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“Toiling in the Danger and in the Morals of Despair”: Risk, Security, Danger, the Constitution, and the Clinician’s Dilemma

Michael L. Perlin*
Alison J. Lynch**

INTRODUCTION

Persons institutionalized in psychiatric institutions and facilities for persons with intellectual disabilities have always been hidden from view.¹ Facilities were often constructed far from major urban centers, availability of transportation to such institutions was often limited, and those who were locked up were, to the public, faceless and seen as less than human.² Although there were sporadic exposés in the nineteenth century and the mid-twentieth century that attempted to shed light on the way these individuals were being forced to live,³ it was not until the civil rights revolution reached psychiatric hospitals and facilities for persons with intellectual disabilities in the early 1970s that there was any true public awareness of the conditions in such facilities.⁴ This increased recognition of the deplorable conditions which were the norm then led to an “explosion” of litigation on behalf of those in psychiatric hospitals or facilities for developmental disabilities, further raising awareness in the public and the courts nationwide.⁵

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1 For a graphic example, see Mental Disability Rights Int’l, *Hidden Suffering: Romania’s Segregation and Abuse of Infants and Children with Disabilities* (2006), http://www.disabilityrightsintl.org/wordpress/wp-content/uploads/romania-May-9-final_withphotos.pdf (reporting on human rights abuses against children with disabilities in institutions in Romania).

2 See, e.g., MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 43 (2000); see also Evelyn W. Lusthaus, *Involuntary Euthanasia and Current Attempts to Define Persons with Mental Retardation as Less Than Human*, 23 *MENTAL RETARDATION* 148, 148 (1985).

3 See MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL*, § 3-2.2, at 3-15 to 3-19 (3d ed. 2016) (discussing work of Dorothea Dix, E.P.W. Packard and Albert Deutsch).

4 See, e.g., Michael L. Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 *LOY. L.A. L. REV.* 1249, 1250–51 (1987).

5 See generally Michael L. Perlin & Meredith R. Schriver, “*You That Hide Behind Walls*”: *The Relationship Between the Convention on the Rights of Persons with Disabilities and the Convention Against Torture and the Treatment of Institutionalized Forensic Patients*, in *TORTURE AND ILL-TREATMENT IN HEALTH-CARE SETTINGS: A COMPILATION* 195 (Am. Univ. Wash. Coll. of Law Ctr. on Humanitarian Law ed., 2013); see also Michael L. Perlin, *International Human Rights and Institutional Forensic Psychiatry: The Core Issues*, in *THE USE OF COERCIVE MEASURES IN FORENSIC PSYCHIATRIC CARE: LEGAL, ETHICAL AND PRACTICAL CHALLENGES* 9 (Birgit Völm & Norbert Nedopil eds., 2016).

However, “[m]uch of [this] case law ignores forensic patients entirely.”⁶ By and large (although not exclusively),⁷ the facilities that were the subject of this litigation (and the concomitant press scrutiny)⁸ were facilities that mostly housed patients who had never been charged with or tried on criminal charges—a fact that is, interestingly and ironically, discordant with the false “ordinary common sense”⁹ belief held by many in society which posits that “[m]ost mentally ill individuals are dangerous and frightening [and] are invariably more dangerous than non-mentally ill persons.”¹⁰

Even in this hidden world of those institutionalized because of psychiatric disability (or alleged disability), forensic patients – mostly those awaiting incompetency-to-stand trial determinations, those found permanently incompetent to stand trial, those . . . acquitted by reason of insanity, and, in some jurisdictions, individuals transferred from correctional facilities – [have always] remain[ed] the most hidden.¹¹

There has been little dignity present either in the conditions of the institutions in which such individuals have been housed or in the treatment that they have received.¹²

Given their involvement with the criminal justice system and the mental health system simultaneously, this population has always been doubly stigmatized. Almost twenty-five years ago, one of the authors (MLP) wrote: “In the criminal

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- 6 Michael L. Perlin, “*Everybody Is Making Love/Or Else Expecting Rain*”: *Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia*, 83 WASH. L. REV. 481, 488 (2008). See also Maya Sabatello, *Where Have the Rights of Forensic Patients Gone?*, 109 AM. SOC’Y INT’L L. PROC. 77, 78 (2015) (“[F]orensic patients . . . remained largely invisible throughout the drafting process [of the United Nations’ Convention on the Rights of Persons with Disabilities [CRPD]”). On the CRPD in general, see *infra* text accompanying notes 132–70.
- 7 See, e.g., *Davis v. Watkins*, 384 F. Supp. 1196, 1201–02 (N.D. Ohio 1974); see also Perlin, *supra* note 6, at 488 (“Of the important [first generation right-to-treatment institutional conditions cases], forensic patients were part of the plaintiff class only in the Ohio case of *Davis v. Watkins*”). For a full discussion of *Davis*, see generally PERLIN & CUCOLO, *supra* note 3, § 7-3.2, at 7-7673 to 7-7876.
- 8 For the role of the press, see Paul Davis, *Wyatt v. Stickney: Did We Get It Right This Time?*, 35 L. & PSYCHOL. REV. 143, 153 (2011).
- 9 See Heather Ellis Cucolo & Michael L. Perlin, *Preventing Sex-Offender Recidivism Through Therapeutic Jurisprudence Approaches and Specialized Community Integration*, 22 TEMPLE POL. & C.R. L. REV. 1, 38 (2012) (“[Ordinary common sense] is self-referential and non-reflective (‘I see it that way, therefore everyone sees it that way; I see it that way, therefore that’s the way it is’).”).
- 10 Michael L. Perlin, “*You Have Discussed Lepers and Crooks*”: *Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 724 n.220 (2003).
- 11 See Perlin & Schriver, *supra* note 5, at 196; see also Perlin, *supra* note 5 (noting that forensic patients have traditionally been hidden from public view, the legal system, and the mental-health system).
- 12 See generally MICHAEL L. PERLIN, *A PRESCRIPTION FOR DIGNITY: RETHINKING CRIMINAL JUSTICE AND MENTAL DISABILITY LAW* 7 (2013); Michael L. Perlin, *Understanding the Intersection Between International Human Rights and Mental Disability Law: The Role of Dignity*, in THE ROUTLEDGE HANDBOOK OF INTERNATIONAL CRIME AND JUSTICE STUDIES 191 (Bruce Arrigo & Heather Bersot eds., 2013). This is not solely a US-based issue. On the disregard for the dignity of forensic patients in Austria, see, for example, Independent Monitoring Committee for the Implementation of the U.N. Convention on the Rights of Persons with Disabilities, *Forensic Commitment-Statement on the Current Situation and Prevention* at 4–5 (Jan. 19, 2015) (discussing “a disregard for dignity”).

justice system, the mentally disabled were doubly cursed as 'mad' and 'bad', and were regularly consigned to lifetime commitments in maximum security facilities."¹³ Attitudes remain the same today.¹⁴ Forensic patients face stigma both from their status as "defendant" and as being "mentally ill."¹⁵

For decades, any person with a mental disability involved in the criminal process at any level was automatically and permanently housed in a maximum security forensic hospital, from which there was virtually no exit route (other than death).¹⁶ The US Supreme Court's 1972 decision in *Jackson v. Indiana*¹⁷—on paper, at least¹⁸—limited the length of time that a forensic person who was not likely to regain his competency to stand trial could be housed in such a facility,¹⁹ unless

13 Michael L. Perlin, *On "Sanism"*, 46 S.M.U. L. REV. 373, 398–99 (1992) (quoting, in part, Ellen Hochstedler, *Twice-Cursed? The Mentally Disordered Criminal Defendant*, 14 CRIM. JUST. & BEHAV. 251 (1987)).

14 See, e.g., James D. Livingston, Katherine R. Rossier & Simon N. Verdun-Jones, *Forensic' Labelling: An Empirical Assessment of Its Effects on Self-Stigma for People with Severe Mental Illness*, 188 PSYCHIATRY RES. 115, 116 (2011).

15 The stigma that forensic patients face was recognized by the Supreme Court as long ago as 1966, in *Baxstrom v. Herold*, 383 U.S. 107, 114–15 (1966) (differences between civil and forensic facilities sufficient to require procedural protections for the individuals subject to placement decisions), as discussed in Roy E. Pardee III, *Fear and Loathing in Louisiana: Confining the Sane Dangerous Insanity Acquittee*, 36 ARIZ. L. REV. 223, 246 n.237 (1994).

16 See A. Louis McGarry, *Demonstration and Research in Competency for Trial and Mental Illness: Review and Preview*, 49 B.U. L. REV. 46, 50 n.20 (1969) (reporting that more men committed as incompetent to stand trial "had left Bridgewater as a result of death than all other avenues combined").

17 406 U.S. 715, 720 (1972).

18 Incredibly, *Jackson* continues to be ignored by about half the states. See Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 U.C.L.A. L. REV. 921, 941 (1985); see also Ellen C. Wertlieb, *Individuals with Disabilities in the Criminal Justice System: A Review of the Literature*, 18 CRIM. JUST. & BEHAV. 332, 336 (1991). Winick's research has been updated in Grant H. Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 9 (1993) (explaining that a decade after Winick published his article, *Jackson* remained "ignored [and] circumvented."); see also Michael L. Perlin, "For the Misdemeanor Outlaw": *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193, 204 (2000) ("[M]ore than half the states allow for the indefinite commitment of incompetent-to-stand-trial defendants, in spite of *Jackson's* specific language outlawing this practice."); Andrew R. Kaufman, Bruce B. Way & Enrico Suardi, *Forty Years After Jackson v. Indiana: States' Compliance with "Reasonable Period of Time" Ruling*, 40 J. AM. ACAD. PSYCHIATRY & L. 261, 261 (2012) (most states out of compliance with *Jackson*). At least one state Supreme Court has specifically sanctioned procedures that ignore the *Jackson* holding. See *State v. Werner*, 796 P.2d 610, 613 (N.M. Ct. App. 1990) (not error to treat dangerous patients committed pursuant to *Jackson* differently from civil patients). For a discussion of all related issues, see Michael L. Perlin, "Wisdom Is Thrown into Jail": *Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness*, 17 MICH. ST. U. J. MED. & L. 343, 347 (2013) (Perlin, *Wisdom*).

19 Said the Court in *Jackson*:

Indiana cannot constitutionally commit the petitioner for an indefinite period simply on account of his incompetency to stand trial on the charges filed against him. . . . [B]y subjecting Jackson to a more lenient commitment standard and to a more stringent standard of release than those generally applicable to all others not charged with offenses, and by thus condemning him in effect to permanent institutionalization without the showing required

there was an independent showing of such dangerousness that he could not safely be housed elsewhere.²⁰ Also, the enactment of the Americans with Disabilities Act (ADA)²¹ has called into question the legality of placing all incompetent patients—no matter what their individual level of dangerousness or their charged offense—in maximum security facilities, solely by nature of the fact that there is a criminal detainer lodged against them.²²

A critical question that remains mostly unanswered for forensic hospitals is the extent of a patient’s perceived dangerousness that is required for such secure hospital commitment as opposed to what is acceptable prior to transfer to a non-secure facility.²³ The question of dangerousness required has been and remains an important one in the minds of patients, those treating them, and the public at large. While some judges and legislators in the United States have begun to directly address the issue, a fair amount of ambiguity remains.²⁴ This ambiguity—along with the lack of agreement and clarification by the courts—may ultimately lead to a

for commitment or the opportunity for release . . . Indiana deprived petitioner of equal protection.

406 U.S. at 720, 730.

20 *Id.* at 728, 733, 738.

21 *See* 42 U.S.C. §§ 12101–213 (2006).

22 Perlin, *supra* note 18, at 201–07. In a study of all cases heard by New Zealand’s Mental Health Review Tribunal over an eighteen year period, it was found that the Tribunal recommended change in legal status in only two percent of all forensic cases. *See* KATEY THOM ET AL., BALANCING INDIVIDUAL RIGHTS WITH PUBLIC POLICY: THE DECISION-MAKING OF THE MENTAL HEALTH REVIEW TRIBUNAL 23 (2014). In Australia, only a “small number” of forensic patients is even provided representation. *See* ELEANORE FRITZE, SHINING A LIGHT BEHIND CLOSED DOORS: REPORT OF THE JACK BROCKHOFF FOUNDATION CHURCHILL FELLOWSHIP TO BETTER PROTECT THE HUMAN RIGHTS AND DIGNITY OF PEOPLE WITH DISABILITIES, DETAINED IN CLOSED ENVIRONMENTS FOR COMPULSORY TREATMENT, THROUGH THE USE OF LEGAL SERVICES 36 n.233 (2015).

23 For discussions of New York’s policy on transfer to non-secure facilities based on CPL § 33.20, see Ernst J. v. Stone, 452 F.3d 186, 188 (2d Cir. 2006); Richard S. v. Carpinello, 628 F. Supp. 2d 286 (N.D.N.Y. 2008); *In re* David B., 766 N.E.2d 565 (N.Y. 2002). For application of the New York “3 track” system of categorizing mental disorders and the appropriateness of secure confinement, see *In re* Amir F., 94 A.D.3d 1209 (N.Y. App. Div. 2012), *In re* Eric U., 40 A.D.3d 1148 (N.Y. App. Div. 2007); *In re* Torres, 166 A.D.2d 228, 228–29 (N.Y. App. Div. 1990) (Commissioner of Mental Health failed to meet burden of showing level of dangerousness required to confine defendant in secure facility); *People v. Salem*, 122 A.D.2d 85 (N.Y. App. Div. 1986). The different “tracks” in the N.Y. system are explained *infra* text accompanying notes 45–50. Ironically, many “non-secure” facilities are becoming increasingly locked down, and it is becoming more difficult to tell the differences between the levels of dangerousness required by these facilities, which should in theory be readily distinguishable.

24 Transfers are, of course, often based on (usually informal) risk assessments. *See infra* text accompanying notes 89–91 on the inherent ambiguity often present in such assessment decision-making. At least one court has ruled that, as the question before it was “*only* with requests for transfer from one mental hospital to another, and not with requests for release, the concern for psychiatric predictions of dangerousness [is] not relevant here.” *In re* Hospitalization of Patterson, 372 A.2d 1173, 1175 (N.J. Super. Ct. Law Div. 1977), *rev’d on other grounds*, 383 A.2d 467 (N.J. Super. Ct. App. Div. 1978), *cert. denied*, 391 A.2d 484 (N.J. 1978).

violation of a person's right to be confined in the least restrictive alternative, a right that applies in all settings to all patients confined in hospitals.²⁵

This potential for the violation of patients' rights is especially troubling because of recent developments in international human rights law, especially the ratification of the United Nations' Convention on the Rights of Persons with Disabilities (CRPD).²⁶ As we will discuss below, the CRPD is the most revolutionary international human rights document ever created that applies to persons with disabilities.²⁷ It furthers the human rights approach to disability—endorsing a social model and repudiating a purely medical model—and recognizes the right of people with disabilities to equality in most every aspect of life.²⁸ Although little attention has been paid to its potential impact on forensic patients,²⁹ we believe it is essential that there be a new focus notwithstanding the fact that virtually no consideration of the Convention's application to this population yet appears in the literature.³⁰

This Article will address these issues individually and together as they appear in the United States and under international law principles.³¹ We will consider "risk" in two ways: first, the need for clinicians to be able to assess a patient's risk in both secure and non-secure facilities and second, the legal risk to clinicians if their assessment is wrong. We will also address "security" because an emphasis on safety is at the forefront of the minds of the public as well as judges involved in cases where dangerousness is considered.³² We will also discuss

25 See *infra* text accompanying notes 65–70, discussing, inter alia, *Sell v. United States*, 539 U.S. 166 (2003); *Olmstead v. L.C.*, 527 U.S. 581 (1999); *Riggins v. Nevada*, 504 U.S. 127 (1992); see also Perlin, *supra* note 18, at 217–18 (discussing these cases in a parallel context).

26 G.A. Res. 61/106, U.N. Doc. A/RES/61/106, at 2 (Jan. 24, 2007); see generally MICHAEL L. PERLIN, INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCED ARE HEARD 143–59 (2012).

27 See generally Michael L. Perlin & Eva Szeli, *Mental Health Law and Human Rights: Evolution and Contemporary Challenges*, in MENTAL HEALTH AND HUMAN RIGHTS: VISION, PRAXIS, AND COURAGE 98 (Michael Dudley et al. eds., 2012); PERLIN, *supra* note 26, at 3–21; Michael L. Perlin, "A Change Is Gonna Come": The Implications of the United Nations Convention on the Rights of Persons with Disabilities for the Domestic Practice of Constitutional Mental Disability Law, 29 N. ILL. U. L. REV. 483, 484 (2009).

28 See, e.g., Aaron A. Dhir, *Human Rights Treaty Drafting Through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 STAN. J. INT'L L. 181, 191–92 (2005).

29 But see Perlin & Schriver, *supra* note 5, at 16. One of the co-authors (MLP) discusses this further in Michael L. Perlin, "God Said to Abraham/Kill Me a Son": Why the Insanity Defense and the Incompetency Status Are Compatible with and Required by the Convention on the Rights of Persons with Disabilities and Basic Principles of Therapeutic Jurisprudence, 54 AM. CRIM. L. REV. 477 (2017).

30 Dhir, *supra* note 28, at 201–02.

31 In this paper, we focus on New York state, but the issues affect forensic facilities in all the states.

32 "Judges are embedded in the cultural presuppositions that engulf us all." PERLIN, *supra* note 2, at 47. On the bias often shown by judges towards litigants with mental disabilities, see, e.g., JOHN PARRY & ERIC Y. DROGIN, CRIMINAL LAW HANDBOOK ON PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE AND TESTIMONY 5 (2000); Perlin, *supra* note 13, at 377. This bias is sanism: "an irrational prejudice of the

“danger” as it is the basis for many statutes governing confinement of the mentally ill, and “dangerousness” itself is a particularly indefinable term in this context. Finally, we will discuss the issue of “human rights” because of the importance of the CRPD as well as the importance of ensuring fair treatment in all nations.

We are then faced with the “clinician’s dilemma,” which occurs each time a treatment provider attempts to combine these previously-described topics into a formula to apply to his patients. This dilemma is made more obvious by the discordance in case law and statutes, as well as organized psychiatry’s reliance on dangerousness predictions that continue to be unreliable at best, and prejudicial at worst. We will also consider all of the issues in question through the prism of TJ in an effort to determine whether current policies are, in fact, therapeutic or anti-therapeutic and whether or not they reflect the “ethic of care” mandated by TJ.³³

The first portion of the title of this paper comes from *Every Grain of Sand*,³⁴ one of Bob Dylan’s very saddest and most beautifully-imaged songs;³⁵ one, according to the critic Paul Williams that “reaches beyond its context to communicate a deeply felt devotional spirit based on universal experiences: pain of self-awareness, and sense of wonder or awe,” and is about “the moment(s) [that] we accept our pain and vulnerability.”³⁶ We believe, as we will discuss subsequently in the Article, that the lyric in question truly defines the conundrum we face.

I. FORENSIC AND SECURE FACILITIES

A. Introduction

To confront the questions that we raise in this paper, it is necessary to first consider the extent of dangerousness that is required for secure hospital commitment versus transfer to a non-secure facility—a question that was first raised to one of the authors (MLP) over eleven years ago by the then-head of the Kirby Forensic Center in New York City, one of New York state’s two maximum

same quality and character of other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry.” See, e.g., Michael L. Perlin, “*Striking for the Guardians and Protectors of the Mind*”: *The Convention on the Rights of Persons with Mental Disabilities and the Future of Guardianship Law*, 117 PENN ST. L. REV. 1159, 1180 (2013).

33 See *infra* text accompanying notes 175–207.

34 Bob Dylan, *Every Grain of Sand*, BOB DYLAN, <http://www.bobdylan.com/us/songs/every-grain-sand> (last visited Mar. 29, 2017).

35 The lyric comes from the first verse:

In the time of my confession, in the hour of my deepest need
When the pool of tears beneath my feet flood every newborn seed
There’s a dyin’ voice within me reaching out somewhere
Toiling in the danger and in the morals of despair.

36 PAUL WILLIAMS, BOB DYLAN: PERFORMING ARTIST, 1974–1986, THE MIDDLE YEARS 1974–1986, at 205 (1992). For a lengthy analysis of *Every Grain*, see generally MICHAEL GRAY, SONG AND DANCE MAN III: THE ART OF BOB DYLAN 400–25 (2000).

security forensic hospitals.³⁷ This issue becomes especially important as "non-secure" facilities have become increasingly locked down to the extent that there is now, in many important ways, little difference between facilities. This lack of discernible differences between various types of facilities looms even larger in light of statutes and judicial decisions mandating that patients be placed in the least restrictive alternative settings appropriate for their treatment.³⁸

B. New York State Law

We will focus here on New York developments. Under the relevant statute, New York Criminal Procedure Law section 330.20(1)(c), the term "dangerous mental disorder" means: (i) that a defendant currently suffers from a "mental illness" and (ii) that "because of such condition he currently constitutes a physical danger to himself or others."³⁹ If we examine the New York Court of Appeals' decisions from the past two decades, certain controlling principles emerge.

It is constitutionally permissible for the state to engage in a presumption that a defendant's "causative mental illness" has continued beyond the date of the original conduct (that would have been criminal but for the defendant's lack of criminal responsibility),⁴⁰ and a finding of current danger may be made:

by presenting proof of a history of prior relapses into violent behavior, substance abuse or dangerous activities upon release or termination of psychiatric treatment, or upon evidence establishing that continued medication is necessary to control defendant's violent tendencies and that defendant is likely not to comply with prescribed medication because of a prior history of such noncompliance or because of threats of future noncompliance.⁴¹

Extended supervision is justified, in significant part, because of the "inability of modern psychiatry to guarantee the safety of the public through effective

37 Email from Jim Hicks, M.D., Assoc. Clinical Dir., Kirby Forensic Center, to Michael L. Perlin, Dir., International Mental Disability Law Reform Project & Online Mental Disability Law Program, New York Law School (Apr. 3, 2006) (on file with authors).

38 See, e.g., N.Y. CRIM. PROC. L. § 330 (McKinney Supp. 2017); *In re Guardianship of Dameris L.*, 956 N.Y.S.2d 848, 853–54 (N.Y. Sup. Ct. 2012).

39 See also, N.Y. CRIM. PROC. L. § 330.20(1)(d) (McKinney Supp. 2017) (stating that "[m]entally ill" means that a defendant currently suffers from a mental illness for which care and treatment as a patient, in the in-patient services of a psychiatric center under the jurisdiction of the state office of mental health, is essential to such defendant's welfare and that his judgment is so impaired that he is unable to understand the need for such care and treatment).

40 *In re George L.*, 648 N.E.2d 475, 480 (1995) (quoting *In re Torsney*, 394 N.E.2d 262, 265 (1979)). *In re George L.* was most recently cited in this context in New York in *Makas v. Mid-Hudson Forensic Psychiatric Center*, 905 N.Y.S.2d 477 (Sup. Ct. 2010); *In re Justice v. Evans*, 23 N.Y.S.3d 749, 750 (App. Div. 2016) (citing *George L.* when holding that a recommitment order must be premised on proof that may include "a history of prior relapses into violent behavior, [or] substance abuse or dangerous activities upon release or termination of psychiatric treatment"); *State v. Matter*, 958 N.Y.S.2d 556, 558 (App. Div. 2013) ("Contrary to respondent's contention, proof of his past conduct is probative of his present mental state.").

41 *George L.*, 648 N.E.2d at 81.

treatment permanently removing the potentiality of recurrent violent acts by persons found not responsible by reason of mental illness, thereby justifying extended continuous supervision over the acquittee by the criminal court through an order of conditions.”⁴²

[Some] constitutionally required minimum level of dangerousness to oneself or others that must be shown before an insanity acquittee may be retained in a non-secure facility, [but] a finding that an individual is ‘mentally ill’ . . . under CPL § 330.20(1)(d)⁴³ contemplates a degree of dangerousness that satisfies due process concerns.⁴⁴

The statute contemplates a three-tier track system.⁴⁵ Those suffering from a “dangerous mental disorder” (Track 1)⁴⁶ are subject to “continued, direct oversight.”⁴⁷ Those “mentally ill” (for these purposes, persons whose illnesses require inpatient care and treatment that is essential to the defendant’s welfare, and who, because of impaired judgment, do not understand the need for such care and treatment) (Track 2) are governed by the civil commitment laws.⁴⁸ Those who are neither mentally ill nor dangerous under these definitions (Track 3) are entitled to immediate release with or without conditions.⁴⁹ Other factors to consider in determining whether a Track 2 acquittee needs continued retention in a non-secure facility include:

- the need to prepare for a safe and stable transition from non-secure commitment to release,
- evidence of recent acts of violence and the risk of harm to the defendant or others,
- the nature of the conduct that resulted in the initial commitment,
- the likelihood of relapse or a cure,
- history of substance or alcohol abuse,

42 *In re Francis S.*, 663 N.E.2d 881, 885 (N.Y. 1995).

43 *See supra* note 39 discussion.

44 *In re David B.*, 766 N.E.2d at 570 (N.Y. 2002). Most recently, in *Makas*, 905 N.Y.S.2d at 480., on the facts of the case before it, the trial court concluded that in the case of an individual who suffered from a mental illness but not a “dangerous” mental illness, it did not have authority to change his commitment from a secure to a non-secure facility.

45 On the differential in appeal processes in Track 1 and Track 2 cases, see *In re Jamie R.*, 844 N.E.2d 285, 291 (N.Y. 2006) (stating that the track status of track 2 patient can only be changed on appeal, not by review hearing); *In re Norman D.*, 818 N.E.2d 642, 643 (N.Y. 2004) (noting that the track status of a track 1 patient can only be changed on appeal, not by review hearing). For more recent discussions of New York’s track system in this context, see *In re Robert T. v. Sproat*, 955 N.Y.S.2d 134, 138 (N.Y. App. Div. 2012); *People v. Sharon T.*, No. 1735/09, 2011 WL 1900047, at *1–2 (N.Y. Sup. Ct. May 18, 2011).

46 *See* N.Y. CRIM. PROC. L. § 330.20(6) (McKinney Supp. 2017).

47 *In re David B.*, 766 N.E.2d at 571 n.4. *See also e.g.*, *Allen B. v. Sproat*, 991 N.Y.S.2d 386 (2014) (a supervising court in a track-1 case may include in an order of conditions for release an effective-evaluation provision).

48 *David B.*, 755 N.E.2d at 571.

49 *Id.*

- the effects of medication,
- the likelihood that the patient will discontinue medication without supervision,
- the length of confinement and treatment,
- the lapse of time since the underlying criminal acts, and
- “any other relevant factors that form a part of an insanity acquittee’s psychological profile.”⁵⁰

C. Constitutional Dimensions

With this statutory predicate, we must also consider the constitutional imperative that we apply the concept of the least restrictive alternative to all institutional mental disability law decision making. There is no question that the constitutional mandate of providing the least restrictive alternative (LRA)—first famously spelled out in a mental disability law context well over forty years ago in the case of *Lessard v. Schmidt*⁵¹—applies to *all* aspects of institutional decision making, whether they involve civil patients or forensic patients. This broad application has been made clear by the US Supreme Court, other relevant federal courts, and the New York state courts.

In *Lessard*, the federal district court ruled that “even if the standards for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort.”⁵² Quoting *Shelton v. Tucker*,⁵³ the court characterized “the most basic and fundamental right [as] the right to be free from unwanted restraint,”⁵⁴ concluding that “persons suffering from the condition of being mentally ill but who are not alleged to have committed any crime, cannot be totally deprived of their liberty if there are less drastic means for achieving the same basic goal.”⁵⁵ The court placed the burden for exploring alternatives to institutionalization on “the person recommending full-time involuntary hospitalization,”⁵⁶ who must prove the following:

- (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable. These alternatives include voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or

50 *Id.* at 572.

51 349 F. Supp. 1078, 1093 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974); *see also* Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 86 n.138 (1991).

52 *Lessard*, 349 F. Supp. at 1095.

53 364 U.S. 479, 488 (1960). *Shelton* involved the associational rights of public schoolteachers; *see id.*

54 *Lessard*, 349 F. Supp. at 1095–96.

55 *Id.* at 1096.

56 *Id.*

relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.⁵⁷

These principles have been articulated in multiple New York state cases, dating back to the 1973 decision of *Kesselbrenner v. Anonymous*:⁵⁸ “To subject a person to a greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined is, it is clear, violative of due process.”⁵⁹ Subsequent New York cases have been in accord. By way of example, *Ughetto v. Acrish* states the principle this way: “The burden of proof at such a hearing is upon the hospital to establish by clear and convincing evidence that the patient poses a substantial threat to himself or others and that involuntary commitment is the least restrictive means available for treatment.”⁶⁰

Courts in other jurisdictions have specifically ruled that the LRA principles apply to the transfer of patients from a less secure hospital to a more secure hospital.⁶¹ Although this issue has never been dealt with squarely by a New York court, the *Mental Hygiene Legal Services ex rel. Aliza K. v. Ford*⁶² decision (which did not require a full due process hearing prior to the transfer of a patient to a more secure facility) indicated that, where the “stigma of being a patient at [the more secure facility] may be greater than that of being hospitalized at [the less secure facility, such a] transfer implicates a liberty interest which triggers rights to procedural due process,”⁶³ citing *Kesselbrenner* and the US Supreme Court’s prison-hospital transfer case of *Vitek v. Jones*.⁶⁴

The LRA principle has been articulated in two very different ways in three US Supreme Court cases. In 1990, in *Riggins v. Nevada*,⁶⁵ reversing a conviction in a case where a competent defendant pleading the insanity defense was medicated at trial against his will, the Court ruled that such medication would only be allowed if the state proved either of the following: that (1) the treatment was “medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins’ own safety or the safety of others,” or (2) there were no less intrusive means by which to obtain an adjudication of the defendant’s guilt or innocence.⁶⁶

57 *Id.*

58 305 N.Y.2d 903, 906 (N.Y. 1973).

59 *Id.* at 905.

60 494 N.Y.S.2d 943, 944 (N.Y. Sup. Ct. 1985) (citing *in re* Harry M., 468 N.Y.S.2d 359 (N.Y. App. Div. 1983)) (reading LRA requirement into Mental Hygiene Law, and holding that only least restrictive alternative consistent with legitimate purposes of such commitment can be imposed).

61 *See, e.g.*, *Scott v. Plante*, 691 F.2d 634 (3d Cir. 1982); *Eubanks v. Clarke*, 434 F. Supp. 1022, 1029 (E.D. Pa. 1977); *see generally*, PERLIN & CUCOLO, *supra* note 3, § 4-4.1.1, at 4-224 to 4-228.

62 705 N.E.2d 1191, 1194–96 (N.Y. 1998).

63 *Id.* at 194.

64 445 U.S. 480, 494 (1980).

65 504 U.S. 127, 132–35 (1992).

66 *Id.* at 135. Subsequently, in *Sell v. United States*, 539 U.S. 166, 178–81 (2003), the Supreme Court expanded on this ruling in a case involving a defendant whom the government was seeking to medicate so as to make him competent to stand trial. In ruling that medication must necessarily further

Then, seven years later, in *Olmstead v. L.C.*,⁶⁷ the Court construed the ADA to mandate that a state may place persons with mental disabilities in a less restrictive setting if the state provides both substantive safeguards in the form of opinions from treatment professionals and procedural safeguards in the form of a waiting list to move people into community settings.⁶⁸ Both before and after its decision in *Olmstead*, the Supreme Court has ruled that the ADA applies to prison settings;⁶⁹ it is inconceivable that a court would rule that it does not apply to a forensic mental health facility.⁷⁰

In short, there is no question that the LRA applies to all cases of persons institutionalized because of mental disabilities, including forensic patients.⁷¹ One of the authors (MLP) has previously argued that this is specifically demanded by the ADA, and we believe that the arguments made there apply specifically to the cases we are discussing in this paper.⁷²

II. ON RISK

As discussed above, the word "risk" carries with it multiple meanings in the context of making determinations about dangerousness, and those determinations affect a patient's level of confinement.⁷³ First, there is the risk posed by the patient

"significant" state interests, the Court underscored that this could only be done if "any alternative, less intrusive treatments are unlikely to achieve substantially the same results." *Id.* at 181.

67 527 U.S. 581, 602 (1999).

68 *Id.* at 602, 605–06. One of the authors (MLP) discusses both *Riggins* and *Olmstead* in this context in Perlin, *supra* note 18, at 217–18 (written prior to the *Sell* decision).

69 *See, e.g.*, *United States v. Georgia*, 546 U.S. 151, 154 (2006); *Pennsylvania Dept. of Corrections v. Yeskey*, 524 U.S. 206, 209 (1998).

70 *See, e.g.*, *Bates v. Dep't of Behavioral & Dev. Serv.*, 863 A.2d 890, 906–07 (Me. 2004).

71 Some cases from other jurisdictions agree. *See, e.g.*, *Schuttemeyer v. Commonwealth*, 793 S.W.2d 124, 128 (Ky. Ct. App. 1990), *reh'g denied* (Ky. Ct. App. 1990), *discretionary review denied* (Ky. 1990) (holding that evidence would not permit finding that hospitalization was least restrictive alternative mode of treatment for defendant found not guilty by reason of insanity, so as to support involuntary hospitalization; testifying psychologist unequivocally stated that involuntary hospitalization was not necessary); *State v. Kinman*, 671 N.E.2d 1083, 1086 (Ohio Ct. App. 1996) (arguing that the state bears the burden to prove by clear and convincing evidence which commitment alternative is least restrictive at initial determination of whether insanity acquittee should be involuntarily committed). Those that disagree—*see, e.g.*, *People v. Cross*, 704 N.E.2d 766, 771 (Ill. App. Ct. 1998) (reasoning that the requirement under corrections law that insanity acquittee be held in secure setting governed over requirement under Mental Health and Developmental Disabilities Code that person involuntarily committed be held in the least restrictive environment possible); *State v. Randall*, 532 N.W.2d 94, 108 (Wis. 1995) (noting that insanity acquitees, unlike other involuntarily committed persons, do not have right, under prior version of patients' rights statute, to confinement in least restrictive conditions necessary to achieve purposes of their commitment)—all predate *Olmstead* and thus should be seen as being of questionable precedential value.

72 *See* Perlin, *supra* note 18, at 194–95 ("I believe that, after *Olmstead*, policies that mandate that all defendants awaiting incompetence and insanity evaluations, all defendants found permanently incompetent . . . and all NGRI acquitees must be evaluated, treated, or confined only in a state's maximum security facility for the criminally insane violate the ADA.").

73 On how assessments of risk and dangerousness are the most important factors in decision making by tribunals tasked with decisions as to release of persons in psychiatric institutions, see THOM ET AL.,

himself. That risk may be to others or to himself, and clinicians must be adequately prepared to predict it accurately, using meaningful assessment tools. Risk and dangerousness are quite interconnected; the risk of danger posed by a patient is what determines that patient's ultimate placement. The risk of future dangerousness is what keeps clinicians using these risk assessment tools and what pushes non-secure facilities to become more and more secure.⁷⁴

However, there is also risk in the context of clinician error. The risk of an inaccurate prediction of dangerousness can have serious consequences for the clinician who made the prediction, as well as anyone harmed by the inaccurately assessed, dangerous individual.⁷⁵ Further, societal beliefs about the inherent danger posed by all mentally ill individuals put pressure on clinicians to make accurate assessments,⁷⁶ but with that comes pressure to keep individuals with mental illness confined, even when dangerousness may not actually be at issue, or the finding of dangerousness may be tenuous at best.⁷⁷ Even the Supreme Court has recognized the "fallibility of psychiatric diagnosis" and the issues that then arise when individuals are deprived of their basic freedoms based on this fallibility.⁷⁸ Dangerousness itself, as a concept, is also a difficult one,⁷⁹ given that it can mean many things in many different contexts, and the fear of dangerousness can have

supra note 22, at 14 (citing, *inter alia*, JILL PEAY, TRIBUNALS ON TRIAL: A STUDY OF DECISION-MAKING UNDER THE MENTAL HEALTH ACT 1983 (1989)).

74 But, on the shortcomings of these instruments, see, e.g., Eric Janus & Robert Prentky, *Forensic Use of Actuarial Risk Assessment with Sex Offenders: Accuracy, Admissibility and Accountability*, 40 AM. CRIM. L. REV. 1443, 1472 (2003) ("[T]o a greater or lesser extent, all ARA [actuarial risk assessment] instruments have shortcomings, and these shortcomings detract from the reliability of the instruments."); see *generally* MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, SHAMING THE CONSTITUTION: THE DETRIMENTAL RESULTS OF SEXUAL VIOLENT PREDATOR LEGISLATION (2017).

75 On such litigation, see generally, PERLIN & CUCOLO, *supra* note 3, § 12-3.14, at 12-198–12-202.

76 On the "extra-legal pressures on experts to find dangerousness," see Nora V. Demleitner, *Abusing State Power or Controlling Risk?: Sex Offender Commitment and Sicherungsverwahrung*, 30 FORDHAM URB. L.J. 1621, 1658-59 (2003), (quoting in part Eric S. Janus, *Preventing Sexual Violence: Setting Principled Constitutional Boundaries on Sex Offender Commitments*, 72 IND. L.J. 157, 202–03(1996) ("[Among such pressures are] a fear of liability or censure from a false prediction of safety; the absence of any external consequences from a false prediction of violence . . . ; and the tendency of clinicians to see those factors which confirm the existing diagnosis and predictions, and ignore those which disconfirm it.").

77 See, e.g., Mark D. Cunningham & Thomas J. Reidy, *Violence Risk Assessment at Federal Capital Sentencing*, 29 CRIM. JUST. & BEHAV. 512, 532–33 (2002) (noting that individuals undertaking violence risk assessment are likely to commit a number of fundamental errors unless guided by reliable scientific methodology and group data, often resulting in an overestimation of violence risk). On the specific issues raised in this context in death penalty cases, see Mark D. Cunningham & Thomas J. Reidy, *Don't Confuse Me with the Facts: Common Errors in Violence Risk Assessment at Capital Sentencing*, 26 CRIM. JUST. & BEHAV. 20, 22 (1999).

78 *Addington v. Texas*, 441 U.S. 418, 429 (1979).

79 See Alexander Tsesis, *Due Process in Civil Commitment*, 68 WASH. & LEE L. REV. 253, 286 (2011) ("If mental illness is difficult to prove, the dangerousness element is even more difficult because it involves a prediction of future behavior.").

consequences for those labeled as "dangerous."⁸⁰ When society believes that a certain group of people are inherently dangerous and pose greater risks than do other groups, that belief can result in the continued violation of those individuals' rights.⁸¹ As a result of these dilemmas, there is extra pressure on clinicians and state officials to always err on the side of retaining patients in more secure conditions, such decisions being unlikely to result in tart criticism.⁸² If the patients involved are forensic patients (thus explicitly having had some contact with the criminal justice system), these decisions become even easier to justify.

A. The Elasticity of the Word "Dangerousness" and its Multiple Meanings.

Twenty-two years ago, in writing about the application of the then-new field of "therapeutic jurisprudence"⁸³ to involuntary civil commitment law, one of the authors (MLP) and two colleagues said this about the "revolution" in commitment law in the 1970s:

Not incidentally, the initiation of more formal hearings forced medical personnel to alter the manner in which they testified. For the first time, psychiatrists were subjected to rigorous cross-examination and were required to substantiate their medical opinions rather than merely make medical conclusions. At the same time, psychiatric diagnostic and predictive skills were more closely scrutinized. Lawyers were often successful in convincing courts that psychiatric diagnoses and predictions of dangerousness were inaccurate. The meaning of dangerousness also became an important area of litigation. Critics charged that the concept was "vague" and "amorphous," and its "elasticity" has made it "one of the most problematic and elusive concepts in mental health law."⁸⁴

Nothing has changed since the publication of that article over two decades ago. There are few words in the legal literature as elastic as "dangerousness,"⁸⁵ an elasticity that is even more singular in light of the fact that it is a word no longer in good currency with researchers and clinicians, who have reconceptualized the

80 On how persons with mental illness are marginalized because of this fear of dangerousness, see Lawrence O. Gostin & Eric A. Friedman, *Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice*, 13 YALE J. HEALTH POL'Y, L. & ETHICS 1, 14 (2013).

81 On the "inherent fallibility of 'preventive' determinations that are based on assessments of future dangerousness" in the area of detention of suspected terrorists, see Catherine Powell, *Scholars' Statement of Principles for the New President on U.S. Detention Policy: An Agenda for Change*, 47 COLUM. J. TRANSNAT'L L. 339, 340–41 (2009).

82 See Robert Sade, *Introduction: Symposium on Evolution, Prevention, and Responses to Aggressive Behavior and Violence*, 32 J.L. MED. & ETHICS 8, 13 (2004).

83 See *infra* text accompanying notes 175–207.

84 Michael L. Perlin, Keri K. Gould & Deborah A. Dorfman, *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?*, 1 PSYCHOL. PUB. POL'Y & L. 80, 86–87 (1995).

85 See, e.g., GREGG BARAK, CRIMINOLOGY: AN INTEGRATED APPROACH 132 (2009).

relevant inquiry as one that considers the degree of risk⁸⁶ via validated risk assessment instruments.⁸⁷ According to Professor Christopher Slobogin, one of the leading legal scholars in this area, “[t]oday, social scientists talk about risk assessment, not predicting dangerousness, to connote the idea that the potential for violence is not something that resides solely in the individual, but rather stems from the interaction of biological, psychological, and social variables.”⁸⁸ But, even using the word dangerousness (the criteria specified in New York in § 330),⁸⁹ we are confronted by the fact that for thirty years, thoughtful judges, writing nuanced opinions, have acknowledged that there are multiple dimensions to the word.

As long ago as 1975, the New Jersey Supreme Court, writing in *State v. Krol*, pointed out that “[d]angerousness is a concept which involves substantial elements of vagueness and ambiguity,”⁹⁰ and the court acknowledged the “difficulty of making valid and meaningful predictions of the likelihood of future harmful conduct”⁹¹ made more difficult by the “subtle but strong pressures upon decision makers to overpredict dangerousness.”⁹² In the same opinion, the court noted that “[a] defendant may be dangerous in only certain types of situations or in connection with relationships with certain individuals” and that any “evaluation of dangerousness in such cases must take into account the likelihood that defendant will be exposed to such situations or come into contact with such individuals.”⁹³

Interestingly, *Krol*, an insanity acquittee case, was one of the first important state court cases to demand individualized risk assessments (without using that

86 See, e.g., Aletha Claussen-Schulz, Marc Pearce & Robert Schopp, *Dangerousness, Risk Assessment, and Capital Sentencing*, 10 PSYCHOL. PUB. POL’Y & L. 471 (2004). On the relationship between criminal history and risk assessments, see Melissa Hamilton, *Back to the Future: The Influence of Criminal History on Risk Assessments*, 20 BERKELEY J. CRIM. L. 75 (2015). Legal scholars have begun to consider seriously and carefully all aspects of risk assessment decision making in a variety of contexts far removed from the topic of this paper. See, e.g., CASS SUNSTEIN, *RISK AND REASON: SAFETY, LAW AND THE ENVIRONMENT* (2004); Jonathan Simon, *Risk and Reflexivity: What Socio-Legal Studies Adds to the Study of Risk and the Law*, 57 ALA. L. REV. 119, 122 (2005). On the related question of the relationship between risk and heuristic reasoning, see Amos Tversky & Daniel Kahneman, *Availability: A Heuristic for Judging Frequency and Probability*, 5 COGNITIVE PSYCHOL. 207 (1973). One of the authors (MLP) discusses the power of heuristics in related contexts in, inter alia, Michael L. Perlin, “*The Executioner’s Face Is Always Well-Hidden*”: *The Role of Counsel and the Courts in Determining Who Dies*, 41 N.Y.L. SCH. L. REV. 201, 231 (1996) (“We know how, as a result of the vividness heuristic, one salient case can lead to the restructuring of an entire body of jurisprudence.”), and Michael L. Perlin & Naomi Weinstein, “*Said I, ‘But You Have No Choice’*”: *Why a Lawyer Must Ethically Honor a Client’s Decision about Mental Health Treatment Even if It Is Not What S/he Would Have Chosen*, 15 CARDOZO PUBLIC L., POL’Y & ETHICS J. __ (2017) (forthcoming), manuscript at 24 (“One single vivid, memorable case overwhelms mountains of abstract, colorless data upon which rational choices should be made.”).

87 See, e.g., Christopher Slobogin, *Dangerousness and Expertise Redux*, 56 EMORY L.J. 275, 277 (2006). On risk assessment in the context of civil commitment, see Alexander Scherr, *Daubert & Danger: The “Fit” of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 13 (2003).

88 Christopher Slobogin, *The Civilization of the Criminal Law*, 58 VAND. L. REV. 121, 127–28 (2005).

89 See *supra* note 39, for the key provisions of this statute.

90 *State v. Krol*, 344 A.2d 289, 301 (N.J. 1975).

91 *Id.*

92 *Id.*

93 *Id.* at 302; see also PERLIN & CUCOLO, *supra* note 3, § 3-5.1.2(b), at 3-102 to 3-109.

phrase): "[The state's] contention that, as a class, persons acquitted by reason of insanity are more likely to be dangerous than other persons does not rationally establish that any particular individual in the class should be confined even if he is not dangerous."⁹⁴ And, "the disposition must be individualized with the focus on the offender, not the offense he committed, although such offense can serve as an indication of the harm the patient is capable of inflicting."⁹⁵

While *Krol* has no precedential value in New York (which has, in cases such as *Jamie R. v. Consilvio*⁹⁶ and *In re Stone*,⁹⁷ embraced—incorrectly in our view—the US Supreme Court's standard articulated in *Jones v. Unites States*,⁹⁸ employing a limited due process model in such cases),⁹⁹ this language should still inform decisionmakers in the individual cases at hand.

B. The Most Recent Research on the Ability of Mental Health Professionals to Predict Dangerousness to Any Level of Medical Certainty

The next question to confront is that of the accuracy of psychiatric predictions,¹⁰⁰ and here it is necessary to begin with the work of Professor John Monahan.¹⁰¹ Monahan's research is crystal clear and uncontroverted: unstructured clinical assessments of dangerousness are neither valid nor reliable,¹⁰² and, at best, they allow clinicians to distinguish violent from non-violent patients "with a modest, better-than-chance level of accuracy."¹⁰³ By contrast, there are structured risk assessment tools—employing different means of statistical or actuarial risk assessment—now available that, by any measure of reckoning,¹⁰⁴ are superior to the unstructured assessments traditionally used.¹⁰⁵ However, as Monahan notes:

94 *Krol*, 344 A.2d at 299.

95 *Id.* at 303.

96 844 N.E.2d 285, 286 n.2 (N.Y. 2006).

97 740 N.Y.S.2d 335, 338 (App. Div. 2002).

98 463 U.S. 354 (1983) (rejecting arguments that it was unconstitutional to retain insanity acquittees for longer periods of time than the maximum sentence for the underlying crime).

99 One of the authors (MLP) critiques this approach as anti-therapeutic in Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 430 n.157(2000).

100 See generally MICHAEL L. PERLIN, MENTAL DISABILITY AND THE DEATH PENALTY: THE SHAME OF THE STATES 19–28 (2013); PERLIN & CUCOLO, *supra* note 3, § 3.4.2.5, at 3-50 to 3-84.

101 Professor Monahan's status as the "leading thinker on this issue" has been constant for over three decades. See, e.g., *Barefoot v. Estelle*, 463 U.S. 880, 920 (1983) (Blackmun, J., dissenting).

102 See John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 394 (2006) (Monahan, *Forecasting*); John Monahan, *Tarasoff at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 498–99 (2006) (Monahan, hereinafter *Developments*).

103 Douglas Mossman, *Assessing Predictions of Violence: Being Accurate About Accuracy*, 62 J. CONSULTING & CLINICAL PSYCHOL. 783, 790 (1994) (discussing Prof. Monahan's work).

104 William Grove & Paul Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y & L. 293, 318 (1996) ("We know of no social science controversy for which the empirical studies are so numerous, varied, and consistent as this one.").

105 Monahan, *Forecasting*, *supra* note 102, at 406–07; Monahan, *Developments*, *supra* note 102, at 511–13.

The . . . scientific literature is clear that structured risk assessment is superior to unstructured risk assessment in accurately predicting violent behavior. But are mental health professionals heeding the research and using structured risk assessments when assessing violence risk? The literature on the incorporation of structured risk assessment into the clinical practice of predicting violence is thin, but all of it suggests that only a minority of mental health professionals routinely employ structured risk assessment.¹⁰⁶

Importantly, the inability of psychiatric professionals to predict violence has been specifically recognized by the US Supreme Court.¹⁰⁷ However, most lower courts have not embraced this finding, and continue to place tremendous amounts of weight on risk assessment measures that are often outdated and scientifically unreliable.¹⁰⁸

See also, e.g., Thomas R. Litwack, *Actuarial Versus Clinical Assessments of Dangerousness*, 7 PSYCHOL. PUB. POL'Y & L. 409, 409 (2001).

106 Monahan, *Developments*, *supra* note 102, at 511, 513.

107 *See, e.g.*, *Heller v. Doe*, 509 U.S. 312, 323–24 (1993) (stating that there are “difficulties inherent in diagnosis of mental illness. It is thus no surprise that many psychiatric predictions of future violent behavior by the mentally ill are inaccurate.” (internal citation omitted)).

108 For an analysis of common risk assessment tools, actuarial tools and standards of professional judgment, see Karl Hanson & Kelly E. Morton-Bourgon, *The Accuracy of Recidivism Risk Assessments for Sexual Offenders: A Meta-Analysis of 118 Prediction Studies*, 21 PSYCHOL. ASSESSMENT 1 (2009); *see generally*, JAY SINGH ET AL., *THE INTERNATIONAL RISK SURVEY: USE AND PERCEIVED UTILITY OF STRUCTURED VIOLENCE RISK ASSESSMENT TOOLS IN 44 COUNTRIES* (2016).

Hanson and Morton-Bourgon discuss the use of risk assessment tools as they relate to predictions of dangerousness, and how these predictions have become standard practice in many areas of law. In particular, those working with sex offenders are particularly conscious of risk assessment tools. Measures such as the STATIC-99 and STATIC-2002 have become, in many jurisdictions, the sole measure of dangerousness prediction in many cases of civil commitment of a sex offender when determining his future dangerousness. While some risk assessment measures may have limited success in predicting actual recurrence of offenses, it is frequently the case that these tools will over-predict the likelihood of re-offense. Risk assessments measure “static” and “dynamic” factors based on the individual, but often do not have reliable predictability. Recent meta-analyses of the most popular risk assessment measures have showed that, even with the addition of multiple factors supposedly linked to recidivism, the predictive capabilities of these risk assessment measures has not dramatically increased beyond its standard percentage of accuracy.

However, it is important to note that this meta-analysis also showed less predictive capability in the unstructured professional judgment risk assessment determination than any of the actuarial tools. While risk assessment for dangerousness in general for violent crimes and specifically for sex offender recidivism is still not an entirely reliable or even, in the case of some less-tested instruments, a valid measurement, it still prevails over the use of the “professional judgment” standard in any study of effectiveness. On these questions in general, see Heather Ellis Cucolo & Michael L. Perlin, “*Far From the Turbulent Space*”: *Considering the Adequacy of Counsel in the Representation of Individuals Accused of Being Sexually Violent Predators*, 18 U. PA. J.L. & SOC. CHANGE 125 (2015) (discussing these instruments and the special abilities needed by counsel to understand them and to effectively cross-examine witnesses who rely on them); *see generally*, PERLIN & CUCOLO, *supra* note 74.

In short, if forensic clinicians are not using the sort of structural tools discussed by Professor Monahan,¹⁰⁹ then, simply, their predictions—though, in hindsight, sometimes accurate—are not grounded on a valid and reliable scientific basis.¹¹⁰ What is especially interesting here is that in at least two of its cases in this area of the law, the New York Court of Appeals has identified imprecision of psychiatric predictivity of dangerousness as a basis for its finding that “psychiatry cannot now guarantee the safety of the public from future dangerous acts of persons found not responsible . . . and will most likely be unable to do so in the foreseeable future”¹¹¹ and as a rationale for relying on legislative categorizations in this area of the law.¹¹²

This decision is a mixed blessing for clinicians and attorneys working in the field of mental disability law.¹¹³ While it is important to recognize the inability of risk assessment techniques to deliver precise predictions about dangerousness and recidivism, it may be equally improper to allow an, at times, uninformed legislature to “categorize” types of defendants based on their symptoms or diagnosis. The New York Court of Appeals is correct in its decision to move away from the traditional reliance on risk assessment measures, but it may be allowing a practice of legislating dangerousness that will result in overbroad and far-reaching categorizations of defendants.

While New York has a clear set of guidelines it follows in order to classify its defendants and their anticipated levels of dangerousness, international mental disability law continues to evolve and change based on worldwide developments and

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- 109 Professor Monahan focuses in his recent writings on three: the HCR-20, the VRAG, and the COVR. See, e.g., Monahan, *Developments*, *supra* note 102, at 504–12. For Professor Monahan’s latest writings in this area, see John Monahan & Jennifer L. Skeem, *The Evolution of Violence Risk Assessment*, 19 CNS SPECTRUMS 419 (2014) (discussing the need for a continuum of structured approaches to risk assessment). On the use of risk assessments in sentencing, see Nicholas Scurich & John Monahan, *Evidence-based Sentencing: Public Openness and Opposition to Using Gender, Age, and Race as Risk Factors for Recidivism*, 40 L. & HUM. BEHAV. 36 (2016).
- 110 Some commentators go even further. See Anton Tolman & Kristine Mullendore, *Risk Evaluations for the Courts: Is Service Quality a Function of Specialization?*, 34 PROF. PSYCHOL. 225, 230 (2003) (“[T]his approach to risk evaluation is clearly ignorant of the specialized body of knowledge that has accrued in the past 2 decades and is characteristic of the ‘unstructured clinical approach’ to evaluation that has been criticized repeatedly (citation omitted) as a method of insufficient reliability and validity for making important judgments.”)
- 111 *In re George L.*, 648 N.E.2d 475, 481 (N.Y. 1995) (citing 1981 N.Y. Sess. Laws 2261 (McKinney)). See also *id.* at 481 n. 5 (citing Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599, 693 (1990) (“The voluminous literature examining the ability of psychiatrists [or other mental health professionals] to predict dangerousness in the indeterminate future has been virtually unanimous: ‘psychiatrists have absolutely no expertise in predicting dangerous behavior.’”).
- 112 See *In re Francis S.*, 663 N.E.2d 881, 885 (N.Y. 1995) (relying on discussion in *Jones v. United States*, 463 U.S. 354, 365 n.13 (1983), of the “very imprecision of the field of psychiatry.”).
- 113 Although counsel is assigned to all persons facing commitment in New York state, see N.Y. MENTAL HYG. L. § 47.03, (McKinney 2007), there are many states without the sort of organized counsel system present there. See PERLIN & CUCOLO, *supra* note 3, § 6-4.4, at 6–54 to 6-58.

increased understanding of mental illness and dangerousness.¹¹⁴ As we will discuss further, the CRPD was a driving force in re-energizing a worldwide recognition of the concepts of mental illness and dangerousness and how they relate to individuals in psychiatric facilities.¹¹⁵

C. The Danger of Erroneous Diagnosis by Clinicians, and the Constitutional Problems it Creates

Ultimately, the question must be asked: does the Constitution allow for an individual to be confined indefinitely and deprived of his liberties based on expert testimony in a field that rapidly changes and constantly redefines the parameters of dangerousness, risk, and illness itself? Although psychiatry and psychiatric diagnosis are accepted practices used to establish the criteria for civil commitment, there has never been a challenge in front of the court that argued that the risk of clinician error should be weighed against the diagnosis made and its ultimate consequences. Notwithstanding this fact, we believe that this is a reasonable question to consider.

The Supreme Court, in *Addington v. Texas*,¹¹⁶ made it crystal-clear that the reasonable-doubt standard is inappropriate when individuals are being confined based on a psychiatric diagnosis.¹¹⁷ The very nature of diagnoses is “based on medical ‘impressions’ drawn from subjective analysis and filtered through the experience of the diagnostician.”¹¹⁸ Even with safeguards that act to quantify diagnostic categories, such as the American Psychiatric Association’s *Diagnostic and Statistical Manual* (often characterized as the “gold standard” of classification¹¹⁹), the subjectivity of a clinician’s diagnosis may be a constitutional problem. The *Addington* Court has come closest to authentically confronting the potential legal issues inherent in an erroneous psychiatric diagnosis with respect to civil commitment.¹²⁰ The Court there chose to recognize the subjectivity inherent in diagnosing complex psychiatric behaviors and used a constitutional analysis to implement a more appropriate standard than a simple preponderance quantum.¹²¹ However, no reported case as of yet has challenged an erroneous diagnosis and subsequent civil commitment on a constitutional basis.

114 See *infra* Part III.

115 See generally, PERLIN, *supra* note 26.

116 441 U.S. 416 (1979) (holding that a “clear and convincing” standard of proof is proper for involuntary commitment).

117 *Id.* at 427–30.

118 *Id.* at 430.

119 E.g., Bruce Winick, *Sex Offender Law in the 1990s: A Therapeutic Jurisprudence Analysis*, 4 PSYCHOL. PUB. POL’Y & L. 505, 513 n. 36 (1998); Bruce Familant, *The Essential Functions of Being a Lawyer with a Non-Visible Disability: On the Wings of a Kiwi Bird*, 15 T.M. COOLEY L. REV. 517, 526 n.53 (1998).

120 See PERLIN & CUCOLO, *supra* note 3, § 4-2.3.2, at 4-97 (citing, inter alia, Donald Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L.REV. 83, 85 (1986)).

121 *Addington*, 441 U.S. at 432–33.

In contrast, the Court in *Heller v. Doe* wrote about the "[e]ase of diagnosis" for individuals with developmental disabilities.¹²² Those diagnoses are based on evidence of disability that is "well-documented throughout childhood" whereas clinicians treating patients with mental illness often do not have the luxury of a complete history of behaviors.¹²³ In fact, the Court in *Heller* specifically recognized the differences between the two types of diagnosis and stated, "as we recognized in an earlier case, diagnosis of mental illness is difficult," citing to *Addington*.¹²⁴ The potential for error seems to be recognized; however, there has been no effort made to address the effects or consequences of erroneous diagnosis.¹²⁵

This lack of adjustment in the law based on what is now known about the potential for erroneous diagnosis may, however, not be solely due to lack of recognition and effort. The conflation of risk with psychiatric diagnosis, made ever-present by ongoing sanism¹²⁶ and heuristics,¹²⁷ will lead to an imbalance in the weighing of erroneous diagnosis versus unconstitutional confinement. Judges concerned with their reputations (and, in some instances, their chances of re-election)¹²⁸ will lean more heavily in favor of commitment regardless of the risk of clinician error, which is unquantifiable and is virtually never presented as a defense.¹²⁹

When clinicians go through the process of making an informed diagnosis, they are rarely concerned with "the law"; there is no safety measure built in to the American Psychiatric Association's Diagnostic and Statistical Manual¹³⁰ to ensure that an erroneous diagnosis does not lead to a future of unconstitutional commitment and stigma.¹³¹ The law has only recently started to understand the fallibility of risk assessment through a constitutional lens. The recognition of the

122 *Heller v. Doe*, 509 U.S. 312, 313 (1993).

123 *Id.*

124 *Id.* at 322.

125 On the question of *Heller's* potential impact on the question of inaccuracy of dangerousness predictions in cases involving individuals with mental illness, see PERLIN & CUCOLO, *supra* note 3, § 4-2.3.2.2, at 4-105 to 4-106.

126 See sources cited *supra* note 32.

127 See BARAK, *supra* note 85, and *supra* note 86.

128 On this question in the parallel area of judicial decision-making in sex offender cases, see generally Heather Ellis Cucolo & Michael L. Perlin, "They're Planting Stories In the Press": *The Impact of Media Distortions on Sex Offender Law and Policy*, 3 U. DENV. CRIM. L. REV. 185 (2013).

129 It is not clear why this is. Perhaps counsel for patients believe the argument is not sufficiently strong and/or perhaps they are concerned that this might have a deleterious impact on their future relationships with the same clinicians.

130 See generally, Michael L. Perlin, "I Expected It to Happen / I Knew He'd Lost Control": *The Impact of PTSD on Criminal Sentencing after the Promulgation of DSM-5*, 2015 UTAH L. REV. 881 (2015).

131 On ways that clinicians have been counseled by leaders in their field to ignore restrictive civil commitment laws, see Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 644-45 (1993), discussing Paul Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 494, 501 (1976), arguing that "wise and benevolent paternalism," should lead to a "moral judgment" that hospitalization is appropriate for patients "incapable of voluntarily accepting help," *in spite of* laws rejecting "need of treatment" as a commitment standard.

danger of erroneous diagnosis is the next logical step for the court to take, following on the hints of understanding of the devastating consequences of erroneous commitment alluded to in *Addington* and *Heller*.

III. INTERNATIONAL HUMAN RIGHTS LAW PRINCIPLES¹³²

Given the ratification of the United Nations' Convention on the Rights of Persons with Disabilities¹³³ (CRPD), the state of the law as it relates to persons with disabilities must be radically reconsidered.¹³⁴ The CRPD is "regarded as having finally empowered the 'world's largest minority' to claim their rights and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection."¹³⁵ This Convention—the most revolutionary international human rights document ever created that applies to persons with disabilities¹³⁶—furtheres the human rights approach to disability and recognizes the right of people with disabilities to equality in most every aspect of life.¹³⁷ It firmly endorses a social model of disability as it reconceptualizes mental health rights as disability rights. The Convention is a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law.¹³⁸ The Convention—"ushering in a new era of disability rights policy"¹³⁹—"sketches the full range of human rights that apply to all human beings, all with a

132 This section is generally adapted from Perlin & Schriver, *supra* note 5.

133 See generally G.A. Res. 61/106, *supra* note 26.

134 See generally PERLIN, *supra* note 26.

135 Rosemary Kayess & Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, 8 HUM. RTS. L. REV. 1, 4 n.17 (2008). See also, e.g., Statements made by the High Commissioner for Human Rights, Louise Arbour, and the Permanent Representative of New Zealand and Chair of the Ad-Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ambassador Don Mackay, at a Special Event on the Convention on Rights of Persons with Disabilities, convened by the UN Human Rights Council (Mar. 26, 2007), <http://www.crin.org/en/library/news-archive/special-event-human-rights-council-new-disability-convention> (last visited Apr. 20, 2017) (quoting statements made by the High Commissioner For Human Rights, Louise Arbour, and the permanent representative of New Zealand and chair of the ad-hoc committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ambassador Don Mackay, at a special event on the Convention on the Rights of Persons with Disabilities, convened by the UN Human Rights Council).

136 See, generally Perlin & Szeli, *supra* note 27; PERLIN, *supra* note 26, at 3–21; Perlin, *supra* note 27.

137 See e.g., Dhir, *supra* note 28.

138 See Paul Harpur & Richard Bales, *The Positive Impact Of The Convention on the Rights of Persons with Disabilities: A Case Study on the South Pacific and Lessons from the U.S. Experience*, 37 N. KY. L. REV. 363, 367 (2010) (CRPD is a "paradigm shift from the medical model to an environmental model to a social justice model of disability"). See also Phillip Fennel, *Human Rights, Bioethics, and Mental Disorder*, 27 MED. & L. 95 (2008); Michael L. Perlin, "Abandoned Love": *The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, 35 L. & PSYCHOL. REV. 121 (2011).

139 William P. Schurgin & Kristen McGurn, *The ADA Amendments Act: Expanded Disability Challenges for Health Care Employers*, Issue No. 20, HEALTHCARE COMPL. REP. 10484213 (C.C.H.), 2009 WL 10484213. See also, Paul Harpur, *Time to Be Heard: How Advocates Can Use the Convention on the Rights of Persons with Disabilities to Drive Change*, 45 VAL. U. L. REV. 1271, 1295 (2011).

particular application to the lives of persons with disabilities."¹⁴⁰ It provides a framework for ensuring that mental health laws "fully recognises the rights of those with mental illness,"¹⁴¹ and mandates *prescriptive* rights in addition to *proscriptive* rights.¹⁴² There is no question that the Convention has "ushered in a new era of disability rights policy."¹⁴³

Disability is a condition that arises from "interaction with various barriers [that] may hinder their full and effective participation in society on an equal basis with others" instead of inherent limitations.¹⁴⁴ The Convention extends existing human rights to take into account the specific rights experiences of persons with disabilities,¹⁴⁵ calling for "respect for inherent dignity"¹⁴⁶ and "non-discrimination."¹⁴⁷ Other articles declare "freedom from torture or cruel, inhuman or degrading treatment or punishment,"¹⁴⁸ "freedom from exploitation, violence and abuse,"¹⁴⁹ and a right to protection of the "integrity of the person."¹⁵⁰ Equality and nondiscrimination are cornerstones of the CRPD's mission. Nations must "recognize that all persons are equal before and under the law," and "prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds."¹⁵¹ The CRPD not only clarifies that states should not discriminate against persons with disabilities, but it also sets out explicitly the many steps that states must take to create an enabling environment so that persons with disabilities can enjoy authentic equality in society.¹⁵²

140 Janet E. Lord & Michael A. Stein, *Social Rights and the Relational Value of the Rights to Participate in Sport, Recreation, and Play*, 27 B.U. INT'L L. J. 249, 256 (2009); see also Ronald McCallum, *The United Nations Convention on the Rights of Persons with Disabilities: Some Reflections*, SOC. SCI. RES. NETWORK ELECTRONIC LIBR. (Mar. 2010), <http://Ssrn.Com/Abstract=1563883>.

141 Bernadette McSherry, *International Trends in Mental Health Laws: Introduction*, 26 L. CONTEXT: SOCIO-LEGAL J. 1, 8 (2008).

142 Prescriptive rights require certain conduct, whereas proscriptive rights forbid particular behavior. See generally Edward J. Imwinkelried, *Expert Testimony by Ethicists: What Should be The Norm?*, 33 J.L. MED. & ETHICS 198, 200 (2005). On the significance of the inclusion of proscriptive and prescriptive rights in human rights treaties in general, see Robert Quinn, *Will the Rule of Law End? Challenging Grants of Amnesty for the Human Rights Violations of a Prior Regime: Chile's New Model*, 62 FORDHAM L. REV. 905, 920 (1994). On their significance in the CRPD context specifically, see Michael L. Perlin, *The Significance of the Convention on the Rights of Persons with Disabilities – And Why It Demands the Creation of an Asian/Pacific Disability Rights Tribunal*, ANN. REP. KANAGAWA U. INST. LEGAL STUD. (2014).

143 Harpur, *supra* note 138, at 1295.

144 G.A. Res. 61/106, *supra* note 26, at 4.

145 Frédéric Mégret, *The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?*, 30 HUM. RTS. Q. 514–15 (2008); see also PERLIN, *supra* note 26, at 143–58.

146 G.A. Res. 61/106, *supra* note 26, art. 3, ¶ A.

147 *Id.* at art. 3, ¶ B.

148 *Id.* at art. 15.

149 *Id.* at art. 16.

150 *Id.* at art. 17.

151 *Id.* at art. 5.

152 On the changes that ratifying states need to make in their domestic involuntary civil commitment laws to comply with Convention mandates, see Bryan Y. Lee, Note, *The U.N. Convention on the Rights of*

Although the United States has not yet ratified the CRPD, President Obama signed the Convention in 2009.¹⁵³ Under such circumstances, “a state’s obligations under it are controlled by the Vienna Convention of the Law of Treaties . . . which requires signatories ‘to refrain from acts which would defeat [the Disability Convention’s] object and purpose.’”¹⁵⁴ Domestic courts in New York have thus cited the CRPD approvingly in cases involving guardianship matters.¹⁵⁵ In one such case Surrogate Judge Kristen Booth Glen noted that that the CRPD was entitled to “‘persuasive weight’ in interpreting our own laws and constitutional protections.”¹⁵⁶ International human rights law demands—at the very least—individualized assessments of risk prior to the imposition of restrictions that limit the liberty of a patient, whether civil or forensic. By way of example, New York’s multi-tier system¹⁵⁷ may run afoul of the CRPD’s Article 5, which, if interpreted broadly, could

- Persons with Disabilities and Its Impact upon Involuntary Civil Commitment of Individuals with Developmental Disabilities*, 44 COLUM. J.L. & SOC. PROBS. 393, 432–45 (2011). See also István Hoffman & György Könczei, *Legal Regulations Relating to the Passive and Active Legal Capacity of Persons with Intellectual and Psychosocial Disabilities in Light of the Convention on the Rights of Persons with Disabilities and the Impending Reform of the Hungarian Civil Code*, 33 LOY. L.A. INT’L & COMP. L. REV. 143, 163–67 (2010) (discussing the application of the CRPD to capacity issues); Perlin, *supra* note 32 (discussing the application of the CRPD to guardianship law); Michael L. Perlin, “*There Are No Trials Inside the Gates of Eden*”: *Mental Health Courts, the Convention on the Rights of Persons with Disabilities, Dignity, and the Promise of Therapeutic Jurisprudence*, in COERCIVE CARE: LAW AND POLICY 193 (Bernadette McSherry & Ian Freckelton ed. 2013) (discussing the application of the CRPD to mental health court systems); Michael L. Perlin, “*Yonder Stands Your Orphan with His Gun*”: *The International Human Rights Implications of Juvenile Punishment Schemes*, 46 TEX. TECH. L. REV. 301, 305 n.19 (2013) [hereinafter *Yonder*] (discussing the application of the CRPD to juvenile punishment schemes); Michael L. Perlin & Naomi Weinstein, “*Friend to the Martyr, a Friend to the Woman of Shame*”: *Thinking About The Law, Shame and Humiliation*, 24 SO. CAL. REV. L. & SOC’L JUST. 1 (2014) (discussing the application of the CRPD to shaming and humiliating practices in the mental health system); Kathryn D. DeMarco, Note, *Disabled by Solitude: The Convention on the Rights of Persons with Disabilities and Its Impact on The Use of Supermax Solitary Confinement*, 66 U. MIAMI L. REV. 523, 541–57 (2012) (discussing the application of the CRPD to solitary confinement in correctional institutions).
- 153 See Michelle Diamant, *Obama Urges Senate to Ratify Disability Treaty*, DISABILITY SCOOP (May 18, 2012), <http://www.disabilityscoop.com/2012/05/18/Obama-Urges-Senate-Treaty/15654/>. The Senate failed to ratify the CRPD on December 4, 2012, for lack of a supermajority of votes. See U.S. Int’l Council on Disabilities, <http://usidc.org/index.cfm> (last visited Sept. 16, 2013). The Democratic leadership promised to bring the Convention up again for ratification in 2015. See *Yonder*, *supra* note 152.
- 154 See *In re Mark C.H.*, 906 N.Y.S.2d 419, 433 (Sur. 2010) (citing Vienna Convention on the Law of Treaties art. 18, May 23, 1969, 1155 U.N.T.S. 331), as discussed in Henry Dlugacz & Christopher Wimmer, *The Ethics of Representing Clients with Limited Competency in Guardianship Proceedings*, 4 ST. LOUIS U. J. HEALTH L. & POL’Y 331, 362–63 (2011).
- 155 See, e.g., *Mark C.H.*, 906 N.Y.S.2d at 419 (finding that due process requires that the guardianship appointment be subject to a requirement of periodic reporting and review); *In re Dameris L.*, 956 N.Y.S.2d 848 (Sur. 2012) (finding substantive due process requirement of adherence to principal of least restrictive alternative applies to guardianships sought for mentally retarded persons).
- 156 *Dameris L.*, 956 N.Y.S. 2d at 855. See Perlin, *supra* note 32, at 1178 n.97 (discussing *Dameris L.* in this context).
- 157 See *supra* text accompanying notes 45–50.

prohibit all discrimination against individuals with disabilities.¹⁵⁸ In practice, individuals with conditions predetermined to pose a risk can be transferred to a more secure facility without a full due process hearing.¹⁵⁹ Article 5 of the CRPD may provide a basis on which to claim that it is improper to discriminate based on the type of diagnosed disability, and that all transfers, regardless of diagnosed conditions, warrant a full due process hearing.

In fact, strong arguments have been made that international human rights law calls into question *all* currently-existing domestic civil commitment schemes, especially if involuntary treatment is a possible "side product" of such commitment.¹⁶⁰ The UN's Committee on the Rights of Persons with Disabilities has, in a general comment, stated that "forced treatment . . . is a violation of [Articles 15, 16 and 17 of the CRPD]."¹⁶¹ The same Committee has characterized the segregation of persons with disabilities in institutions as "a pervasive and insidious problem that violates a number of rights guaranteed under the Convention."¹⁶² An annual report of the UN High Commissioner for Human Rights is similarly quite clear: "Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished."¹⁶³ The international framework has now been put in place by the UN and those nations that have ratified the CRPD. It now falls to the individual nations and courts to uphold these mandates in case law and put into practice what is so clearly expressed in the CRPD: individuals with disabilities are entitled to give

158 Lee, *supra* note 152, at 429. On the need for all participants in the *forensic* system to understand the significance of international human rights as they affect cases of persons with mental disabilities, see Michael L. Perlin & Valerie McClain, "Where Souls Are Forgotten": *Cultural Competencies, Forensic Evaluations and International Human Rights*, 15 PSYCHOL. PUB. POL'Y & L. 257, 258 (2009).

159 *E.g.*, Mental Hygiene Legal Servs. *ex rel.* Aliza K. v. Ford, 705 N.E.2d 1191, 1194 (1998).

160 This is clearly contemplated under New York case law. *See, e.g.*, Ernst J. v. Stone, 452 F.3d 186 (2d Cir. 2006); *In re* Eric U., 835 N.Y.S. 2d 518 (N.Y. App. Div. 2007).

161 United Nations Office of the High Commissioner for Human Rights, Comm. on the Rights of Persons with Disabilities, General Comment No. 1 ¶ 42, (2014), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>.

162 *Id.* ¶ 46.

163 Annual Report of the U.N. High Comm'r for Human Rights & Reports of the Office of the High Comm'r and the Secretary-General, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*, ¶ 49, U.N. Doc. A/HRC/10/48 (Jan. 26, 2009). *See also* Interim Report of the Special Rapporteur of the Human Rights Council, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 64, U.N. Doc. A/63/175 (July 28, 2008) ("Many States, with or without a legal basis, allow for the detention of persons with mental disabilities in institutions without their free and informed consent, on the basis of the existence of a diagnosed mental disability often together with additional criteria such as being a 'danger to oneself and others' or in 'need of treatment.' The Special Rapporteur recalls that article 14 of CRPD prohibits unlawful or arbitrary deprivation of liberty and the existence of a disability as a justification for deprivation of liberty.").

consent on institutionalization, a critical matter affecting their freedom and liberties.¹⁶⁴

There is limited relevant case law from the inter-regional human rights courts and commissions, but what little case law does exist supports the arguments set forth in this Article. In *Case of Furlan and Family v. Argentina*,¹⁶⁵ a case involving a fourteen-year-old who suffered from permanent brain damage as a result of an accident on a field that was the property of the Argentinean army, the Inter-American Court of Human Rights, in ordering reparations and equitable relief, relied on the CRPD for the proposition that it was “imperative” that states adopt “affirmative measures to “respect and ensure human rights,” “according to the particular protection needs” of the individual person,¹⁶⁶ so as to “promote social inclusion practices.”¹⁶⁷ The fact that, by way of example, there is no right to a hearing under New York’s track transfer scheme¹⁶⁸ falls afoul of the “affirmative measures” requirement mandated by the *Furlan* court.

Elsewhere, in a child care case involving a potential loss of custody of a premature baby on the part of a mother with learning disabilities, the European Court of Human Rights found that the state’s procedures provided an effective vehicle through which a guardian’s actions could be challenged, and thus it found no violation of the CRPD.¹⁶⁹ However, in the course of its opinion, that court noted that, under the Convention, the state was obligated to provide “appropriate accommodation to facilitate disabled persons’ effective role in legal proceedings.”¹⁷⁰ Again, there is no evidence that such “appropriate accommodation[s]” are made in cases involving changes in track status in New York or parallel proceedings in other domestic jurisdictions.¹⁷¹

Even with mounting support in international human rights law, nations continue to ignore the basic rights given in the CRPD to individuals with disabilities. New York and other US jurisdictions have consistently failed to recognize the need for a more comprehensive due process system for individuals who are to be transferred to a secure facility. The international cases that appropriately recognize the rights of individuals with disabilities show that there is widespread recognition of the importance of giving a voice to these marginalized

164 On the implications of such arguments for the viability of mental status defenses in the criminal law, see Perlin, *supra* note 29 (both the incompetency status and the insanity defense are compatible with and required by the CRPD).

165 Provisional Measures, Order of the Court, Inter-Am. Ct. H.R. (ser. C) No. 246 (Aug. 31, 2012), http://www.corteidh.or.cr/docs/casos/articulos/resumen_246_ing.pdf.

166 *Id.* at 46 (emphasis added).

167 *Id.*

168 See sources cited *supra* note 45; see also *Savastano v. Nurnberg*, 548 N.Y.S.2d 555 (App. Div. 1989) (finding transfer from municipal acute-care facility to hospital without a hearing constitutional).

169 See *R.P. v. United Kingdom*, 2013 Eur. Ct. H.R. 1, 22–23; *Glor v. Switzerland*, 2009 Eur. Ct. H.R. 1, 11.

170 *R.P.*, 2013 Eur. Ct. H.R. at 20–21.

171 For a discussion of other European cases finding extensive human rights violations in cases involving persons with mental disabilities, see Perlin, *supra* note 32, at 1169–70.

individuals. It is the hope of these authors that the United States follows suit and ends the pervasive patterns and practices of discriminatory legislation.

In a recent paper, one of the authors (MLP) and another co-author focused on six issues involving forensic patients that needed to be re-conceptualized in light of these developments:¹⁷²

- Although there is a robust literature on the CRPD and on the UN Convention against Torture, there is virtually no mention of the plight of forensic patients. So, even within the world of those who focus broadly on these human rights issues, this population has remained invisible.
- Conditions at forensic facilities around the world continue to "shock the conscience," and it is essential that any "anti-torture" publication (such as this one) highlight this.
- Even when regional courts and commissions have found international human rights violations in cases involving forensic patients (e.g., *Victor Rosario Congo v. Ecuador*)¹⁷³, the discussion of these cases largely ignores the plaintiffs' statuses as forensic patients
- There are few lawyers and fewer "mental disability advocates" providing legal and advocacy services to this population,
- There is little mention in the survivor movement literature about the specific plight of forensic patients.
- Forensic patients in facilities for persons with intellectual disabilities are particularly absent from the discourse.¹⁷⁴

In the course of that paper, we argued that the treatment of forensic patients globally violated international human rights law principles.¹⁷⁵ We believe that it is imperative that institutional administrators begin to come to grips with the significance of these principles for the population in question.

A. *Therapeutic Jurisprudence*¹⁷⁶

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence

172 See generally Perlin & McClain, *supra* note 158.

173 Case 11.427, Inter-Am. C.H.R., Report No. 63/99, OEA/Ser/L/V/II.102, doc. 6 rev., ¶ 54 (1999), discussed in this context in, inter alia, Michael L. Perlin, *An Internet-based Mental Disability Law Program: Implications for Social Change in Nations with Developing Economies*, 40 FORDHAM INT'L L.J. 435, 447–48 (2007).

174 Perlin & Schriver, *supra* note 5, at 201–02.

175 *Id.* at 216–17.

176 This section is partially adapted from Perlin, *Wisdom*, *supra* note 18, at 361–64, Perlin, *Yonder*, *supra* note 152, at 330–36, and Michael L. Perlin & Alison J. Lynch, "All His Sexless Patients": *Persons with Mental Disabilities and the Competence to Have Sex*, 89 WASH. L. REV. 257, 277–79 (2014). Further, it distills the work of one of the co-authors (MLP) over the past two decades, beginning with Michael L. Perlin, *What Is Therapeutic Jurisprudence?*, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993).

(TJ).¹⁷⁷ TJ recognizes that the law—potentially a therapeutic agent—can have therapeutic or anti-therapeutic consequences for individuals involved in both the civil and criminal justice systems.¹⁷⁸ The critical question is whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while, at the same time, not subordinating principles of due process?¹⁷⁹ Professor David Wexler, one of the creators of this field of scholarship/theory, has been clear about this for over two decades the law’s use of “mental health information to improve therapeutic functioning . . . [cannot] imping[e] upon justice concerns,”¹⁸⁰ a position with which we entirely agree.¹⁸¹

TJ “asks us to look at law as it actually impacts people’s lives,”¹⁸² focusing on the law’s influence on emotional life and psychological well-being.¹⁸³ TJ seeks to inform lawyering practices and influence policy “by using social science data and methodology to study the extent to which a legal rule, procedure, or practice promotes the psychological and physical well-being of the people it affects.”¹⁸⁴ It

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- 177 See, e.g., DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (1990); DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (1996); BRUCE J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 6–11* (2005); David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 *TOURO L. REV.* 17 (2008); PERLIN & CUCOLO, *supra* note 3, § 2–6, at 2-43 to 2-66. Wexler first used the term in a paper he presented to the National Institute of Mental Health in 1987. See David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 *L. & HUM. BEHAV.* 27, 32–33 (1992).
- 178 See Michael L. Perlin, “*His Brain Has Been Mismanaged with Great Skill*”: *How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?*, 42 *AKRON L. REV.* 885, 912 (2009); Kate Diesfeld & Ian Freckelton, *Mental Health Law and Therapeutic Jurisprudence*, in *DISPUTES AND DILEMMAS IN HEALTH LAW* 91 (Ian Freckelton & Kate Peterson eds. 2006) (offering a transnational perspective).
- 179 See Perlin, *supra* note 6, at 510 n.139; Perlin, *supra* note 10, at 719 n.195. On how therapeutic jurisprudence “might be a redemptive tool in efforts to combat sanism, as a means of ‘strip[ping] bare the law’s sanist façade,’” see Michael L. Perlin, “*Baby, Look Inside Your Mirror*”: *The Legal Profession’s Willful and Sanist Blindness to Lawyers with Mental Disabilities*, 69 *U. PITT. L. REV.* 589, 591 (2008), quoting, in part, PERLIN, *supra* note 2, at 301. See also Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 *T. JEFFERSON L. REV.* 575, 585–86 (2008); Bernard P. Perlmutter, *George’s Story: Voice and Transformation through the Teaching and Practice of Therapeutic Jurisprudence in a Law School Child Advocacy Clinic*, 17 *ST. THOMAS L. REV.* 561, 599 n.111 (2005).
- 180 David B. Wexler, *Therapeutic Jurisprudence and Changing Concepts of Legal Scholarship*, 11 *BEHAV. SCI. & L.* 17, 21 (1993). See also, e.g., David Wexler, *Applying the Law Therapeutically*, 5 *APPL. & PREVENT. PSYCHOL.* 179 (1996).
- 181 “An inquiry into therapeutic outcomes does not mean that therapeutic concerns ‘trump’ civil rights and civil liberties.” Perlin, *supra* note 99, at 412; Michael L. Perlin, *Where the Winds Hit Heavy on the Borderline: Mental Disability Law, Theory and Practice, Us and Them*, 31 *LOY. L.A. L. REV.* 775, 782 (1998).
- 182 Bruce J. Winick, *Foreword: Therapeutic Jurisprudence Perspectives on Dealing With Victims of Crime*, 33 *NOVA L. REV.* 535, 535 (2009).
- 183 David B. Wexler, *Practicing Therapeutic Jurisprudence: Psycholegal Soft Spots and Strategies*, in DENNIS P. STOLLE ET AL., eds., *PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION* 45 (2000).
- 184 Keri K. Gould & Michael L. Perlin, “*Johnny’s in the Basement/Mixing up his Medicine*”: *Therapeutic Jurisprudence & Clinical Teaching, Introduction to Therapeutic Jurisprudence: Issues, Analysis, and Applications*, 24 *SEATTLE U. L. REV.* 339, 353–54 (2000). See also Christopher Slobogin, *Therapeutic*

mandates that "law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law, should attempt to bring about healing and wellness."¹⁸⁵ In this context, it has been suggested that psychological health is a "fundamental legal interest."¹⁸⁶

TJ utilizes socio-psychological insights into the law and its applications,¹⁸⁷ and it is also part of a growing comprehensive movement in the law toward establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively, and respectfully.¹⁸⁸ TJ has thus been described as "a sea-change in ethical thinking about the role of law . . . a movement towards a more distinctly relational approach to the practice of law . . . which emphasise[s] psychological wellness over adversarial triumphalism."¹⁸⁹ TJ thus supports an ethic of care.¹⁹⁰

TJ and its practitioners place great importance on the principle of a commitment to dignity.¹⁹¹ Professor Amy Ronner describes the "three Vs": voice, validation and voluntariness,¹⁹² arguing:

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- Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193, 197 (1995) (TJ "adopt[s] a preference for laws that promote well-being").
- 185 Bruce J. Winick, *A Therapeutic Jurisprudence Model for Civil Commitment*, in INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVES ON CIVIL COMMITMENT 23, 26 (Kate Diesfeld & Ian Freckelton eds., 2003).
- 186 Douglas B. Marlowe et al., *A Sober Assessment of Drug Courts*, 16 FED. SENT'G REP., 153, 155 (2003).
- 187 Diesfeld & Freckelton, *supra* note 178, at 582.
- 188 Susan Daicoff, *The Role of Therapeutic Jurisprudence Within the Comprehensive Law Movement*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION, *supra* note 183, at 465. On the relationship between therapeutic jurisprudence, procedural justice and restorative justice, see generally PERLIN, *supra* note 12.
- 189 Warren Brookbanks, *Therapeutic Jurisprudence: Conceiving an Ethical Framework*, 8 J.L. & MED. 328, 329–30 (2001); see also Bruce J. Winick, *Overcoming Psychological Barriers to Settlement: Challenges for the TJ Lawyer*, in THE AFFECTIVE ASSISTANCE OF COUNSEL: PRACTICING LAW AS A HEALING PROFESSION 341 (Marjorie A. Silver ed., 2007); Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLINICAL L. REV. 605, 605–06 (2006). The use of the phrase dates to CAROL GILLIGAN, IN A DIFFERENT VOICE 73 (1982).
- 190 See, e.g., Gregory Baker, *Do You Hear the Knocking at the Door? A "Therapeutic" Approach to Enriching Clinical Legal Education Comes Calling*, 28 WHITTIER L. REV. 379, 385 (2006); Brookbanks, *supra* note 189; David B. Wexler, *Not Such a Party Pooper: An Attempt to Accommodate (Many of) Professor Quinn's Concerns about Therapeutic Jurisprudence Criminal Defense Lawyering*, 48 B.C. L. REV. 597, 599 (2007); Winick & Wexler, *supra* note 189, at 605–07.
- On the explicit link between TJ and the notion of "ethic of care," see Susan Daicoff, *Lawyer, Be Thyself: An Empirical Investigation of the Relationship between the Ethic of Care, the Feeling Decisionmaking Preference, and Lawyer Wellbeing*, 16 VA. J. SOC. POL'Y & L. 87, 122 n.234 (2008); Susan Daicoff, *Making Law Therapeutic For Lawyers: Therapeutic Jurisprudence, Preventive Law, and the Psychology of Lawyers*, 5 PSYCHOL., PUB. POL'Y. & L. 811 (1999).
- 191 See BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 161 (2005). See generally PERLIN, *supra* note 12; Perlin, "There Are No Trials Inside the Gates of Eden," *supra* note 152.

What “the three Vs” commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant’s story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronouncement that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions.¹⁹³

The question to be posed here is this: to what extent are the practices and procedures discussed in this paper consonant with TJ? Do they best ensure that these principles written about by Professor Ronner—the principles of voluntariness, voice, and validation—be fulfilled in matters involving residents of forensic institutions? Certainly, there is little about what happens that is *voluntary* on the part of the patients; maximum security facilities bespeak involuntariness *in se*.¹⁹⁴ There is little evidence that the patients in question have much of a *voice* (if at all) in their treatment or in the conditions of their confinement.¹⁹⁵ Although we know that fairness and procedural justice inevitably increase compliance with court orders,¹⁹⁶ we also know that procedural justice is often solely lacking in all forensic facility decision making.¹⁹⁷ One of us (MLP), in writing some years ago about sexual autonomy in psychiatric hospitals, concluded, “Much of the case law ignores forensic patients entirely.”¹⁹⁸ So do the developments expanding TJ concepts to institutionalized persons in general largely ignore forensic patients?

At the outset, there is no evidence that there is any requirement that New York’s risk assessment measures comport with the ways that the behavioral community agrees are most likely to yield accurate and valid findings: through the

192 Amy D. Ronner, *The Learned-Helpless Lawyer: Clinical Legal Education and Therapeutic Jurisprudence as Antidotes to Bartleby Syndrome*, 24 *TOURO L. REV.* 601, 627 (2008). On the importance of “voice,” see also DIESFELD & FRECKELTON, *supra* note 178, at 588.

193 Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles*, 71 *U. CIN. L. REV.* 89, 94–95 (2002). See generally AMY D. RONNER, *LAW, LITERATURE AND THERAPEUTIC JURISPRUDENCE* (2010).

194 Consider in this context Joel Haycock’s caution that therapeutic jurisprudence risks should not be considered solely from the perspective of the *clinician*, but, rather, from the “perspective of the objects of the mental health law.” Joel Haycock, *Speaking Truth to Power: Rights, Therapeutic Jurisprudence, and Massachusetts Mental Health Law*, 20 *NEW ENG. J. ON CRIM. & CIV. CONFINEMENT* 301, 317 (1994).

195 On the question of, for example, the freedom of sexual autonomy in forensic facilities, see generally, Perlin, *supra* note 6; MICHAEL L. PERLIN & ALISON J. LYNCH, *SEXUALITY, DISABILITY, AND THE LAW: BEYOND THE LAST FRONTIER?* (2016).

196 Cucolo & Perlin, *supra* note 9, at 69 (citing Raymond Paternoster et al., *Do Fair Procedures Matter?: The Effect of Procedural Justice on Spouse Assault*, 31 *LAW & SOC’Y REV.* 163, 160 (1997)).

197 See, e.g., *Davis v. Balson*, 461 F. Supp. 842, 874–878 (N.D. Ohio 1987).

198 Perlin, *supra* note 6, at 488.

use of the sort of structured risk assessment instruments urged by Professor Monahan and his colleagues.¹⁹⁹ In an assessment of the potential value of TJ in the rehabilitation of persons with severe mental illness, William Spaulding and his colleagues stress that "everyone is best served when the determinations of risk upon which restrictive interventions are based must be as accurate, precise, and complete as clinical technology allows."²⁰⁰

This sort of assessment was specifically endorsed by the late Professor Bruce Winick—one of the two original "fathers" of TJ—in an article he wrote about applying the law therapeutically in domestic violence cases, one that relies extensively on Professor Monahan's work.²⁰¹ The risk management model, Prof. Winick noted, is supported by the principles of TJ, providing an individual with incentives through which "to modify his behavior in order to reduce the extent or restrictiveness of the conditions imposed by the court";²⁰² such a model also provides incentives, Winick argues, to "minimize or avoid the interferences with [individuals'] liberty that are justified as a result of the determination that they are dangerous."²⁰³ Beyond this, Professor Spaulding and his colleagues—in line with, though chronologically pre-dating, Professor Ronner's call for "voice"—conclude that, "If patients can become more involved in the risk evaluation itself, then patients' involvement in treatment can be fostered; thus more compliance with treatment and aftercare planning can be expected in the long run,"²⁰⁴ and they note that, "At the very least, involving patients in risk evaluations does not appear to have anti-therapeutic consequences."²⁰⁵ There is, to the best of our knowledge, no such patient involvement in the New York system. With the stated outcome as treatment and recovery, it only makes sense that individuals are included and engaged in matters involving their hospitalization.²⁰⁶ Jurisdictions that choose not

199 It is telling that there is not a single reported New York case that cites to Professor Monahan's research on risk assessment.

200 William Spaulding, Jeffrey Poland, Eric Elbogen & A. Jocelyn Ritchie, *Applications of Therapeutic Jurisprudence in Rehabilitation for People with Severe and Disabling Mental Illness*, 17 T.M. COOLEY L. REV. 135, 161–62 (2000). On the need for therapeutic jurisprudence and international human rights principles to be integrated in the treatment of offenders, see Astrid Birgden, *Maximizing Desistance: Adding Therapeutic Jurisprudence and Human Rights to the Mix*, 42 CRIM. JUST. & BEHAV. 19 (2015).

201 Bruce J. Winick, *Applying the Law Therapeutically in Domestic Violence Cases*, 69 UMKC L. REV. 33 (2000).

202 *Id.* at 58.

203 *Id.* at 53.

204 Spaulding et al., *supra* note 200, at 169.

205 *Id.*

206 See Ronner, *supra* note 192, at 94–95 (on the need for "voice"). In a recent article about dignity and the civil commitment process, Professors Jonathan Simon and Stephen Rosenbaum embrace therapeutic jurisprudence as a modality of analysis, and focus specifically on this issue of voice: "When procedures give people an opportunity to exercise voice, their words are given respect, decisions are explained to them their views taken into account, and they substantively feel less coercion." Jonathan Simon & Stephen A. Rosenbaum, *Dignifying Madness: Rethinking Commitment Law in an Age of Mass Incarceration*, 70 U. MIAMI L. REV. 1, 51 (2015). It is important to consider how this "plays out" in the context of what is discussed in this paper.

to allow patient involvement should recognize the therapeutic benefits of giving a patient a stake in his recovery. Not only will it provide that patient with a voice, but it will also lead to better aggregate data in risk assessments, since the cooperation of a patient greatly increases the kind of information gained in risk evaluations and allows for a more individualized assessment.²⁰⁷ Finally, a turn to TJ principles will make it more likely that the international human rights principles discussed here will be privileged.²⁰⁸

CONCLUSION / RECOMMENDATIONS

In general, many courts in the United States continue to rely on imperfect and potentially prejudicial risk assessment measures to make determinations about a patient's appropriate, and least restrictive, setting for continued treatment. While some courts lag behind on recognizing the dangers (to the patients) that may arise from improper determinations of a patient's risk, New York has proven itself somewhat ahead of many other state courts. When taken together, the New York Court of Appeals decisions in this area form a partially coherent body of case law. We say "partially coherent," however, because there are important gaps in this statement of the law: how do we determine and define "dangerousness" in this context, and how do we contextualize this definition with (1) the constitutional requirements of the LRA and (2) the demonstrated invalidity of unstructured interviews? Although there is an important database of cases (all from other jurisdictions) that consider the positive attributes of structured interviews, these all deal with assessment of alleged sexually violent predators and persons with anti-social personality disorders, not institutional placements.²⁰⁹ We are thus still in uncharted territory.

207 The mental health court model requires active participation from the individuals involved. Not only does this promote the therapeutic jurisprudential tenets of voice and validation, but it leads to an overall improvement in services and long-term outcomes when those individuals are fully involved in their case services and treatment plans. See Ginger Lerner Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 587 (2010) ("Participation in the mental health court will result in comparatively fewer episodes of re-incarcerations and better access to health care."); see generally, Michael L. Perlin, "*The Judge, He Cast His Robe Aside*": *Mental Health Courts, Dignity and Due Process*, 3 MENT. HEALTH L. & POL'Y J. 1 (2013).

208 See, e.g., Michael L. Perlin, "*The Ladder of the Law Has No Top and No Bottom*": *How Therapeutic Jurisprudence Can Give Life to International Human Rights*, 37 INT'L J. L. & PSYCHIATRY 535 (2014); Perlin, *supra* note 30; see also Simon & Rosenbaum, *supra* note 206, at 36–41 (discussing the international human rights implications of involuntary civil commitment policies).

209 See, e.g., *United States v. Barnette*, 211 F.3d 803, 815 (4th Cir. 2000) (Psychopathy Checklist Revised ["PCL-R"] admissible); *Lee v. State*, 854 So. 2d 709, 711–12 (Fla. Dist. Ct. App. 2003) (Rapid Risk Assessment for Sex Offense Recidivism ["RRASOR"], Minnesota Sex Offender Screening Tool-Revised ["MnSOST-R"], PCL-R, Sex Offender Risk Appraisal Guide ["SORAG"], and Violence Risk Appraisal Guide ["VRAG"] admissible), as cited in Monahan, *Forecasting*, *supra* note 102, at 408–09 n.71.

So, what should be done? Here are some recommendations:

- It is absolutely essential that the LRA principles be considered in every case. As the highest court in the United States has routinely upheld a patient's right to be treated in the least restrictive environment,²¹⁰ it should be regarded as legally operative in determining the actual placement of all patients. Freedom from a secure facility or an allegedly non-secure facility that has increasingly become secure is a right guaranteed by the concept of the LRA, when appropriate for the particular patient, and must be considered in each case as a unique and *individualized* determination.
- It is absolutely essential that each state develop a mechanism through which organized, dedicated counsel is available to all forensic patients.²¹¹
- It is absolutely essential that decision-makers familiarize themselves with the bases of international human rights law so as to insure that the rights guaranteed by the CRPD are applied to all forensic patients.
- It is absolutely essential that decision-makers familiarize themselves with the basic principles of therapeutic jurisprudence so as to best insure that the three principles articulated by Professor Ronner—voice, voluntariness and validation—be honored in forensic facilities.
- Finally, it is absolutely essential that all persons doing clinical evaluations familiarize themselves with John Monahan's recent writings on dangerousness predictions, on the failure of unstructured interviews, and on the need to use structured risk assessment tools.

We believe that if clinicians take these recommendations seriously, many of the dilemmas we have been discussing will be ameliorated. It is impossible for us to achieve meaningful mitigating change in our mental disability law system unless we begin to take these issues seriously and to re-envision the way we regulate the

210 See *supra* text accompanying notes 65–72.

211 See, e.g., Michael L. Perlin, *I Might Need a Good Lawyer, Could Be Your Funeral, My Trial: Global Perspective on Clinical Legal Education and the Right to Counsel in Civil Commitment Cases, and Its Implications for Clinical Legal Education*, 28 WASH. U. J. L. & POL'Y 241, 242 (2008) (saying it is clear that "only in those jurisdictions that had dedicated counsel programs was there any coherent body of reported civil commitment case law."); PERLIN & CUCOLO, *supra* note 3, § 6-4.2 at 6-53 ("It appears beyond dispute that an organized and regularized scheme for providing . . . counsel comes closest to guaranteeing at least minimally adequate counsel.").

practice of mental disability law (especially, though not exclusively, *institutional* mental disability law) using these tools of legal change.²¹²

We conclude by reconsidering both parts of our title. Clearly, the “clinician’s dilemma” is a real one. Balancing the factors of “risk,” “security,” and “danger” with “constitution[al]” mandates is not an easy task. But it is one that must be done. And for the lyric: some may be puzzled why we chose a song that is about “isolation, desolation and failure.”²¹³ But we think the line in question resonates in this context. This work—the assessment of “danger”—can certainly feel like “toiling.” But also the remainder of the phrase—“the morals of despair”—is just as relevant. This work *can* inspire feelings of “despair.” But it must be infused with a sense of “moral[ity]” as well. And we believe that, the incorporation of these recommendations into this work, will, in the long run, lessen the level of “despair.”

212 See generally Perlin, *supra* note 207.

213 OLIVER TRAGER, KEYS TO THE RAIN: THE DEFINITIVE BOB DYLAN ENCYCLOPEDIA 181 (2004).