

161. *E.g.*, Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968).

162. *Id.*

163. Persons who are found NGRI might, in appropriate cases, be subsequently civilly committed pursuant to a parens patriae or a police power rationale, depending upon the particular clinical situation. But even if different durational limits are set for the two classifications (as previously urged), and even if an NGRI defendant is committed pursuant to the police power (with an authorized duration that would presumably be lengthier than would be the case with parens patriae commitments), the person committed following a verdict of NGRI should not be held for a period exceeding the maximum criminal penalty for the charged offense. See Burt, R., and Morris, N. A proposal for the abolition of the incompetency plea. *University of Chicago Law Review*, 40:66-95, 1972, p. 74 n. 30.

164. *E.g.*, Goldstein, J., and Katz, J. Abolish the "insanity defense"—why not? *Yale Law Journal*, 72:853-876, 1963. See also the section of the proposed Federal criminal code (Sec. 502) which, if enacted, would abolish the insanity defense in Federal criminal cases: "It is a defense to a prosecution under any federal statute that the defendant, as a result of mental disease or defect, lacked the state of mind required as an element of the offense charged. Mental disease or defect does not otherwise constitute a defense." S. 1400, 93rd Congress, 1st session. Note that the proposal, which is cast entirely in cognitive terms, would do away with "volitional" aspects of the existing insanity defense (such as that aspect often inappropriately referred to as "irresistable impulse"). And "cognitive" mental illness will be relevant, under the proposal, only if it serves to actually negate a required element of the *mens rea*. The proposal does not directly address the question whether evidence of "diminished capacity" not reaching levels of full-blown insanity would also be admissible to negate *mens rea*, but the proposal's use of the language "mental disease or defect" may suggest an implicit rejection of lesser "diminished capacity" type defenses.

165. National Commission on Reform of Federal Criminal Laws. *Working Papers of the National Commission on Reform of Federal Criminal Laws*, vol 1, Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1970. 724 pp., p. 251.

166. Monahan, J. Abolish the insanity defense?—not yet. *Rutgers Law Review*, 26:719-740, 1973.

167. *Id.* at 723-725. Reproduced with permission of *Rutgers Law Review;* copyright Rutgers University.

168. Wexler, D.B. Therapeutic justice. *Minnesota Law Review*, 57:289-338, 1972, pp. 309-311 (emphasis as in the original). Reproduced with permission.

169. Monahan, J. Abolish the insanity defense?—not yet. *Rutgers Law Review*, 26:719-740, 1973, pp, 721-723. Monahan's article cites a wealth of literature in support of his conclusion. (Quote reproduced with permission; copyright Rutgers University.)

170. Some of those persons, however, might escape criminal conviction by arguing successfully that, because of mental defect, they were unable to form the required criminal intent. Following their acquittal, those persons might, if their clinical conditions warrant it, be committed to mental hospitals through the civil commitment route.

171. A brief discussion of the various approaches, together with pertinent references, can be found in Wexler, D.B. Therapeutic justice. *Minnesota Law Review*, 57:289-338, 1972, pp. 308-311.

172. A discussion of the 1968 law and its defects appears in Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, pp. 154-158.

173. *Id.* at 157.

174. *Id.* at 158.

175. *E.g.*, Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968).

176. *Id.*

177. *Cf.* Olson v. Pope, No. 8361, Superior Court of Solano County, California, March 28, 1973, p. 9, where the court, in an unpublished opinion, said "despite all indications in favor of parole the record suggested that the Adult Authority [parole board] had denied parole because of the vindictive attitude of some residents of the community where the offenses were committed and that if this were established as a fact, it was tantamount to the Authority's acting on whim, caprice and rumor."

178. *Cf.* Arizona Revised Statutes Sec. 36-565(D): "The medical director of the agency shall not be held civilly liable for any acts committed by the released patients." See also Ennis, B.J. Civil liberties and mental illness. *Criminal Law Bulletin*, 7:101-127, 1971.

179. *Cf.* Bandura, A. Behavior theory and the models of man. *American Psychologist*, 29:859-869, 1974, pp. 861-862.

180. Thus, Bandura (*id.*) discusses diffusion with disapproval:

> A common dissociative practice is to obscure or distort the relationship between one's actions and the effects they cause. People will perform behavior they normally repudiate if a legitimate authority sanctions it and acknowledges responsibility for its consequences. By displacing responsibility elsewhere, participants do not hold themselves accountable for what they do and are thus spared self-prohibiting reactions. Exemption from self-censure can be facilitated additionally by diffusing responsibility for culpable behavior. Through division of labor, division of decision making, and collective action, people can contribute to detrimental practices without feeling personal responsibility of self-disapproval.

181. It is interesting to note that the scheme of jury release of NGRI's was actually proposed by Arizona hospital officials who were reluctant to release unilaterally patients who had been committed as NGRI.

182. This writer is aware of instances at the Arizona State Hospital where patients with a past history of violence have been deemed by the hospital staff to be ready for release but where the staff was reluctant to exercise its unilateral release authority. In such instances, the staff often advised the patient or the patient's counsel to seek release by petitioning the court for a hearing. At the hearing, the hospital staff would happily testify in favor of the patient's release.

183. 395 F.2d 642 (D.C. 1968).

184. *Id.* at 651.

185. *Id.* at 652.

186. See, *e.g.*, National Commission on Reform of Federal Criminal Laws. *Working Papers of the National Commission on Reform of Federal Criminal Laws*, vol. 1, Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1970. 742 pp., p. 250:

> No matter what insanity defense approach is taken, it is likely that large numbers of abnormal persons will continue to be placed in correctional institutions. . . . In view of the large numbers of persons of all personality types who will continue to be found in correctional institutions, rehabilitative efforts must be directed to mentally abnormal offenders who are placed in them.

The same report, quoting Dr. Jonas Robitscher, continues, *id*:

> [I]f psychiatric and other rehabilitation services are provided, it will not make any real difference if a disturbed person who has admittedly done an illegal act is treated in prison or in a mental hospital; in either case he will have problems of guilt, in either case he will respond—if he responds at all—only to thoroughgoing and sincere efforts to help him whether the setting is called prison or hospital.

187. See, *e.g.*, Bermanger v. State, 307 N.E. 2d 891, 897 (Ct. App. Ind. 1974) (citations omitted):

> The fact that defendant here has been sentenced and confined pursuant to a criminal penal statute rather than confined for treatment as a Criminal Sexual Deviant does not deprive him of the right to care and treatment if it be needed. Even as an inmate of a prison, he is entitled to such rehabilitative medical and psychiatric care as is indicated.

188. See University of Alabama Center for Correctional Psychology. "Minimum Mental Health Standards for the Alabama Correctional System," 1972 (mimeo).

189. *E.g.*, Matthews v. Hardy, 420 F.2d 607 (D.C. Cir. 1969); United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969). Actually, since *Matthews* and *Schuster* require such safeguards even for involuntary *transfers* (deprivations which are less onerous that full-blown *commitments*), those cases provide *a fortiori* support for the proposition that involuntary *commitments* must conform to the prescribed safeguards.

190. *Id.* Both *Matthews* and *Schuster* technically involved involuntary transfers rather than full-blown involuntary commitments, and both cases relied in part on the likelihood that, because of parole board policies, prisoners transferred to mental hospitals would serve longer terms than would be the case if they were not transferred. See the discussion in note 123, *supra*.

191. *Schuster* and particularly *Matthews* were concerned with these nonquantitative aspects of hospitalization, and it is likely that *Matthews* (and perhaps *Schuster* as well) would have reached the identical result had time-prejudice not been present. See the full discussion in note 123, *supra*. Although *Matthews* and *Schuster* relied on equal protection theory, due process considerations could independently support the constitutional necessity of some semblance of pretransfer fair procedure. See discussion in note 123, *supra* and the recent case of Clonce v. Richardson, No. 73 CV. 373-S (W.D. Mo. 1974), holding that because of the "major change in the conditions of confinement" involved in being transferred from a prison to a behavior modification program, due process requires some sort of pretransfer hearing.

192. Clonce v. Richardson, No. 73 CV. 373-S (W.D. Mo. 1974) required, on due process grounds, a hearing to authorize the transfer of a prisoner to a behavior modification program at the Medical Center for Federal Prisoners at Springfield, Missouri. Although *Clonce* involved a transfer from a prison to *another* institution—and to a mental institution at that—the court was not so much concerned with the location of the two institutions involved or with their labels, as with the fact that the transfer involved a "major change in the conditions of confinement." Since even an intra-

institutional transfer from the general prison population to a prison psychiatric unit is likely to involve major changes in the conditions of confinement, *Clonce* can easily be extended to reach that situation. *Cf.* Wolff v. McDonnell, 94 S.Ct. 2963 (1974) (recent case, relied on by *Clonce* court, requiring due process protections prior to transferring prisoner, for disciplinary reasons, from the general prison population to solitary confinement cell of the same institution). The *Clonce* and *Wolff* due process requirements, if applied to psychiatric unit transfers, could presumably be satisfied by an *administrative* hearing. The question remains open, however, whether *equal protection* considerations would mandate a *judicial*-type proceeding if such is the practice followed in the jurisdiction for ordinary civil commitment proceedings.

It should be noted that there is one often unrecognized advantage in transferring disturbed convicted offenders to prison psychiatric units rather than to units (even security units) at civil hospitals: The more that a hospital houses convicted offenders, the more reluctant the courts will be to allow disruptive *civil* patients to share those quarters. *Cf.* Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 305 N.E. 2d 903, 350 N.Y.S.2d 889 (1973) (due process violated when dangerous civil patient transferred to Matteawan, an institution housing large numbers of convicted criminal patients); Donaldson v. O'Conner, 493 F.2d 507, 511 (5th Cir. 1974) (civil patient's right to treatment denied, in part, because one-third of the patients in his ward were criminals).

193. Until recently, such was the case in Arizona. See Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, pp. 174-188.

194. *Id.*

195. The disincentive structure is discussed in the empirical study of the Arizona situation. *Id.*

196. See *id.* at 183 and n. 167 (discussing the need for voluntary admission procedures). As will be mentioned in greater detail below, Arizona's new mental health law now permits voluntary hospital admission of prisoners.

197. See Walsh v. State ex rel. Eyman, 104 Ariz. 202, 450 P.2d 392 (1969).

198. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, p. 185.

199. See People ex rel. Brown v. Herold, 29 N.Y.2d 939, 280 N.E.2d 362, 329 N.Y.S.2d 574 (1972). *Brown* involved a suit against the Director of Dannemora State Hospital, challenging the Department of Corrections' policy denying good time allowances to all mentally ill prisoners. *Brown* held the Department's policy to be violative of the statutory scheme and of the equal protection clause, at least as applied to prisoners who have not been declared legally incompetent, and who thus may be competent to weigh the risks and benefits of electing the New York good time allowance plan.

200. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, p. 185.

201. *Id.* at 186.

202. Sawyer v. Sigler, 320 F. Supp. 690 (D. Neb. 1970).

203 *E.g.*, U.S. ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969); People ex rel. Slofsky v. Agnew, 68 Misc.2d 128, 326 N.Y.S.2d 477 (Sup. Ct., Clinton Co., 1971).

204. Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, p. 186 (emphasis supplied).

205. The mechanism of parole-to-hospital is not simply a legal euphemism for parole denial. It can significantly affect the "parolee's" living conditions. In Arizona, for example,

> transferred prisoners are placed automatically in the Maximum Security Unit of the state hospital and—for security reasons—are usually retained in that unit during their entire stay at the hospital. If a prisoner-patient were granted parole, however, he would seemingly no longer constitute a "special" security or escape risk, and might well be transferred to the general hospital population, where living conditions are less restrictive and more pleasant and where chances for psychiatric recovery seem substantially greater. The possibility of leaving the Maximum Security Ward and entering the general hospital population is raised not only by the granting of parole, but also by the expiration of a transferred inmate's penal sentence—which is another reason why prisoners contemplating transfer to the hospital ought to be concerned with the computation of their "good time" credits.

Id. at 186 n. 178 (citations omitted). Copyright (c) 1971 by the Arizona Board of Regents. Reprinted by permission.

206. People ex rel. Slofsky v. Agnew, 68 Misc.2d 128, 326 N.Y.S. 2d 477 (Sup. Ct., Clinton Co., 1971).

207. See generally 326 N.Y.S.2d at 479.

208. *Id.*

209. Arizona Revised Statutes, Sec. 31-224(E)-(G). After this section was written, new legislation went into effect which substantially revamped the Arizona statute. In this writer's opinion, the new statute is less desirable than the one it replaces and much less suitable as a model for adoption elsewhere.

210. Morris, G. Mental illness and criminal commitment in Michigan. *University of Michigan Journal of Law Reform*, 5:1-66. 1971, pp. 6-18.

211. *Id.* at 15.

212. *Id.* at 16 n. 39.

213. *Id.*

214. As an original proposition, it is not at all clear that all civil patients must be treated alike (without making parens patriae and police power distinctions) for security purposes any more than they must all be treated alike for purposes of durational limits, scrutiny of the release decision, etc. Just as equal protection probably permits distinctions to be drawn between parens patriae and police power patients concerning length of confinement and release procedures, it might also permit security distinctions to be drawn. Parens patriae patients could, for example, be rebuttably presumed to require little security, and police power patients could be rebuttably presumed to require some degree of security. Thus far, however, the courts have not distinguished for security purposes between subgroups of civil patients. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969) (State must prove need for security even in case of police power patient); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973) (assaultive civil patient should not be transferred to facility for criminally insane; purpose of civil commitment—even regarding police power patients—is therapeutic, not the protection of the public). Courts *have*, however, distinguished between civil patients as a whole and so-called "criminal" patients. And one court has come close to bridging the gap by distinguishing, for security purposes, between civil patients and *convicted criminals* who are *civilly* committed to the hospital. United States *ex rel.* Schuster v. Herold, 410 F.2d 1071, 1084 (2d Cir. 1969):

> Thus, our decision today does not mean that all distinctions between civilian and prisoner patients must be swept aside. We do say that prisoner patients are entitled to *substantially* the same safeguards afforded non-prisoners before

commitment. For example, Sec. 85 of the Mental Hygiene Law provides that before being committed to Matteawan, there must be a judicial determination that the individual to be committed is dangerous to himself and others. Such a procedure may not be appropriate for a prisoner because the additional security facilities of Matteawan or Dannemora might be thought necessary to confine convicts with sentences still to serve, who may be more prone to escape from a hospital than civilians.

215. Seemingly, one factor contributing to the conclusion in Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974) that a parens patriae patient had been denied the right to treatment was his confinement with, and legitimate fear of, many dangerous patients. *Id.* at 511. Patients often fear "crawlers" and "creepers"—inmates who assault sleeping patients.

216. See Power v. United States, 152 F. Supp. 872 (D.Mass. 1957), where the administratrix of Power's estate brought suit against the United States because Power, a patient in a Veterans Administration psychiatric facility, was killed by McGowan, another patient. The Government won a dismissal, but presumably only because (*id.* at 874)

> McGowan, who caused Power's death, had never demonstrated qualities of assaultiveness or belligerence prior to this occurrence. Certainly it was not to be reasonably foreseen that he was the type of patient who would strike another patient and thereby cause serious injury or death. . . .

217. See New York State Association for Retarded Children v. Rockefeller, 357 F. Supp. 752, 764 (E.D.N.Y. 1973), where the court ordered the hiring of additional staff to relieve the problem of inter-resident assaults, and where the court recognized that "one of the basic [constitutional] rights of a person in confinement is protection from assaults by fellow inmates. . . ." Another remedy likely to reduce assaults would be the increased availability of private rooms for residents. See generally Note. Eighth amendment rights of prisoners: Adequate medical care and protection from the violence of fellow inmates. *Notre Dame Lawyer*, 49:454-469, 1973.

218. Note. Eighth amendment rights of prisoners: Adequate medical care and protection from the violence of fellow inmates. *Notre Dame Lawyer*, 49:454-469, 1973.

219. Although certain *pre*-commitment acts should be taken into account in determining security status, the decision to place a particular patient in a secure facility should, in this writer's view, be made by an administrative body (to be discussed more fully *infra*) after commitment, and should not be made at the time of commitment by the *commitment court itself.* In that regard, consider the following discussion of the problem relating to the Arizona State Hospital

> The SCC [Special Classification Committee] is sometimes baffled by civil commitment orders containing language to the effect that the patient is "to be held in the Maximum Security Ward." A problem arises when the SCC is faced with a patient's request to transfer out of Maximum Security and at the same time with a commitment order containing the above language. In such a case the SCC does not know whether it is bound to follow the order—in which case it is easier to discharge the patient than to change his ward—or whether the committing court has exceeded its authority, in which case the SCC could, with legal impunity, disregard the superfluous language if it felt treatment could be appropriately carried on in a ward other than Maximum Security. Since the pertinent statute speaks merely of ordering a patient confined in the state hospital, Ariz. Rev. Stat. Ann. Sec. 36-514(C) (Supp. 1970-71), the latter course of action by the SCC would seem permissible. In any case, committing courts should refrain from attempting to tie the hospital's hands with respect to the appropriate ward of confinement. This is particularly so in view of the fact that few judges are sufficiently acquainted with the facilities of the hospital to recognize, for example, that tight security is available not only in the Maximum Security Unit (Encanto Hall), but also in a slightly less restrictive ward (Hermosa Hall), and that even the general population wards do not grant grounds privileges to all patients.

Wexler, D.B., and Scoville, S.E. The administration of psychiatric justice: Theory and practice in Arizona. *Arizona Law Review*, 13:1-259, 1971, p. 219 n. 30, Copyright (c) 1971 by the Arizona Board of Regents. Reprinted by permission.

220. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 305 N.E. 2d 903, 350 N.Y.S. 2d 889 (1973).

221. 440 F.2d 249 (D.C. Cir. 1971).

222. *Id.* at 251. The potential for confusion is apparent since, in this context, it is often difficult to distinguish "medical" from "nonmedical" considerations, and the exception might therefore swallow the rule.

223. *Id.* at 251 n. 4.

224. *E.g.*, Clonce v. Richardson, No. 73 CV. 373-S (W.D. Mo. 1974).

225. *Id.* at 251-252 (citations omitted). Note that an earlier case in the District of Columbia Circuit, Williams v. Robinson, 432 F.2d 637 (D.C. Cir. 1970) had recognized that due process requires that a patient prior to transfer (or, in emergencies, soon after transfer) be given an apportunity to test the evidence against him and to present his side of the case. *Jones* filled in the particulars of what that opportunity ought to entail. The main thrust of *Williams* (reaffirmed in point 6 of the *Jones* standards) related to the scope of judicial review of a hospital's administrative decision to transfer a patient. *Willaims* asserts that, if hospital officials wish to avoid broad judicial review and time-consuming court battles, hospitals must maintain adequate records which, on their face, indicate that a reasonable administrative decision has been reasonably arrived at. As the court in *Williams* put it, 432 F.2d at 643:

> Given mechanisms adequate to insure a complaining patient a fair opportunity to place facts and arguments supporting his position in the administrative record, we might well be able to conclude that the patient, as well as the hospital, could be bound by the record made in the administrative proceedings. If so, the process of judicial review would be greatly simplified and the burden on doctors and hospital administrators, who would no longer be required to come to testify in court on these proceedings, would be substantially reduced.

226. 94 S. Ct. 2963 (1974).

227. The latter point is probably covered by *Jones*, although a literal reading of *Jones'* requirement number 3 might lead to the conclusion that a patient could in some cases be allowed only to respond in writing to the allegations in the interview memoranda.

228. 94 S. Ct. at 2981.

229. Clonce v. Richardson, No. 73 CV. 373-S (W.D. Mo. 1974).

230. *But cf.* Negron v. Prieser, No 74 Civ. 1480 (S.D.N.Y. 1974), recognizing that there may be reason for treating "medical" security decisions with fewer safeguards than "disciplinary" security decisions. *Negron* may therefore be at odds with *Clonce.*

While the conclusion of *Clonce* seems sound, there is some analytical difficulty in determining whether the *Clonce* case itself was an appropriate vehicle for announcing the result reached by the court. The petitioners in *Clonce* actually raised two separate claims: that the severe restrictions involved in the Springfield behavior modification program (the START program) violated *substantive* constitutional guarantees, and that the summary process of involuntary transfer into the program violated *procedural* due process. Because the START program was terminated during the course of the litigation, and because there was no evidence that contemplated future programs would involve identical deprivations, the court in *Clonce* dismissed the substantive issues as moot, and thus did not attempt to reach the merits of the substantive constitutional claim. But the court in *Clonce* did reach the procedural question, and held that, since the transfer involved a "major change in the conditions of confinement," due process requires an accompanying fair hearing. One wonders, however, why the *Clonce* court did not similarly hold the procedural matter moot, for if a hearing is required only if a "major change" in confinement conditions is involved, there is no reason to assume that future Federal behavior modification programs will involve the severe deprivations (major changes in confinement conditions) that were present in the terminated START program. The mootness issue, therefore, should perhaps have been addressed as a whole, and should not have been split into substantive and procedural components yielding differing results.

Note, too, that although the *Clonce* court technically did not address the substantive merits of the START deprivations, the court in effect assumed, for the purposes of argument, that those deprivations did not amount to a constitutional violation, and that they therefore could be involuntarily thrust on prisoners as long as the prisoners were provided a procedural due process hearing. If, however, the START deprivations amounted to a substantive constitutional violation, and if inmates could therefore be involuntarily subjected only to behavior modification transfers that did not rise to a constitutional level of deprivation, one wonders whether such transfers would be viewed as entailing a sufficiently "major" change in the conditions of confinement to trigger under *Clonce* a procedural due process right to a prior hearing. The unresolved question would be posed by the hypothetical transfer of inmates from a prison where living conditions *exceed* constitutional minima to a behavior modification program where, as a matter of right, conditions of confinement conform only to bare, minimal constitutional requirements, other amenities being available only as reinforcers to be earned. *Cf.* Wexler, D.B. Of rights and reinforcers. *San Diego Law Review*, 11:957-971, 1974, p. 969; Wexler, D.B. Token and taboo: Behavior modification, token economies, and the law. *California Law Review*, 61:81-109, 1973.

231. Morris, G. Mental illness and criminal commitment in Michigan. *University of Michigan Journal of Law Reform*, 5:1-66, 1971, p. 14.

232. Wexler, D.B. Dicta. *Virginia Law Weekly*, February 28, 1975, p. 4.

233. *Id.* at 2.

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DHEW Publication No. (ADM) 76-331
Printed 1976

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