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"Toiling in the Danger and in the Morals of Despair": Risk, Security, Danger, the Constitution, and the Clinician's Dilemma

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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 often seen as less than human.\(^2\) Although there were sporadic exposes in the nineteenth century and the mid-twentieth century which 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 in these facilities 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.\(^5\)

However, much 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.

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\(^7\) See e.g., Davis v. Watkins, 384 F. Supp. 1196, 1201-02 (N.D. Ohio 1974). See 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, 2 PERLIN, supra note 3, § 3A-3.3, at 57-59

\(^8\) For the role of the press, see Paul Davis, Wyatt v. Stickney: Did We Get It Right This Time?, 35 LAW & PSYCHOL. REV. 143 (2011).

\(^9\) See Heather Ellis Cucolo & Michael L. Perlin, Preventing Sex-Offender Recidivism through Therapeutic Jurisprudence Approaches and Specialized Community Integration, 22 TEMPLE POLITICAL & CIVIL RTS. L. REV. 1, 38 (2012) (“[ordinary common sense]” is self-referential and non-
which posits that “most mentally ill individuals are dangerous and frightening [and] are invariably more dangerous than non-mentally ill persons.” 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 remained the most hidden. 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 such individuals have received.

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

reflective (‘I see it that way, therefore everyone sees it that way; I see it that way, therefore that’s the way it is’).”


11 See Perlin & Schriver, supra note 5, at xx.

In the criminal justice system, the mentally disabled were doubly cursed as “mad” and “bad”, and were regularly consigned to lifetime commitments in maximum security facilities.\(^\text{13}\)

Attitudes remain the same today.\(^\text{14}\) Forensic patients face stigma both from their status as “defendant” and as being “mentally ill.”\(^\text{15}\)

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).\(^\text{16}\) The US Supreme Court’s 1972 decision in \textit{Jackson v. Indiana}\(^\text{17}\) -- on paper, at least\(^\text{18}\) -- 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 there was an independent showing of such dangerousness that he could not safely be housed elsewhere. 20 Also, the


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”; “by 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 for commitment or the opportunity for release...Indiana deprived petitioner of equal protection” 406 U.S. at 729-30.

20 Jackson, 406 U.S. at 739 n. 25.
enactment of the Americans with Disabilities Act\textsuperscript{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.\textsuperscript{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.\textsuperscript{23} The question of dangerousness required has been and remains an important

\textsuperscript{21} See 42 U.S.C. §§ 12101 et seq.

\textsuperscript{22} Perlin, MisdemeANor Outlaw, supra note 18, at 201-07.

In a study of all cases heard by New Zealand’s Mental Health Review Tribunal over an 18 year period, it was found that the Tribunal recommended change in legal status in only 2\% 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).

\textsuperscript{23} See In re David B., 97 N.Y.2d 267 (2002), Richard S. v. Carpinello, 628 F.Supp.2d 286 (N.D. 2008) and Ernst J. v. Stone, 452 F.3d 186, 188 (2d Cir. 2006) for discussions of New York’s policy on transfer to non-secure facilities based on CPL § 33.20. For application of the New York “3 track” system of categorizing mental disorders and the appropriateness of secure confinement, see People v. Salem, 122 A.D.2d 85 (2\textsuperscript{nd} Dept 1986), In re Amir F., 94 A.D.3d 1209 (3\textsuperscript{rd} Dept. 2012), In re Eric U., 40 A.D.3d 1148 (3\textsuperscript{rd} Dept. 2007), Matter of Torres, 166 A.D.2d 228 (1\textsuperscript{st} Dept. 1990) (Commissioner of Mental Health failed to meet burden of showing level of dangerousness required to confine defendant in secure facility). The different “tracks” in the NY system are explained infra text accompanying notes 44-49. 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.
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. This ambiguity — along with the lack of agreement and clarification by the courts — may ultimately lead to a violation of a person’s right to be confined in the least restrictive alternative, which applies in all settings to all patients confined in hospitals. 24

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). 25 As we will discuss below, the CRPD is the most revolutionary international human rights document ever created that applies to persons with disabilities. 26 It furthers the human rights approach to disability — endorsing a social model and repudiating a purely-

24 See infra text accompanying notes 64-69, discussing, inter alia, Riggins v. Nevada, 504 U.S. 127 (1992), and Olmstead v. L.C., 527 U.S. 581 (1999), and see Perlin, Misdemeanor Outlaw, supra note 18, at 217-18, discussing these cases in a parallel context.


medical model -- and recognizes the right of people with disabilities to equality in most every aspect of life.\textsuperscript{27} Although little attention has been paid to its potential impact on forensic patients,\textsuperscript{28} 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 in the literature.\textsuperscript{29}

This paper will address these issues individually and together as they appear in the United States and under international law principles.\textsuperscript{30} 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.\textsuperscript{31} We will also discuss “danger” as it is the basis for many statutes governing...


\textsuperscript{28} But see, Perlin & Schriver, supra note 5.

\textsuperscript{29} Id. at xx.

\textsuperscript{30} In this paper, we focus on New York state, but the issues affect forensic facilities in all the states.

\textsuperscript{31} “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., Perlin, supra note 13, at 377; JOHN PARRY & ERIC DROGIN, CRIMINAL LAW HANDBOOK ON PSYCHIATRIC
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 United Nations Convention on the Rights of Persons with Disabilities, 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 caselaw 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 therapeutic jurisprudence, 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 therapeutic jurisprudence.32

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32 See infra text accompanying notes 130-49.
The first portion of the title of this paper comes from Every Grain of Sand,\textsuperscript{33} one of Bob Dylan’s very saddest and most beautifully-imaged songs,\textsuperscript{34} 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 that is about the moment(s) that we accept our pain and vulnerability.”\textsuperscript{35} We believe, as we will discuss subsequently in the paper, 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 seven years ago by the then-head of the Kirby Forensic Center in

\textsuperscript{33} See http://www.bobdylan.com/us/songs/every-grain-sand.

\textsuperscript{34} The lyric comes from the first verse:

\begin{quote}
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
\end{quote}

New York City, one of NY state’s two maximum security forensic hospitals. 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.  

B. New York state law

As we indicated in the Introduction, we will focus here on New York developments. Under the relevant statute, CPL § 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. If we read the New York Court of Appeals’ decisions from the past two decades, certain controlling principles emerge:

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36 Email from Jim Hicks, M.D., to Michael L. Perlin (April 3, 2006) (on file with author).

37 See e.g., N.Y. CRIM. PRO L. § 330; In re Guardianship of Dameris L., 956 N.Y.S.2d 848 (Sur. 2012).

38 See also, CPL § 330.20(1)(d):

"Mentally 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
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), 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.”

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

welfare and that his judgment is so impaired that he is unable to understand the need for such care and treatment...


40 George L., 624 N.Y.S. 2d at 105.

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)42 “contemplates a degree of dangerousness that satisfies due process concerns.”43

The statute contemplates a three-tier track system.44 Those suffering from a “dangerous mental disorder” (Track 1)45 are subject to “continued, direct oversight.”46 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, does not understand the need for such care and treatment) (Track 2) are governed by the civil commitment laws.47 Those who are neither mentally ill nor dangerous under these definitions (Track 3) are entitled to immediate release with or

42 See supra note 38.
43 Matter of David B., 739 N.Y.S. 2d 858, 863 (2002). Most recently, in Makas, supra, 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.
44 On the differential in appeal processes in Track 1 and Track 2 cases, see Matter of Norman D., 785 N.Y.S. 2d 1(2004) (track status of track 1 patient can only be changed on appeal, not by review hearing), and Matter of Jamie R., 810 N.Y.S. 2d 738 (2006) (track status of track 2 patient can only be changed on appeal, not by review hearing). For the most recent discussions of New York’s track system in this context, see Robert T. v. Sproat, 955 N.Y.S.2d 134, 138 (A.D. 2012), and People v. Sharon T., 929 N.Y.S.2d 202 (Sup. 2012).
45 See CPL § 330.20(6).
46 David B., 739 N.Y.S. 2d at 864 n.4.
47 Id.
without conditions. 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,
- 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.”

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

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48 Id.
49 Id. At 865.
institutional mental disability law decisionmaking. 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 over 40 years ago in the case of Lessard v. Schmidt \(^50\) – applies to all aspects of institutional decisionmaking, 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 NY 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. \(^51\)

Quoting Shelton v. Tucker, \(^52\) the court characterized “the most basic and fundamental right” as “the right to be free from unwanted restraint,” \(^53\) 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.” \(^54\) The court placed the burden for

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51 Lessard, 349 F. Supp. at 1095.


53 Lessard, 349 F. Supp. at 1095-96.

54 Id. at 1096.
exploring alternatives to institutionalization on "the person recommending full-time involuntary hospitalization," 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 relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.

These principles have been articulated in multiple NY state cases, dating back to the 1973 decision of *Kesselbrenner v. Anonymous*: “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.” Subsequent NY cases have been in accord. By way of example, *Ughetto v. Acrish* states it this way: “The burden of proof at such a hearing is upon the hospital to establish by clear and convincing evidence that

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55 Id.
56 Id.
58 Id. at 892.
the patient poses a substantial threat to himself or others and that involuntary commitment is the least restrictive means available for treatment.”

Courts in other jurisdictions have specifically ruled that the LRA principles apply to transfers of patients from a less secure hospital to a more secure hospital. Although this issue has never been dealt with squarely by a NY court, the Mental Hygiene Legal Services ex rel. Aliza K. v. Ford 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,” citing Kesselbrenner and the US Supreme Court’s prison-hospital transfer case of Vitek v. Jones.

The LRA principle has been articulated in two very different ways in two US Supreme Court cases. In 1990, in Riggins v. Nevada, reversing a conviction in a case where a competent defendant pleading the insanity defense was medicated at trial

59 494 N.Y.S.2d 943, 944 (Sup. 1985), citing Matter of Harry M., 468 N.Y.S.2d 359 (A.D. 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 ).
62 Id. at 153.
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. Then, seven years later, in Olmstead v. L.C., the Court construed the Americans with Disabilities Act 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. Both before and after its decision in Olmstead, the Supreme Court has ruled that the ADA applies to prison settings; it is inconceivable that a court would rule that it does not apply to a forensic mental health facility.

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65 Id. at 135.
67 Id. at 602, 605-06. One of the authors (MLP) discusses both Riggins and Olmstead in this context in Perlin, Misdemeanor Outlaw, supra note 18, at 217-18.
69 See e.g., Bates v. Department of Behavioral and Developmental Services, 863 A.2d 890 (Me. 2004).
In short, there is no question that the LRA applies to all cases of persons institutionalized because of mental disabilities, including forensic patients.\(^70\) One of the authors (MLP) has argued in a law review article 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.\(^71\)

II. On risk

\(^70\) Some cases from other jurisdictions agree. See e.g., State v. Kinman, 671 N.E.2d 1083, 1084 (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); Schuttemeyer v. Commonwealth, 793 S.W.2d 124, 128 (Ky. Ct. App. 1990), reh'g denied (1990), and discret. rev. denied. (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). Those that disagree—see e.g., 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); 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) – all predate *Olmstead*, and thus should be seen as being of questionable precedential value.

\(^71\) *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.”
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. First, there is the “risk” posed by the patient 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.

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. Further, societal beliefs about the inherent danger posed by all

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

73 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) (“to a greater or lesser extent, all ARA [actuarial risk assessment] instruments have shortcomings, and these shortcomings detract from the reliability of the instruments”).

74 On such litigation, see generally, 3 PERLIN, supra note 3, at §§ 7A-6.53 to &A-6.6, at 377-88 (2d ed. 2002).
mentally ill individuals put pressure on clinicians to make accurate assessments, 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. 

Dangerousness itself, as a concept, is also a difficult one, given that it can mean many things in many different contexts, and the fear of dangerousness can have consequences for those labeled as “dangerous.” When society’s belief that a certain


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.”


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.

77 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”).

78 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:
group of people are inherently dangerous and pose greater risks than other groups, that belief can result in the continued violation of those individuals’ rights. 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. 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.

Eighteen years ago, in writing about the application of the then-new field of “therapeutic jurisprudence” to involuntary civil commitment law, one of the authors (MLP) said this about the “revolution” in commitment law in the 1970’s:

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

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81 See infra text accompanying notes 130-49.
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."82

Nothing has changed since the publication of that article. There are few words in
the legal literature as elastic as "dangerousness", 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 relevant inquiry as one that considers the
degree of “risk assessment” 83 via validated risk assessment instruments. 84 According to

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Legal scholars have begun to consider seriously and carefully all aspects of risk
assessment decisionmaking 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 Ass to the Stury of Risk and the Law, 57 ALA. L. REV. 119 (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
Professor Christopher Slobogin, one of the leading legal scholars in this area: “Today, 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.” But, even using the word “dangerousness” (the criteria specified in New York in § 330), 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 NJ Supreme Court, writing in State v. Krol, pointed out that “Dangerousness is a concept which involves substantial elements of vagueness and ambiguity,” and acknowledged the “difficulty of making valid and meaningful predictions of the likelihood of future harmful conduct,” made more difficult by the “subtle but strong pressures upon decision makers to overpredict dangerousness.”

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) (citations omitted) (“We know how, as a result of the vividness heuristic, one salient case can lead to the restructuring of an entire body of jurisprudence.”).

See e.g., Christopher Slobogin, Dangerousness and Expertise Redux, 56 EMORY L.J. 275, 277 (2006).


See supra note 38.


Id.

Id.
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.”

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

While Krol has no precedential value in New York (which has, in cases such as Jamie R. v. Consilvio and In re Stone, embraced – incorrectly in our view – the US

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90 Id. See 1 PERLIN, supra note 3, § 2A-4.4b, at 133-39.
91 Krol, 344 A. 2d at 299.
92 Id. at 303.
Supreme Court’s standard articulated in Jones v. United States,95 employing a limited due process model in such cases),96 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,97 and here it is necessary to begin with the work of Professor John Monahan.98 Monahan’s research is crystal-clear and uncontroverted: unstructured clinical assessments of dangerousness are neither valid nor reliable,99 and, at best, allow clinicians to distinguish violent from non-violent patients “with a modest, better-than-
chance level of accuracy." 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, are superior to the unstructured assessments traditionally used. However, as Monahan notes:

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.

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101 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”).


103 Monahan, Developments, supra note 99, at 511. And see id., at 513.
Importantly, the inability of psychiatric professionals to predict violence has been specifically recognized by the U.S. Supreme Court. 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.

104 See, e.g., Heller v. Doe, 509 U.S. 312, 323-24 (1993) (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)).


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
In short, if forensic clinicians are not using the sort of structural tools discussed by Professor Monahan, then, simply, their predictions – though, in hindsight, sometimes accurate – are not grounded on a valid and reliable scientific basis. What is especially interesting here is this: in at least two of its cases on this area of the law, the NY Court of Appeals has identified imprecision of psychiatric predictivity of dangerousness as a basis for its finding that “psychiatry cannot now guarantee the
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. See, on this question in general, Michael L. Perlin & Heather Ellis Cucolo, “Far From the Turbulent Space”: Considering the Adequacy of Counsel in the Representation of Individuals Accused of Being Sexually Violent Predators (paper presented to the American Criminological Society, November 22, 2013) (on file with authors) (discussing these instruments and the special abilities needed by counsel to understand them and to effectively cross-examine witnesses who rely on them).

106 He focuses in his recent writings on three: the HCR-20, the VRAG, and the COVR. Monahan, Developments, supra note 99, at 504-12.


[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 as a method of insufficient reliability and validity for making important judgments.
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,"\textsuperscript{108} and as a rationale for relying on legislative categorizations in this area of the law."\textsuperscript{109}

This decision is a mixed blessing for clinicians and attorneys working in the field of mental disability law. 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 NY 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 increased understanding of mental illness and dangerousness. As we will discuss further, the


\textsuperscript{109} Francis S., 640 N.Y.S. 2d at 844 (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”).
Convention on the Rights of Persons with Disabilities 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.

III. International human rights law principles

Given the ratification of the United Nations’ Convention on the Rights of Persons with Disabilities (CRPD), the state of the law as it relates to persons with disabilities must be radically reconsidered. 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." This Convention is the most revolutionary international

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110 This section is generally adapted from Perlin & Schriver, supra note 5.
111 See generally, CRPD, supra note 25.
112 See generally, PERLIN, supra note 25.
human rights document ever created that applies to persons with disabilities. The Disability Convention furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in most every aspect of life. It firmly endorses a social model of disability and reconceptualizes mental health rights as disability rights – a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law. “The Convention sketches the full range of human rights that apply to all human beings, all with a particular application to the lives of persons with disabilities.” It provides a framework for ensuring that mental

114 See generally, Perlin & Szeli, supra note 26; PERLIN, supra note 25, at 3-21; Perlin, supra note 26.

115 See e.g., Dhir, supra note 27.


health laws “fully recognize the rights of those with mental illness.” \(^{118}\) There is no question that it has “ushered in a new era of disability rights policy.” \(^{119}\)

It describes disability as a condition arising 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, \(^{120}\) and extends existing human rights to take into account the specific rights experiences of persons with disabilities. \(^{121}\) It calls for "respect for inherent dignity" \(^{122}\) and "non-discrimination." \(^{123}\) Subsequent articles declare "freedom from torture or cruel, inhuman or degrading treatment or punishment," \(^{124}\) "freedom from exploitation, violence and abuse," \(^{125}\) and a right to protection of the "integrity of the person." \(^{126}\)

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\(^{120}\) CRPD, *supra* note 25, Art. 1 and Pmbl., Para. E


\(^{122}\) CRPD, *supra* note 25, Article 3(A).

\(^{123}\) Id., Article 3(B).

\(^{124}\) Id., Article 15.

\(^{125}\) Id., Article 16.

\(^{126}\) Id., Article 17
The CRPD is unique because it is the first legally binding instrument devoted to the comprehensive protection of the rights of persons with disabilities. It not only clarifies that States should not discriminate against persons with disabilities, but 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.127

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

As part of this enterprise, we will consider six core issues that must be “on the table” if the scope of the underlying problems is to be understood:

a. Although there is a robust literature on the CRPD and on the CAT, 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.

b. 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.

c. Even when regional courts and commissions have found international human rights violations in cases involving forensic patients (e.g., *Victor Rosario Congo v. Ecuador*), the discussion of these cases largely ignores the plaintiffs’ statuses as forensic patients.

d. There are few lawyers and fewer “mental disability advocates” providing legal and advocacy services to this population,

e. There is little mention in the survivor movement literature about the specific plight of forensic patients.
f. Forensic patients in facilities for persons with intellectual disabilities are particularly absent from the discourse. 128

In the course of that paper, we argued that the treatment of forensic patients globally violated international human rights law principles. 129 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.

IV. Therapeutic jurisprudence 130

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence. 131 Initially employed in cases involving individuals with mental disabilities, but subsequently expanded far beyond that narrow area, therapeutic jurisprudence presents a new model

128 Perlin & Schriver, supra note 5, manuscript at xxx.
129 Id. at xxx.
130 This section is generally adapted from Perlin & Schriver, supra note 5; Perlin, Wisdom, supra note 18; Perlin, Yonder, supra note 127.
for assessing the impact of case law and legislation, recognizing that, as a therapeutic
agent, the law that can have therapeutic or anti-therapeutic consequences. The
ultimate aim of therapeutic jurisprudence is to determine whether legal rules,
procedures, and lawyer roles can or should be reshaped to enhance their therapeutic
potential while not subordinating due process principles. There is an inherent tension
in this inquiry, but David Wexler clearly identifies how it must be resolved: “the law’s
use of “mental health information to improve therapeutic functioning [cannot] impinge

\[132\]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); see Kate Diesfeld & Ian Freckelton, Mental Health Law and Therapeutic Jurisprudence, in
DISPUTES AND DILEMMAS IN HEALTH LAW 91 (Ian Freckelton & Kate Peterson eds. 2006) (for a
transnational perspective).

\[133\]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 (2008); Michael L. Perlin, “You Have Discussed Lepers and

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, 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); Ian Freckelton, Therapeutic Jurisprudence Misunderstood and
upon justice concerns.\textsuperscript{134} As one of us (MLP) has written elsewhere, “An inquiry into therapeutic outcomes does not mean that therapeutic concerns ‘trump’ civil rights and civil liberties.”\textsuperscript{135}

Therapeutic jurisprudence “asks us to look at law as it actually impacts people’s lives”\textsuperscript{136} and focuses on the law’s influence on emotional life and psychological well-being. \textsuperscript{137} It suggests 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”.\textsuperscript{138}

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\textsuperscript{138} Bruce Winick, \textit{A Therapeutic Jurisprudence Model for Civil Commitment, In INvoluntary Detention and Therapeutic Jurisprudence: International Perspective on Civil Commitment}, 23, 26 (Kate Diesfeld \& Ian Freckelton eds., 2003).
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Therapeutic jurisprudence “is a tool for gaining a new and distinctive perspective utilizing socio-psychological insights into the law and its applications”. It is also part of a growing comprehensive movement in the law towards establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively, and respectfully. In its aim to use the law to empower individuals, enhance rights, and promote well-being, therapeutic jurisprudence has 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 emphasises psychological wellness over adversarial triumphalism”. That is, therapeutic jurisprudence supports an ethic of care.

139 Diesfeld & Freckelton, supra note 132, at 582.
140 Susan Daicoff, The Role of Therapeutic Jurisprudence Within The Comprehensive Law Movement, in STOLLE, supra note 137, at 365.
142 See e.g., 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, 605-07 (2006); 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); Brookbanks, supra note 141; Gregory Baker, Do You Hear the Knocking
One of the central principles of therapeutic jurisprudence is a commitment to dignity. Professor Amy Ronner describes the “three Vs”: voice, validation and voluntariness, arguing:

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 pronunciation that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings

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prosper when they feel that they are making, or at least participating in, their own decisions.\(^{145}\)

The question to be posed here is this: to what extent are the practices and procedures discussed earlier in this paper consonant with therapeutic jurisprudence? Do they best insure 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. 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.\(^{146}\) Although we know that fairness and procedural justice inevitably increase compliance with court orders,\(^{147}\) we also know that procedural justice is often solely lacking in all forensic facility decisionmaking.\(^{148}\) One of us (MLP), in writing some years ago about sexual autonomy in psychiatric hospitals, concluded, "Much of the case law ignores forensic


\(^{146}\) On the question of e.g., the freedom of sexual autonomy in forensic facilities, see generally, Perlin, *supra* note 6.


patients entirely.\textsuperscript{149} So do the developments expanding therapeutic jurisprudence concepts to institutionalized persons in general largely ignore forensic patients?

V. 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 NY 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 considers the positive attributes of structured interviews, these all deal with assessment of alleged sexually violent

\textsuperscript{149} Perlin, \textit{supra} note 6, at 488.
predators and persons with anti-social personality disorders, not institutional placements. We are thus still in unchartered territory.

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, 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 considered in each case as a unique and individualized determination.

- 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.


151 See supra text accompanying notes 64-71.
• 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 each and every person 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 ameliorative change in our mental disability law system unless we begin to take these issues seriously and to re-envision the way we regulate the practice of mental disability law (especially, though not exclusively, institutional mental disability law) using these tools of legal change. 152

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 “constitutional” 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.” 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.”