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Corrections Law: The Supreme Court and Treatment in Correctional and Forensic Mental Health Facilities: Recent Trends and Decisions

By Michael L. Perlin*

On a Perry Mason rerun on TV the other night, there was a scene in a darkroom. Paul Drake (Perry’s original investigator) had taken a picture of a crime scene, and was developing the negative. Forms and shapes began to emerge slowly as the blank piece of developing paper “came alive,” and, eventually, the viewer was able to see the completed picture (which, needless to say, gave Perry a clue that no one else saw). The image serves as a defining metaphor for this topic: recent trends in mental health law from a legal perspective: The United States Supreme Court continues, bit by bit, partial image by partial image, to fill in pieces of a multidimensional puzzle.

This puzzle has many subcomponents: the extent of the civil and constitutional rights that are owed mentally disabled individuals facing the involuntary civil commitment process; the rights owed to such persons during institutionalization; the rights owed upon release from psychiatric facilities; the rights owed such persons when they are awaiting trial in jail or following sentence to penal facilities; the impact that mental disability has on the criminal trial process (as to such questions as the admissibility of confessions made by severely mentally disabled individuals, the application of the privilege against self-incrimination to pretrial psychiatric interviews, the right to access to expert witnesses to assist in trial preparation); the limits of legal regulation of mental health providers; the ways that courts assess privilege and/or subordinate mental health professional expertise during the trial process; the constitutional limitations on incompetency to stand trial and insanity defense proceedings; and the role of mental disability in capital punishment decision making.

Each year, additional pieces of this puzzle are filled in.¹ Sometimes, the impact of the real world on clinicians and forensic mental health professionals is fairly clear; sometimes, it is murkier.² Over the years, certain


baseline principles become “burned in” in a way that clarifies some of the Court’s core values; for example, the Court, it is now clear, believes that the standard of proof in an involuntary civil commitment case is higher than in a “typical” civil case but lower than in a criminal case.\(^3\) Other gaps remain, leading us to ponder how the Court would decide a case with a certain fact pattern if only it were to be presented: for example, an issue that the Court will deal with this term, the constitutionality of employing a different burden of proof in cases involving the involuntary civil commitment of mentally ill persons from that used in cases involving mentally retarded persons.\(^4\)

In other areas, one can only speculate. Although the Court has dealt on the merits with questions involving the right of prisoners and of criminal defendants awaiting trial to refuse treatment,\(^5\) it has sidestepped the same question when it arose in a case involving civil patients,\(^6\) and has shown no inclination to return to it. While it has found that juveniles are entitled to fewer procedural due process rights at involuntary civil commitment hearings than are adults,\(^7\) it has never considered the important question of the scope of rights due to individuals facing, for example, outpatient commitment.\(^8\) Whether the court will ever choose to address these questions is simply anybody’s guess.

Yet, in the past four years, the Supreme Court has chosen to decide five important mental disability law cases that have a potentially significant impact on both clinicians and forensic witnesses. Each of these cases is briefly discussed and its potential impact on the constitutional rights owed to individuals institutionalized in correctional and forensic mental health facilities is appraised as well as the potential liability of providers if these rights are violated.\(^9\)


\(^4\) After the presentation of this paper, the Supreme Court decided, in Heller v. Doe, 113 S. Ct. 2637 (1993), that such a differing burden of proof did not violate the equal protection clause. See 1 Perlin, note 1 supra, § 3.39A (1994 pocket part); Michael L. Perlin, The Law and Mental Disability § 1.24 (1994).


\(^8\) See, e.g., 1 Perlin, note 1 supra, § 3.78.

One preliminary observation—the notion of “criminalization of the mentally ill”—may not be helpful in resolving these issues. The best empirical research rebuts the notions that deinstitutionalization has had much of a significant impact on “criminalization” and that deinstitutionalization has led to the overuse of the incompetency-to-stand-trial process as a means of dealing with nuisance offenders, and suggests that, while mentally ill persons are frequently treated more poorly in many aspects of the correctional system than are nonmentally ill persons, the link to deinstitutionalization policies is simply not there. 10

The Supreme Court Cases

In 1990, the Supreme Court turned to mental disability law questions on two separate occasions. In one decision, it considered for the first time on the merits of the question of the right of an institutionalized population to refuse the involuntary administration of psychotropic medication; in the other, it turned for the first time to the question of the constitutional limitations that could be placed on the voluntary commitment process.

Washington v. Harper

In Washington v. Harper, 11 the court answered the question of whether a convicted prisoner could be forcibly medicated against his will. Here, the court found that the due process clause applied to institutional medication decision making, on the theory that prisoners possessed a “significant liberty interest” in avoiding the unwanted administration of such drugs. 12 On the other hand, the need to consider prison safety and security led it to uphold a state regulation limiting the prisoner’s right, as the regulation was “reasonably related to legitimate penological interests.” 13 While the question of drug side effects was a factor to consider, the Court chose to focus instead on the “needs of the institution,” including the “safety of prison staff’s and administrative personnel” and the “duty to take reasonable measures for the prisoners’ own safety.” 14

While providing the prisoner with a limited remedy, the majority in Harper selectively chose to stress those aspects of the data available on the effects of antipsychotic drugs that discussed the benefits of such medication, while at the same time acknowledging but discounting the harmful and debilitating effects of these drugs. 15 Harper thus accommo-


11 494 U.S. 210 (1990); see generally, 2 Perlin, note 1 supra, § 5.64A (1994 pocket part); Perlin, note 4 supra, § 2.22.

12 Harper, 494 U.S. at 222.

13 Id.

14 Id. at 223–224.

15 See Harper, 494 U.S. at 240 n.5 (Stevens, J., concurring in part & dissenting in part):

The Court relies heavily on the Brief filed by the American Psychiatric Association et al. and the Washington State Psychiatric Association . . . to discount the severity of these
dated social science evidence with an important strand of the Supreme Court's penological jurisprudence: "Prison security concerns will, virtually without exception, trump individual autonomy interests."  

Zinermon v. Burch

In the other 1990 case, Zinermon v. Burch, the Court looked at an entirely different issue: the interplay between Section 1983 civil rights remedies and the voluntary hospital admissions process. Put simply, Zinermon held that a voluntary patient could proceed with a civil rights damages action under 42 U.S.C. § 1983 against state hospital officials where he charged that those officials should have known that he was incompetent to voluntarily commit himself to the hospital at the time he signed voluntary admission forms.

However, medical findings discussed in other briefs support conclusions of the Washington Supreme Court and challenge the reliability of the Psychiatrists' Brief.

Compare e.g., id. at 230 (majority relies on Psychiatrists' Brief for proposition that tardive dyskinesia is found in 10 to 25 percent of hospitalized patients), to id. at 239 n.5 (Stevens, J., concurring in part & dissenting in part) (chances greater than one in four of patient developing tardive dyskinesia, and rate is increasing).

In Harper, both the state and the defense submitted studies discussing drug side effects. While both sets of studies acknowledged the side effects' seriousness, they disagreed on how pervasive they were in institutional populations. See id. at 229.

16 See Perlin & Dorfman, note 9 supra, at 57.
19 Zinermon, 494 U.S. at 118, 119.
20 Id. at 118–120.
21 Id. at 127–130.
22 Id. at 138–139.
23 Id. at 134–137.
24 Id. at 130–139.
25 Id. at 132–135.
issues—notes that "the very nature of mental illness" makes it "foreseeable" that such a person "will be unable to understand any preferred 'explanation and disclosure of the subject matter' of the forms that a person is asked to sign, and will be unable 'to make a knowing and willful decision' whether to consent to admission." 27

Mental illness, he added, created "special problems" regarding informed consent, suggesting that the state might not be justified in "taking at face value" a mentally ill person's request for admission and treatment at a mental hospital. 28 As a person incapable of making an informed decision is similarly likely to be unable to benefit from a voluntary patient's right to request discharge, 29 such a person would be in danger of being confined indefinitely without benefit of the procedural safeguards inherent in the involuntary placement process. 30

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28 Zinermon, 494 U.S. at 133 n.18.


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30 Zinermon, 494 U.S. at 133.


32 Riggins, 112 S. Ct. at 1812.

33 See id. at 1816 (800 mgs. within the "toxic range"); see also, id. at 1819 (Kennedy, J., concurring) (expert testified that 800 mgs. was a sufficient dosage to "tranquilize an elephant"). Other experts testified that the drug could make the defendant "uptight," or could cause "drowsiness or confusion"; as amicus, the American Psychiatric Association stated that, in extreme cases, the sedative properties of the drug might even "affect thought processes." Id. at 1816.
ry that, as he was professing an insanity defense, he had a right to have
the jury see him in "his true mental state." After hearing conflicting ex-
pert testimony, the trial judge de-
nied defendant's motion.

Defendant presented an insanity
defense at trial, and testified that
"voices in his head" had told him that
killing the victim would be justifiable
homicide. He was found guilty and
sentenced to death. On appeal, the
Supreme Court, in 1992, reversed.
While it presumed that the adminis-
tration of the drugs was "medically
appropriate," it weighed whether
that administration, nevertheless, de-
prived the defendant of a fair trial.
In answering this question, it turned
first to the conclusion in *Harper*
that "the forcible injection of medication
into a nonconsenting person's body
represents a substantial interference
with that person's liberty," and fo-
cused on *Harper*'s discussion of such
drugs' side effects. As *Harper*
found forced drugging of a convicted
prisoner impermissible absent a find-
ing of overriding justification, a pretrial
detainee (such as Riggins) would be entitled to "at least as much
protection."

Although the Court did not set
down a bright-line test articulating
the state's burden in sustaining forced
drugging of a detainee at trial, it
found that this burden would be met
had the state demonstrated medical
appropriateness and consideration of
less intrusive alternatives, either (1)
"essential for the sake of Riggins'
own safety or the safety of others,", or (2) a lack of less intrusive means
by which to obtain an adjudication of
the defendant's guilt or innocence.
It noted further that it was *not*
declining whether a *competent*
criminal defendant could refuse drugs if the ces-
sation of such medications would
make him incompetent to stand trial.
The error below may well have
impaired the defendant's trial rights,
the majority found. The drugs' side

41 Riggins, 112 S. Ct. at 1814 (quoting
*Harper*, 494 U.S. at 229).
42 See *Riggins*, 112 S. Ct. at 1814-
1815 (quoting *Harper*, 494 U.S. at 229-
230).
43 *Riggins*, 112 S. Ct. at 1815.
44 Id. (citing *Bell v. Wolfish*, 441 U.S.
520, 545 (1979); *O' Lone v. Estate of
45 *Riggins*, 112 S. Ct. at 1815.
46 Id. Questions involving the compe-
tency determination process are dis-
cussed in United States v. Charters, 863
F.2d 302 (4th Cir. 1988), cert. denied,
494 U.S. 1016 (1990); see generally,
Michael L. Perlin, "Are Courts Compe-
tent to Decide Competency Questions?
Stripping the Facade from *United
States v. Charters*," 38 U. Kan. L. Rev. 957
effects might have affected not just the defendant's outward appearance, but also "the content of his testimony . . . , his ability to follow the proceedings, or the substance of his communication with counsel." Finally, it concluded that allowing the defendant to present expert testimony to explain the side effects could not possibly be curative of the possibility that defendant's own testimony, his interaction with counsel, or his trial comprehension were compromised by the drugs, and even with this testimonial assistance, an "unacceptable risk of prejudice remained."

Justice Kennedy (the author of *Harper*) concurred, taking a stronger antidrugging position than did the majority. Focusing carefully and extensively on the potential for side effects, he wrote that he would not allow the use of antipsychotic medication to make a defendant competent to stand trial "absent an extraordinary showing" on the state's part, and noted further that he doubted this showing could be made "given our present understanding of the properties of these drugs." In discussing the side effects, Justice Kennedy concentrated on their potential impact on defendant's fair trial rights, their alteration of his demeanor in a way that "will prejudice his reactions and presentation in the courtroom," and their rendering him "unable or unwilling" to assist counsel. If the medication inhibits the defendant's capacity to react to the proceedings and to demonstrate "remorse or compassion," the prejudice suffered by defendant can be especially acute at the sentencing stage.

Coming so soon after the decision in *Harper, Riggins* is somewhat surprising. It differs importantly from *Harper* in that the court treated *Harper* as a prison security case, while it read *Riggins* as a fair trial case; yet, this difference in the litigants' legal status self-evidently has no effect on the physiological or neurological potential impact of the drugs in question. Nevertheless, the side-effects language in *Harper* (subordinated there because of security reasons) is emphasized in *Riggins* (where such issues are absent) by nature of the Court's consideration of the question in the context of a fair trial question. *Riggins'* use of "less intrusive alternatives" language is especially surprising. Since the Supreme Court chose to bypass this construction in *Youngberg v. Romeo* and to use in its place the phrase "reasonably non-restrictive confinement conditions" as part of its articulation of a "substantial professional judgment" test, it has appeared that there was simply no place for this doctrine in mental disability law. *Riggins* has given it new life in the context of a criminal case, and it will thus be necessary for litigators and judges to


52 See Perlin & Dorfman, note 9 supra, at 57-58.

53 Compare *Riggins*, 112 S. Ct. at 1819 (Kennedy, J., concurring), stressing "litigational" side effects.


55 Id. at 324; see generally 2 Perlin, note 1 supra, § 4.36.

56 *Youngberg*, 457 U.S. at 322-323; see generally 2 Perlin, note 1 supra, § 4.35.

rethink the potential reapplication of the "less intrusive means" or "least restrictive alternative" test in subsequent federal constitutional litigation.58

Foucha v. Louisiana

_Foucha v. Louisiana_, the second 1992 case, presented an appeal from a state case that had upheld the continued postinsanity acquittal of a defendant who had been found to be no longer mentally ill but who might potentially still be dangerous.59 At the hearing below, no expert had testified "positively" that Foucha would be a danger if he were to be released; one witness stated, "I don't think I would feel comfortable in certifying that he was not a danger to himself or to other people."60

In a sharply split opinion, the Supreme Court, per Justice White, reversed. Since the basis for holding Foucha in a hospital as an insanity acquittee had disappeared, the Court found the state could no longer hold him on that basis,61 relying on its opinion in _O'Connor v. Donaldson_62 for the proposition that, once the basis for a constitutionally permissible commitment disappeared, an individual could no longer be institutionalized.

It rejected on three different bases the state's argument that Foucha's antipersonality diagnosis provided a permissible rationale for further institutionalization. First, Foucha could not be civilly committed as currently mentally ill and dangerous, since antisocial personality disorder is not viewed as a "mental illness."63 Second, the Court found that if he could no longer be held as an insanity acquittee, he was entitled to constitutionally adequate procedures to establish permissible grounds for his confinement.64 Finally, stressing the "fundamental nature" of the individual's "right to liberty,"65 the Court concluded that Foucha—who had never been convicted of a crime—could not be punished.66 The state had _not_ shown, by clear and convincing evidence, that the defendant was mentally ill and dangerous, and Foucha could thus no longer be kept institutionalized; the testimony adduced below was an insufficient basis for such a finding.67

Justice O'Connor concurred, and Justice Kennedy dissented in an opinion joined by the Chief Justice, arguing that, notwithstanding the jury's verdict of not guilty by reason of insanity in Foucha's underlying criminal trial, the case did not differ substantially from one in which a defendant had been convicted of the precedent crime, and that earlier civil cases relied on by the majority (such as _O'Connor_ and _Addington v. Tex._)

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58 See M. Perlin, "Law as a Therapeutic and Anti-Therapeutic Agent" (paper presented at the Massachusetts Department of Mental Health's Division of Forensic Mental Health's annual conference, Auburn, Mass. (May 1992), at 9 (discussing these implications of Riggins)).


60 _Foucha_, 112 S. Ct. at 1786.

61 _Id._ at 1784.

62 422 U.S. 563, 574-575 (1975); see 1 Perlin, note 1 supra, § 2.12.

63 _Foucha_, 112 S. Ct. at 1784-1785.

64 _Id._ at 1785.


66 _Foucha_, 112 S. Ct. at 1785 (citing Jones v. United States, 463 U.S. 354, 369 (1983)).

67 _Foucha_, 112 S. Ct. at 1786.
as) should thus be inapplicable,\(^{69}\) characterizing the distinction between a "not guilty by reason of insanity" (NGRI) and a "guilty but mentally ill" (GBMI) verdict as a trivial "choice of nomenclature."\(^{70}\)

Justice Thomas also dissented in an opinion joined by the Chief Justice and Justice Scalia. He focused at some length on the possibility of "calculated abuse of the insanity defense" by defendants who might feign the plea, and speculated as to how the public might react to the specter of a "serial killer... returned to the streets immediately after trial."\(^{71}\)

Medina v. California

The final 1992 Supreme Court case, Medina v. California,\(^{72}\) dealt with what might appear at first blush simply a narrow legal question: whether placement of the burden of proof on the defendant at an incompetency to stand trial proceeding violates due process. However, this case also has potentially important implications for forensic witnesses and clinicians.

Medina was jailed after being arrested on multiple murder counts. His counsel moved for a competency hearing on the grounds that he was unsure whether the defendant had the ability to participate in the proceedings.\(^{73}\) Medina was found competent based on a local statute that the defendant bore the burden of proof to show incompetency.\(^{74}\) He was tried, convicted, and sentenced to death.\(^{75}\) On appeal, the Supreme Court affirmed.\(^{76}\)

It rejected defendant's argument that fundamental fairness required that the burden of proof be allocated to the state.\(^{77}\) On the other hand, it conceded that an impaired defendant might be limited in his ability to assist counsel in demonstrating incompetence, although that inability, by itself, might constitute probative evidence of incompetence, noting further that defense counsel will often have "the best informed view" of the defendant's ability to participate in his defense.\(^{78}\)

Justice O'Connor concurred (on behalf of herself and Justice Souter), expressing concern that defendants will feign incompetence, and that the placement of the burden on the defendant may have a prophylactic effect by ensuring that the greatest amount of available information as to the defendant's mental condition is before the court.\(^{79}\)

Justice Blackmun dissented (on behalf of himself and Justice Stevens). He stressed language in Drope v. Missouri that the right to be tried while competent is "fundamental" to the adversary system of justice,\(^{80}\) and added that the right to be tried while competent was the "foundational right" for the effective exercise of all other criminal trial process rights.\(^{81}\)

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\(^{68}\) 441 U.S. 418 (1979) (clear and convincing evidence required burden of proof in civil commitment hearing).

\(^{69}\) Foucha, 112 S. Ct. at 1793-1794 (Kennedy, J., dissenting).

\(^{70}\) Id. at 1793.

\(^{71}\) Id. at 1801-1802; see also id. at 1797 (Kennedy, J., dissenting).

\(^{72}\) 112 S. Ct. 2572 (1992); see generally 3 Perlin, note 1 supra, § 14.05A (1994 pocket part); Perlin, note 4 supra, § 4.06.

\(^{73}\) Id. at 2574.
The fact that, in cases where the evidence is inconclusive, a defendant may be subjected to trial introduces a "systematic and unacceptably high risk" that persons will be tried and convicted "who are unable to follow or participate in the proceedings determining their fate." In addition, Justice Blackmun concluded that the court's confidence in defense counsel's role was misplaced. First, the state generally has much better direct access to pretrial defendants, especially those like Medina who awaited trial under locked psychiatric security observation. Second, psychiatric testimony is generally dispositive at competency hearings; in over 90 percent of cases, courts agree with expert conclusions. Experts' opinions are thus generally privileged over those of trial counsel.

The Impact of the Cases

As a result of these cases, one can be fairly sure about the following propositions. First, persons who are not mentally ill can no longer be constitutionally detained in forensic mental health facilities. This holding of Foucha seems to be crystal clear and nonnegotiable (unless, of course, there is a change in personnel on the Court, and the new Court chooses to consider the issue once again).

Second, any decision to medicate a defendant awaiting trial must be thought out very carefully, and the entire question of drugging-to-make competent needs to be carefully reexamined. While the Riggins case did not address this latter question (since it was not preserved correctly on appeal), the majority's language (and the even more emphatic concurring opinion by Justice Kennedy) clarifies the Court's concern about this entire area.

Third, there can no longer be any question that procedural due process protections apply to institutional drugging questions. Even though the plaintiff in Harper was unsuccessful, the principles embedded in the case were employed by the court to find in Riggins' favor. Also, it is axiomatic that civil patients cannot have fewer constitutional rights than convicted prisoners, so it seems that Harper is the final word on the debate over whether or not a constitutional right to refuse applies to civil hospitals. It clearly does.

Fourth, there is now no longer any question that the Section 1983 civil rights relief is available as a litigation tool to individuals seeking to challenge the legitimacy of their confinement, no matter what their commitment category. Zinermon clarifies this, and it is inconceivable to me that a lower court might reject this finding in a case involving a person facing involuntary civil commitment.

It is possible that Medina may result in an increased number of seriously mentally ill persons in jails and prisons. If the decision's result is that fewer "borderline" defendants (borderline in the lay sense, not in the Diagnostic and Statistical Manual sense) are found incompetent to stand trial, then it is likely that they will be tried, convicted, and imprisoned. This may, in time, make institutional management of correctional facilities more difficult.

Perhaps the most revealing aspect of Medina is Justice O'Connor's concurrence. O'Connor, who wrote the majority in Riggins, focuses on her major concern and rationale: that defendants may seek to feign incompetency to stand trial, and that placement of the burden of proof on the defendant may lessen the likelihood of such a defendant's success. This "fear of feigning" is reflected both in Justice Kennedy's and Justice Thomas's dissents in Foucha as well,
and remains one of the dominating principles of the Supreme Court's jurisprudence in his area, in spite of uncontradicted evidence that such malingering is statistically rare and virtually never successful in practice.

Foucha may result in states amending statutes to define "mental illness" so as to include antisocial personality disorder, which was Terry Foucha's diagnosis. The dilemma here is an interesting one: Many states, such as Louisiana, amended their insanity defense statutes to make sure that Anti-Social Personality Disorder (ASPD) defendants could not avail themselves of an insanity plea. Was the state "hoist by its own petard" in Foucha? Will legislatures now feel that the risk of an occasional extra insanity acquittee is less troubling than the risk that a dangerous individual might be released from all custodial restraints?

Will Foucha lead to the creation of an intermediate type of facility for "dangerous-but-no-longer-mentally-ill" individuals? Would the creation of such a facility be constitutionally permissible? Is Foucha—who had been involved in several altercations with other patients while institutionalized—excused, by reason of the NGRI verdict, from taking responsibility for what would otherwise be considered criminal acts committed at a forensic facility? Does it make sense to prosecute such cases?

What will be the fallout of Justice Thomas's focus on the worst fears about insanity acquittees—that they "faked" the insanity defense in the first place and that the improper use of the defense will allow for the speedy release of serial killers? His opinion profoundly demonstrates the degree to which judges can distort social science evidence. Again, the empirical data is clear that the insanity defense is rarely feigned, that such attempts are invariably "seen through" by fact finders, and that "successful" acquittees are generally institutionalized in maximum security facilities for far longer periods than they would have been incarcerated in penal facilities had they been convicted of the predicate crimes. His reference to "serial killers" is even more perplexing here, given the fact that Foucha's underlying charges were burglary and firearms offenses.

Harper and Riggins together may lead to more right to refuse litigation being brought by "other populations": Defendants awaiting incompetency to stand trial determinations; defendants found permanently incompetent to stand trial under Jackson v. Indiana, defendants found NGRI. Riggins may also lead to a closer look at all questions involving the involuntary administration of medication in jails, and may even begin to stem the ten-year exodus of right-to-refuse-treatment cases from federal court to state courts.

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84 See generally Perlin, "Myths," note 34 supra; Perlin, Jurisprudence, note 34 supra.

85 See e.g., David Schretlen & Hal Arkowitz, "A Psychological Test Battery to Detect Prison Inmates Who Fake Insanity or Mental Retardation," 8 Behav. Sci. & L. 75 (1990) (92 to 95 percent of all subjects correctly classified as either faking or not faking).

86 See Foucha, 112 S. Ct. at 1782-1783.
Finally, Zinermon may lead the states to mandate some sort of due process hearing prior to the acceptance of any voluntary application for admissions. New Jersey, for instance, has amended its court rules to provide for hearings when a patient wishes to convert from voluntary to involuntary status. Will such hearings simply be, in former Chief Justice Burger’s famous phrase, “time-consuming procedural minuets”; will they serve to insulate clinicians from constitutional tort liability; or will they serve as a meaningful check to make sure that individuals like the plaintiff in Zinermon—who thought he was signing himself into “heaven”—not be improperly admitted to psychiatric hospitals without some measure of due process?

None of this will have any impact if mentally disabled individuals are not afforded adequate counsel both in civil and criminal matters. The majority opinion in Medina, for example, seems to be silently premised on the faulty assumption that adequate counsel is available to defendants seeking to contest their trial competency. All empirical surveys with the Right to a Fair Trial,” 17 Newsletter Am. Acad. Psychiatry & L. 81, 82 (1992).

92 In such cases, “the court shall hold a hearing within twenty days to determine whether the patient had the capacity to make an informed decision to convert to voluntary status and whether the decision was made knowingly and voluntarily,” providing that counsel “previously appointed” shall represent the patient at such a hearing. N.J. Ct. R. 4:74-7(g)(l) (1990).


...have concluded that this is simply not so, and that counsel made available to mentally disabled criminal defendants is regularly substandard. The quality of counsel remains the single most important factor in the disposition of cases involving mentally disabled criminal defendants, and where this counsel is absent, the results are predictable. The fact that thirteen years after the court’s decision in Jackson, almost half of the states had failed to implement it bespeaks the inadequacy of counsel in this area.

Impact on Correctional Mental Health Services

A brief summary of the expected impact of these cases on two specific questions is in order: the extent of the constitutional rights owed to individuals institutionalized in correctional mental health facilities, and the potential liability of providers if these rights are violated.

First, nothing in any of these cases deals directly with the issue resolved by the Supreme Court in 1976 in Estelle v. Gamble—that the government is obligated to provide medical care to those it incarcerates.


95 See 2 Perlin, note 1 supra, § 8.02.


98 422 U.S. 97, 104 (1976); see 3 Perlin, note 1 supra, § 16.22; Perlin, note 4 supra, § 4.44.
several post-Gamble cases expanded this concept to include a limited right to mental health care, subsequent cases, decided after the Supreme Court’s 1982 Youngberg opinion that articulated the “subsequent professional judgment standard,” were far more cautious in mandating such services. The question that must be pondered here is whether the Riggins decision use of “least intrusive means” language in any way augurs a potential shift away from the professional judgment standard of Youngberg. It is simply too early to tell.

On the question of liability, it is necessary to turn to Zinermon. This case expands the Section 1983 civil rights liability in an area where most of the Supreme Court’s other recent decisions had made it more difficult to maintain suit in cases involving tortious acts of state employees. Neither the majority nor the dissent appears to countenance the actions of the state defendants in Zinermon, and there is no reason to assume that the decision was strictly an idiosyncratic one limited to its own facts. Although successful civil rights suits on behalf of mentally disabled plaintiffs are still rare, the Zinermon decision certainly makes it likely that there will be at least a modest upsurge in damages litigation in this area in the future.


100 See, e.g., Hoptowit v. Ray, 682 F.2d 1237 (9th Cir. 1982); Capps v. Atiyeh, 559 F. Supp. 894 (D. Or. 1982).

101 See, e.g., Daniels v. Williams, 474 U.S. 327 (1986); see generally Susan Bandes, “Monnell, Parratt, Daniels and Davidson: Distinguishing a Custom or Policy From a Random, Unauthorized Act,” 72 Iowa L. Rev. 101 (1986).

102 See 3 Perlin, note 1 supra, § 12.25 (collecting cases); Perlin, note 4 supra, § 3.14 (same).

Foucha also flags important liability issues. The Court’s decision seems almost a cue bid, making it clear to litigators in states with Louisiana-like statutes that nonmentally ill insanity acquittees can no longer be held in forensic facilities. Clearly, there are liability implications here as well.

Conclusion

Finally, a word about some alternative academic approaches that may help shed new light on some of these issues. Researchers and scholars have been using a series of constructs to help illuminate this answer, such as heuristics, sanism, and pretextuality. “Heuristics” is a cognitive psychology construct that refers to implicit thinking devices that individuals use to oversimplify complex, information-processing tasks. The vivid case is remembered and made representative of the whole universe of cases; information is processed to “fit” preexisting pictures of the subject matter in question; we listen to evidence that confirms our views, and reject evidence that might force us to reconsider; we “ignore or misuse items of rationally useful information.”

“Sanism” is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based largely on ste-

103 For a similar approach, see, e.g., Perlin, “Decoding,” note 2 supra (right to refuse treatment).

104 See, e.g., Perlin, note 46 supra, at 966 n.46.

reotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of false "ordinary common sense" and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.\(^\text{106}\)

The entire relationship between the legal process and mentally disabled litigants is often pretextual. Courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decision making,\(^\text{107}\) specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends."\(^\text{108}\)

Finally, "therapeutic jurisprudence" studies the role of the law as a therapeutic agent.\(^\text{109}\) This perspective recognizes that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or antitherapeutic consequences, and questions whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeuic potential, while not subordinating due process principles.\(^\text{110}\)

While an impressive body of literature has been produced, there has not yet been a systematic investigation into the reasons why some courts decide cases "therapeutically" and others "antitherapeutically." One could conclude that sanism is such a dominant psychological force that it (1) distorts "rational" decision making; (2) encourages (albeit on at least a partially unconscious level) pretextuality; and (3) prevents decision makers from intelligently and coherently focusing on questions that are meaningful to therapeutic jurisprudential inquiries.\(^\text{111}\)

A reconsideration of the Supreme Court cases using these filters might help bring some coherence to any area that has been, for many years, a "doctrinal abyss,"\(^\text{112}\) and might fill in a few more pieces of the puzzle.

**Postscript**

In the 1992 term, the Supreme Court's "doctrinal abyss" deepened.\(^\text{113}\) In *Godinez v. Moran*,\(^\text{114}\) it


\(^{112}\) See Perlin, "Supreme Court," note 2 *supra*.


\(^{114}\) 113 S. Ct. 2680 (1993).
addressed a question over which the lower courts had split: Was there a higher standard of competency to plead guilty than to stand trial? It ended the controversy by holding that the standard for pleading guilty was no higher than for standing trial.

In earlier proceedings, the Ninth Circuit Court of Appeals had reversed a district court denial of Moran’s application for a writ of habeas corpus, concluding that the trial record should have led the trial court to “entertain a good faith doubt about [Moran’s] competency to make a voluntary, knowing, and intelligent waiver,” and that waiver of constitutional rights required a “higher level of mental functioning than that required to stand trial,” a level it characterized as “the capacity for reasoned choice.” The Supreme Court reversed, per Justice Thomas, rejecting the notion that competence to plead guilty must be measured by a higher (or even different) standard from that used in competency-to-stand-trial cases.

It reasoned that a defendant who was found competent to stand trial would have to make a variety of decisions requiring choices: whether to testify, whether to seek a jury trial, whether to cross-examine his accusers, and, in some cases, whether to raise an affirmative defense. While the decision to plead guilty is a “profound one,” “it is no more complicated than the sum total of decisions that a defendant may be called upon to make during the course of a trial.” Finally, the court reaffirmed that any waiver of constitutional rights must be “knowing and voluntary.” It concluded on this point:

Requiring that a criminal defendant be competent has a modest aim: It seeks to ensure that he has the capacity to understand the proceedings and to assist counsel. While psychiatrists and scholars may find it useful to classify the various kinds and degrees of competence, and while States are free to adopt competency standards that are more elaborate than the Dusky formulation, the Due Process Clause does not impose these additional requirements.

Justices Kennedy and Scalia concurred, noting their concern with those aspects of the opinion that compared the decisions made by a defendant who pleads guilty with those made by one who goes to trial, and expressing their “serious doubts” that there would be a heightened competency standard under the Due Process clause if these decisions were not equivalent.

115 See 3 Perlin, note 1 supra, § 14.20 (discussing cases).
116 After Moran was found competent to stand trial, he discharged his counsel and pled guilty (explaining that he wanted to prevent the presentation of mitigating evidence at his sentencing), id. at 2683, the court accepted his guilty plea, finding that it had been “freely and voluntarily” given. Id. He was subsequently sentenced to death. Id.
118 Godinez, 113 S. Ct. at 2682.
119 Id. at 2686.
120 Id.
121 Id. at 2687 (quoting Parke v. Raley, 113 S. Ct. 517, 523 (1992)).
123 Godinez, 113 S. Ct. at 2688 (emphasis added).
Justice Blackmun dissented (for himself and Justice Stevens), focusing squarely on what he saw as the likely potential that Moran’s decision to plead guilty was the product of “medication and mental illness.”

He reviewed the expert testimony as to the defendant’s state of depression, a colloquy between the defendant and the trial judge in which the court was informed that the defendant was being given medication, the trial judge’s failure to inquire further and discover the psychoactive properties of the drugs in question, the defendant’s subsequent testimony as to the “numbing” state of the drugs, and the “mechanical character” and “ambiguity” of the defendant’s answers to the court’s questions at the plea stage.

On the question of the multiple meanings of competency, Justice Blackmun added:

[The majority cannot isolate the term “competent” and apply it in a vacuum, divorced from its specific context. A person who is “competent” to play basketball is not thereby “competent” to play the violin. The majority’s monolithic approach to competency is true to neither life or the law. Competency for one purpose does not necessarily translate to competency for another purpose.]

He concluded:

To try, convict and punish one so helpless to defend himself contravenes fundamental principles of fairness and impugns the integrity of our criminal justice system. I cannot condone the decision to accept, without further inquiry, the self-destructive “choice” of a person who was so deeply medicated and who might well have been severely mentally ill.

Justice Blackmun’s dissent in Godinez is a powerful document that speaks simultaneously to the empirical realities of the criminal trial process, the impact of mental illness and medication on a defendant’s capacity for reasoned choice, and, perhaps, most important, the role of pretextuality in the incompetency-to-stand-trial process. He rejects the formulistic approach of Justice Thomas’s majority opinion, weighs the pertinent social science evidence, and demonstrates how the trial record reflects the “ambiguity” of the controlling colloquy between counsel and the trial judge.

The underlying tensions of the case are exacerbated even further because the defendant had been sentenced to death. The Supreme Court has considered the relationship between mental illness and the competency to be executed, the relationship between mental retardation and the competency to be executed, and,

124 Id. at 2692.

125 Id. at 2692–2693. See also id. at 2696 (“such drugs often possess side effects that may ‘compromise the right of a medicated criminal defendant to receive a fair trial . . . by rendering him unable or unwilling to assist counsel,’ ” (quoting Riggins v. Nevada, 112 S. Ct. 1810, 1818–1819 (1992) (Kennedy, J., concurring)).


127 Id. at 2696.


129 See Ford v. Wainwright, 477 U.S. 399 (1986); see 3 Perlin, note 1 supra, §§ 17.02–17.06; see generally Perlin, Jurisprudence, note 34 supra.

130 See Penry v. Lynaugh, 492 U.S. 302 (1989); see 3 Perlin, note 1 supra, §§ 17.06A (1994 pocket part), 17.09; see generally Perlin, Jurisprudence, note 34 supra.
more recently, has declined to consider on the merits the constitutionality of medicating a defendant so as to make him competent to be executed. The decision in Godinez—virtually guaranteeing less searching

131 See Perry v. Louisiana, 498 U.S. 38 (1990); see 3 Perlin, note 1 supra, § 17.06B (1994 pocket part); see generally Perlin, Jurisprudence, note 34 supra.

inquiries in cases involving defendants of questionable competency—will likely complicate even further this area of mental disability law jurisprudence.

132 See, e.g., United States v. Day, 998 F.2d 622, 627 (8th Cir. 1993) (rejecting defendant’s claim that the court should have conducted a competency hearing prior to allowing him to proceed pro se).