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Mental Disorder and Criminal Justice

Stephen J. Morse*

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Introduction

The criminal law treats some people with severe mental disorders doctrinally and practically differently at virtually every stage of the criminal justice process, beginning with potential incompetence to stand trial and ending with the question of competence to be executed, and such people have special needs when they are in the system. This chapter begins by exploring the fundamental mental health information necessary to make informed judgements about how the criminal justice system should respond to this

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population, including discussion of the causal relation between mental disorder and criminal behavior. The next section addresses the prevalence of mental disorders in jail and prisons and the mental health needs of mentally disabled inmates. The last section addresses criminal mental health law doctrines. Throughout, the chapter considers how changes could promote greater justice and humanity in the law's treatment of criminal offenders who suffer from mental disorders. A brief conclusion follows. Specific recommendations are made in bold and a complete list of those recommendations is found in an appendix at the end of the chapter. Less important recommendations are discussed, but are not separately made in bold.

This chapter is different from most of the others in this report. Rather than addressing a discrete topic within criminal justice, it discusses the role of mental disorder throughout the entire criminal justice system. It is therefore necessarily considerably longer than almost all the other chapters. Readers will have different interests, so a table of contents was provided to permit easy access to those sections that a particular reader might find most relevant.

A final preliminary matter is that the American Bar Association has recently adopted its fourth edition of Criminal Justice Mental Health Standards.[1] Like this chapter, it addresses the entire criminal justice process. Readers interested in the issues this chapter discusses should also read the ABA Standards. Although there are many areas of agreement, there are also areas of disagreement and the argument and scope of analysis offered differ.

Recommendation: Readers interested in the role of mental disorder in the criminal justice system should consult the ABA Criminal Justice Mental Health Standards.

I. Mental Disorders Background

Mental disorders encompass both mental disorder and intellectual disability (intellectual developmental disorder). Both are included in the American Psychiatric Association's, Diagnostic and Statistical Manual of

[1] American Bar Association, Criminal Justice Mental Health Standards, 4th. Ed. (2016). http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf. The current version replaces standards adopted in 1984.Professor Christopher Slobogin, who was chair of the ABA task force charged with revising the standards, has provided a particularly informative review of the 4th edition. Christopher Slobogin, *The American Bar Association's Criminal Justice Mental Health Standards: Revisions for the Twenty-First Century*, 44 HASTINGS CONSTITUTIONAL L. Q. 1 (2016).

Mental Disorders, Fifth Edition—DSM-5.[2] No consensual generic definition of mental disorder exists, however. Here is the definition DSM-5 provides,

> "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."[3]

Like the previous definitions earlier editions of DSM used, this one has been quite controversial. It should be apparent that it is not precise. On the other hand, the lack of a good general definition does not mean that the work of classifying mental disorders cannot be done. The question, to which we will return, is how scientifically sound and clinically useful the classification system is.

There are a number of important considerations about mental disorder that law reformers should understand. Diagnosis is based virtually entirely and in most cases entirely on behavioral criteria, defined here broadly to include cognitions (thoughts, beliefs), feelings, perceptions, desires, and actions. There is no external standard, such as a biological or psychological marker, to which the diagnostician can appeal to determine if the diagnosis is accurate. The mark of accuracy is whether two independent diagnosticians can agree on the diagnosis, which is called inter-rater reliability and which can be expressed numerically after correcting for chance agreement. Current diagnostic categories vary in their reliability, but, based on relatively rigorous field testing of the categories, they are typically much higher than the

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[2] American Psychiatry Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5TH ED. (2014).Intellectual Disability was formerly termed "mental retardation" and then "developmental disorder." The bulk of the manual addresses mental disorder and this type of disability is far more prevalent in the population than intellectual disability.

[3] *Id.* at 20

reliability of DSM-II categories published in 1968. Reliability has not increased much since the publication of DSM-III in 1980, however.

Few clinicians in any setting seek an independent confirmation of their diagnosis, so the actual reliability of diagnoses in the hurly-burly of everyday practice is not clear. In research, investigators often use rating scales that may be more or less structured and that typically have known reliabilities. When judging the reliability of an individual assessment or a large scale study, say, of the prevalence of mental disorder in a prison population, it is always useful to ask about the reliability of the evaluation method used to make the diagnoses. An unreliable diagnosis warrants extreme caution.

Even if a diagnosis is reliable, a further question is whether the category is valid. Validity refers to whether the category is a genuine and meaningful one. In the area of diagnostic categories, the issue is whether "nature is carved at the joints" as the categories describe or are the categories simply definitional. For example, I can define a cluster of strong personal preferences as the Brahms-Broncos-Bacon syndrome that applies to those people who express strong positive preference for the composer, football team and food. I assume one could reliably identify people as having B-B-B syndrome, but would they be alike in any other meaningful way? In mental health, a category may be meaningfully distinct if it has, for example, different genetic bases, different family histories, different treatment responses, and different neural correlates compared to other disorders. At present, the validity data for most diagnostic categories is considerably weaker than the reliability data, and there is much reason to believe that the allegedly discrete disorders may not be genuinely different (except definitionally).[4] For purposes of further discussion, however, I will bracket reliability and validity concerns.

Even if two people are reliably diagnosed with the same disorder, their behavioral presentations can be markedly different because the behaviors that will justify a discrete diagnosis can be remarkably heterogeneous. This is part of the reason why diagnostic reliability can be fraught. For the law, this is a crucial point. Criminal law criteria are acts and mental states—hold aside circumstances elements, which often

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[4] For example, a recent review of functional Magnetic Resonance Imaging (fMRI) studies of various mental disorders indicates that there are no significant differences between the brain regions that activate across the various disorders. Emma Sprooten et al, *Addressing Reverse Inference in Psychiatric Neuroimaging: Meta-Analyses of Task-RelatedBrain Activation in Common Mental Disorders*, HUMAN BRAIN MAPPING (2016).

themselves require an accompanying mental state. The behavioral heterogeneity of diagnoses means that a diagnosis cannot *per se* answer any criminal law question. One must investigate the behavior underlying the diagnosis in order to determine if the subject's apparently abnormal behavior in fact meets a legal criterion. Some people with major mental disorders are incompetent to stand trial or legally insane; most such sufferers are neither incompetent nor legally insane. Whether a defendant with mental disorder meets a legal criterion must be evaluated case by case based on the subject's behavior. For the law, behaviors speak louder than diagnoses, psychological test data, neuroimages, or any of the panoply of methods diagnosticians employ in their work.

Long ago, I proposed and still believe that many of the difficulties caused by imprecision and controversy in mental health concepts and categories could be avoided by the law eschewing technical diagnostic terms and focusing instead purely on the underlying behavior that is in any case the basis for diagnoses.[5] This recommendation met with scant success. Nonetheless, law reformers should recognize that the behaviors that justify a diagnosis make no rational sense in context. Less serious mental disorder is less irrational; more serious mental disorder, which is often marked by gross loss of contact with reality (psychosis), is markedly irrational. The law is mostly concerned with people whose mental abnormalities render them incapable of ordinary rationality in a particular context. This is the crucial issue. A technical diagnosis answers no legal question beyond the behavior upon which the diagnosis is based. Before leaving the topic of diagnosis, it is important to call attention to three diagnostic categories that are common among criminal justice defendants and people incarcerated in jails and prisons: antisocial personality disorder, addiction, which DSM-5 terms substance abuse disorders (which are individuated according to the substance abused and are characterized as "mild, moderate or severe") and sexual disorders. Personality disorders as a class identify maladaptive behavior patterns that are, roughly speaking, characterological, rather than marked by discrete cognitive, mood or perceptual abnormalities. Antisocial personality disorder is diagnosed based on consistent disregard for and violation of the rights of others, as manifested by at least 5 of 7 listed criteria, 6 of

[5] Stephen J. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law* S. CAL. L. REV. (1978).

which are chronically antisocial behaviors. Only 1 of the 7 criteria—lack of remorse—is psychological and need not be present to make the diagnosis. There is a real question whether this category, which is estimated to include 60-80% of inmates in secure custody, is properly considered a type of mental disorder rather than simply a description of purely antisocial behavior.

There is a diagnostic entity seemingly similar to antisocial personality disorder, "psychopathy," which does include important psychological criteria, such as lack of conscience and lack of empathy, and which can be reliably diagnosed. It is estimated that 15-25% of prison inmates have this disorder, which overlaps imperfectly with and is different from antisocial personality disorder. Psychopathy is also the subject of an ambitious research program in many labs, including its relation to criminal behavior, but it is not included in DSM-5 although it seems to justify being considered a disorder more than antisocial personality disorder.

According to DSM-5, substance abuse is diagnosed when the persistent use of a substance causes clinically and functionally significant impairment, such as health problems and the failure to meet major responsibilities. Many addiction researchers in the field consider the criteria to be the persistent seeking and using of substances despite adverse consequences and often accompanied by subjective craving. The National Institute of Drug Abuse considers addiction to be a chronic and relapsing brain disease, but there is a strong case that this is an inaccurate and reductive definition and there is even dispute about whether addiction should be considered a disorder at all. Despite such disputes, it is clear that a very high percentage of felony arrestees test positive for various substances and many defendants and inmates have serious problems with substance use.

Sexual disorders are marked by abnormal sexual desires that are acted on or cause significant distress. Offenders who commit sexual crimes, such a pedophilia, exhibitionism, and voyeurism, commonly would be diagnosed with these disorders. Why such desires are considered the potential symptom of a disease rather than normal human variation is an open question. Nonetheless, the objects of some desires are considered both illegal and immoral to obtain and thus acting on them is criminalized even though virtually no one thinks that one "chooses" the objects of one's sexual desire. Rather, they are typically discovered through life experience, especially in adolescence or young adulthood.

Although antisocial personality disorder, addiction and sexual disorder diagnoses apply to so many criminal offenders, these disorders seldom trigger special legal treatment. For example, none will typically be sufficient to trigger incompetence to stand trial proceedings or to be the basis for an insanity defense. In many states, these diagnoses are specifically excluded as the potential basis for an insanity defense. Indeed, the Supreme Court has rejected a constitutionally required a defense for addicts whose criminal behavior is symptomatic of the disease of addiction.[6]

The most common special treatments for these groups are non-compulsory diversion of non-violent defendants to specialty problem-solving courts and special quasi-criminal commitment of so-called mentally abnormal sexually violent predators, a practice the Supreme Court has upheld.[7] In later sections of this chapter I shall return to whether the current legal treatment of these three categories of disorders is wise.

The next issue of importance is the efficacy of various treatment methods, especially for severe mental disorder because less severe disorders tend not to trigger special legal treatment and do not as compellingly warrant treatment provision. There are three primary treatment modes for people with serious disorders: pharmacotherapy with psychotropic medication, psychological therapy (individual and group), and psychosocial rehabilitation. The latter two are typically more labor intensive if done correctly and criminal justice system resources are limited. Consequently, for severe disorders, pharmacotherapy is typically the treatment of first resort. Such treatments can be enormously useful, but they are of benefit to only a moderate number of people who have them. The usual rule is about one-third of patients improve markedly, about one-third improve moderately, and about one third do not improve at all. Moreover, although they may be of help in reducing cognitive and mood abnormalities, they do not necessarily help people with the interpersonal and social deficits that often result from mental disorder, especially chronic disorder. There is essentially no marker to guide clinicians in the choice of which drug from within an appropriate class will work best. There are general guidelines, but therapy is empirically-guided in individual cases. Finally, many psychotropic drugs have

[6] Powell v. Texas, 1968.
[7] Kansas v. Hendricks (1997), Kansas v. Crane (2002).

serious side effects, which explains why many patients fail to adhere to the prescription regimen. To the extent that mood or cognitive abnormalities render an offender incompetent at any stage in the criminal justice process, pharmacotherapy may alone restore competence although it would be insufficient to meet all the offender's mental health needs.

For the diagnoses of antisocial personality disorder, addiction, psychopathy, and sexual disorders previously discussed, there is either no effective treatment (antisocial personality disorder, psychopathy) for adults or the treatments are of limited efficacy (addiction, sexual disorders), especially with an uncooperative patient. To the extent that addicts use substances as a form of self-medication to deal with the suffering a co-morbid disorder produces, treating the co-morbidity may help ameliorate the addiction, but addiction tends to take on a life of its own. After unsuccessful attempts to quit, most addicts in the general population ultimately stop using on their own and without treatment when they have good enough reason to do so.[8] Whether the same is true of addicted inmates is unknown.

As a bridge between the issues of treatment and prediction, which will be addressed shortly, let us consider the causal relation between mental disorder and criminal conduct. The most important thing to recognize for lawyers and policy-makers is that mental disorders that apparently play a causal role do not turn the person into an automaton. People with mental disorders act for reasons just like people without such disorders. Consider Daniel M'Naghten, for example, who believed the Tory party was persecuting him and was attempting to kill him. He therefore planned, formed the intent to kill the prime minister, Peel, to save his own life and acted on that intent (although, in the event, he killed Peel's private secretary, Drummond, who was riding in the prime minister's carriage that day). Abnormal perceptions or beliefs motivate people with mental disorders and they then act on those beliefs. Their criminal acts should not be understood mechanistically, like a fever that spikes as the result of an underlying infection. Causation should be understood in this context in terms of assessing the defendant's reasons for action.

Finally, simply because a mental disorder played a causal role in explaining criminal behavior, it does not follow that the person could not control that behavior. The notion of loss of control of action is

[8] Gene Heyman, ADDICTION: A DISORDER OF CHOICE (2009).

notoriously fraught. Although a minority of jurisdictions also have a control test for legal insanity in addition to a cognitive test and the Supreme Court has approved the use of control criteria for sexual predator commitments,[9] the meaning of these tests independent of a rationality problem is conceptually and empirically unclear. For these reasons, both the American Psychiatric Association and the American Bar Association recommended abolition of control tests for legal insanity.

Now let us turn to the statistical association between mental disorder and criminal behavior generally, but with the understanding just explored that the underlying causal account in an individual case should be understood in terms of reasons for action. If the relation is strong, adequate treatment might have a preventive effect and knowledge about a subject's mental disorder might enhance the accuracy of predictions about future criminal behavior. Policy makers should not be swayed, however, by a few high profile acts of violence committed by people who apparently had mental disorders. Instead, they should focus on the best large scale studies that have been properly done methodologically.

Investigation of good studies discloses a far weaker connection between major mental disorder and criminality than many people stereotypically assume. Most people with mental disorder do not engage in serious criminal behavior and are more likely to be victims of violence than perpetrators. The rates of serious criminal behavior among people with major mental disorder is approximately the same as the population as a whole—about 3-4%--unless the person is also abusing substances, which does increase the rate. This is unsurprising because people with serious disorders do have higher rates of substance use problems, probably because they are self-medicating to deal the pain of mental disorder and related problems. Nonetheless, even in this co-morbid population—people with major mental disorder and substance abuse—the rate of serious criminal behavior is low. Moreover, the association between psychotic states and violent behavior is weak and inconsistent. The strongest association between mental disorder and violent conduct is self-harm, especially suicide by gun. This is tragic, but not a criminal justice issue.

In short, there are clear cases in which mentally abnormal thoughts and moods may be causally related to criminal conduct, but

[9] Crane

for the most part, major mental disorder is not a major cause of crime. There is a powerful moral and social argument that better mental health services should be provided to the population at large and especially to those without the resources to afford private care. It is a mistake, however, to believe that more aggressive mental health care, including increased use of involuntary civil commitment or compulsory treatment, will make much inroad in preventing serious criminal behavior. Such interventions, which often involve substantial deprivations of liberty, may have positive mental health outcomes for some sufferers, but they will have slight impact on criminal conduct.

The final general issue is the relation of mental disorder to the prediction of future criminal behavior. Policymakers must recognize that very serious violent behaviors are relatively low frequency. That is, the base-rate for such behavior is small. It is very difficult to predict low base-rate behaviors accurately unless one has a very sensitive prediction method that has a high true positive rate. Unfortunately, with low base-rate behaviors, a sensitive method may identify most true positives, but it will also produce a vast number of false positives in which criminal behavior will be predicted but will not occur.

At present, there are three general types of prediction methods that are used in mental health (and in other contexts): clinical prediction, semi-structured clinical judgment (SCJ), and actuarial. In the former, the predictor decides what data are relevant and how to combine them based on his personal experience. In the latter, the types of data to be obtained, the methods for obtaining them and how they should be weighed are prescribed based on large scale studies that produce an algorithm for prediction. The outcome is pre-ordained by the algorithm. This is the method used by large life insurance companies to assess death risk among applicants for life insurance policies. In SCJ, the predictor typically uses some type of structured prediction rating scale, but then may adjust the outcome depending on personal experience and judgment. Actuarial prediction is vastly more accurate than clinical prediction, which tends to be quite inaccurate. There is a dispute about whether actuarial is more accurate than SCJ, but for now the default probably is that they are about equally accurate and both are substantially more accurate than clinical. Nonetheless, probably the majority of predictions made in the criminal mental health context are clinical despite the clear evidence that this is not best practice. That must change. SCJ or actuarial prediction methods should be mandated if they exist for the type of prediction in question.

If none exists, there is no alternative to clinical judgment but policymakers and decision makers should understand how inaccurate such prediction will be.

Recommendation: When predicting future behavior, the most accurate type of prediction method available should be used. If actuarial or structured clinical judgment methods are available for the type of prediction in question, they should always be preferred to purely clinical prediction.

Using a mental disorder variable as part of a criminal behavior prediction system can improve accuracy, but not by much. Many other variables, such as sex, age and especially prior history, are far better predictors than a diagnosis. One diagnosis that is associated with higher accuracy is psychopathy because it includes antisocial behavior as part of its criteria and thus builds in prior history. Still, it independently does increase accuracy. One would expect this among a population marked by indifference to morality and the rights and needs of others. Among the highest risk group of inmates or forensic patients with mental disorder, short term prediction is decently good with actuarial methods, approaching 70% accuracy. With less risky people in these populations, the accuracy drops off markedly. In general, however, accuracy is produced largely by variables other than diagnosis. In brief, mental disorder is a very weak predictor of future criminal behavior.

Given the history of the United States, there is a serious question whether one sensitive variable that perhaps increases accuracy in the criminal justice system—race--should be used when predicting future criminal behavior, both among subjects with and without mental disorder. It would be hard to avoid using it, especially unwittingly, in the case of clinical and SCJ, but it could be omitted from an actuarial algorithm. There is general consensus that race independently of, say, socioeconomic status, is at most an extremely weak predictor. Using it contributes to negative stereotypes and arguably perpetuates the structural problems that cause the association between race and criminal behavior. Policy makers must be sensitive to the issue when considering predictive technologies, but race could safely be ignored in most instances without compromising accuracy.

Recommendation: Race should not be considered as a variable when predicting future behavior.

II. Mental Disorder Among Criminal Justice Inmates: Prevalence and Needs

According to large scale epidemiological studies that used DSM-IV diagnostic categories, which are largely similar to those in DSM-5, about 1 in 10 United States adults suffers from some mental disorder. The most serious disorders, e.g., schizophrenia, major depression, bipolar disorder (manic depression), have lower rates. For example, schizophrenia is diagnosed in about 1-2% of the general population. The prevalence of disorders among prison and jail inmates varies substantially by jurisdiction and by the diagnostic criteria used and the methodology employed to collect the data. Nonetheless, there is wide agreement that mental disorder and especially serious mental disorder is considerably more prevalent among inmates than among the general population.[10] Estimates run from about 50-75% of inmates, with higher rates in jails, and among females and younger people. These numbers have risen substantially in recent decades, including the numbers of inmates with serious mental disorders, including psychotic and major mood disorders. For example, on any given day according to the American Psychiatric Association, between 2.3 and 3.9 percent of inmates in state prisons are estimated to have schizophrenia or another psychotic disorder; between 13.1 and 18.6 percent have major depression; and between 2.1 and 4.3 percent suffer from bipolar disorder. Drug problem prevalence is cloudier because of the changes in diagnostic criteria, but estimates range from 25-60 % and co-morbidity seems true for about 45-50 %. Whatever the precisely accurate prevalence is in fact, it is clear that prison and jail inmates

[10] All the following data come from the sources cited in this note. See, Dean Aufderheide, *Mental Illness In America's Jails And Prisons: Toward A Public Safety/Public Health Model*, HEALTH AFFAIRS BLOG (April 1, 2014). http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/; Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT (JULY, 1999); Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT (REVISED 12/2006); Azza AbuDagga et al, *County Jails: A Survey of Jail Staff's Perspectives: A Research Report From Public Citizen's Health Research Group and The Treatment Advocacy Center* (2016); Margot Schlanger, *Prisoners with Disabilities*, This Report at XX, Table 1 (2017).

The next section of this chapter returns to the particularly vexing problem of why the prevalence has risen so greatly in local jail populations.

suffer from very high rates of mental disorders and more people with serious disorders are in prisons and jails than hospitals.[11]

In addition to the suffering that many inmates with mental disorder experience as a result of the disorder itself, inmates with disorder are more likely to be victimized and placed on suicide watch, can be management problems, are more likely to get into fights, and to have other difficulties. In addition, as a result of their history of mental disorder, many have substantial interpersonal and psychosocial deficits that make it difficult for them to be productive, law-abiding members of the community. Treatment needs in prisons and jails are large and acute.

The United States Constitution gives little purchase to the mental health treatment rights of people incarcerated in the criminal justice system. The Court has never held that there is a general right to adequate mental health treatment in either the criminal justice or involuntary civil commitment contexts. Two cases, Estelle v. Gamble[12] and Youngberg v. Romeo,[13] provide only minimal guidance. In *Estelle*, which addressed the constitutional right to health care of prisoners generally, the Court noted that the prisoner had no access to services other than those the prison provided, but held that an 8th Amendment violation was colorable only if the prison demonstrated "serious indifference" to the health care needs of an inmate. This is a very low bar. One assumes that ordinary indifference would not raise a potential claim.

In *Youngberg*, the Court was asked to decide whether the Due Process clause guaranteed a profoundly intellectually disabled inmate of a civil state institution the rights to safety in confinement, freedom from bodily restraints and treatment. Applied in the context of intellectual disability, the latter was termed training or "habilitation." The Court held that the inmate had the first two rights and the third so far as it was necessary to guarantee the first two. But the Court also noted that no constitutional violation would obtain if "professional judgment" was used to determine the inmate's needs and otherwise inadequate habilitation would be acceptable within broad limits if it resulted from insufficient availability of state resources. It should be apparent that these two cases do not offer strong constitutional support

[11] This is true, but it ignores the evidence that hospitalization would not be necessary for most people with severe disorders if appropriate services were provided in the community.
[12] 429 U.S. 97 (1976)
[13] 457 U.S. 307 (1982).

for the state's need to provide robust, effective mental health treatments in prisons and jails. As long as the state is not seriously indifferent to prisoners' mental health needs, and, assuming *Youngberg* roughly applies to prisoners, some professional judgment is applied (even if constrained by state resources), constitutional requirements are satisfied. As a matter of morality and justice, however, this is unconscionable.

It is of course unrealistic to expect prisoners to receive the highest level of care that would be available in freedom and on the open market. But, at the least, they should receive a level of care reasonably adequate to meet medical, psychiatric and psychological ethical standards. There is widespread agreement that mental health treatment for prisoners, especially in local jails, does not meet this standard.[14] Medication is typically available in prisons, but far less so in jails. Adequate pharmacological treatment for psychotic, severe mood, and serious anxiety disorders is not a simple matter, however. Done properly, it requires a careful evaluation and careful follow-up to consider how the medication chosen is working and whether the dosage or the medication itself needs to be changed.

For many reasons, there are simply insufficient numbers of mental health professionals working in the prisons and jails to satisfy this need. There are large numbers of inmates who need help, but states and localities seldom budget enough resources. Most qualified professionals would rather work in more pleasant environments. In virtually all jurisdictions, only psychiatrists among the mental health professionals are qualified to prescribe medication. Psychologists, social workers and psychiatric nurses are limited to providing psychological services, which, although important, are not the first line of treatment in custodial settings, and there are simply not enough psychiatrists properly to prescribe and follow the care of inmates. Outside of prison, a great deal of psychotropic medication is prescribed by family physicians, internists and other primary care doctors, and non-psychiatrist prison doctors can prescribe, but such professionals are not mental health specialists and the quality of care is lower.

A major reform that would permit enhanced pharmacological treatment would be to authorize other mental health professionals to

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[14] See, Treatment Advocacy Center, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (2014). *TACReports.org/treatment-behind-bars*

prescribe psychotropic medications. Psychologists who have special training in psychopharmacology already have prescription privileges in limited jurisdictions, including Louisiana, New Mexico and Illinois. Many psychiatrists object to this, but it would immeasurably alleviate the burden of providing more adequate and available drug treatment without endangering patients. Even if a jurisdiction was unwilling to permit non-physicians to prescribe psychotropic medications generally, the practice might be limited to other professionals working in jails and prisons. In my opinion, psychiatric social workers and psychiatric nurses as well as psychologists who undergo the necessary training should have prescription privileges for psychiatric medications.

Recommendation: Non-physician health care providers in jails and prisons, especially psychologists, psychiatric social workers, and psychiatric nurses, who have received adequate training in prescribing psychotropic medication should be permitted to prescribe psychotropic medication.

Psychotherapy (counseling) and psychosocial rehabilitation are indicated for many people with mental disorder for whom drug treatment might be useful but still insufficient to help alleviate psychological abnormalities and to decrease interpersonal and social skill deficits. These services can be provided by any trained mental health professional, not just by psychiatrists, but they can be labor intensive, especially individual therapies with sufficient frequency of provision to be useful. Such services are rare in custodial settings, although various forms of group therapy are often available. How effective such services are with prisoners and which ones have not been rigorously evaluated, so it seems to me premature to recommend much greater allocation of resources for psychological services. Rather, experimental trials of various forms of therapies should be performed to develop the data base to determine whether and for whom such services are cost-benefit justified.

Treatments for the special populations of addicts and sexually disordered sexual criminals are of limited efficacy. Indeed, some data concerning the latter suggests that treatment is an increased risk factor for recidivism. If treatments for these types of offenders were effective, then it would probably be quite cost-benefit justified to make them

available. Relevantly, the Supreme Court held in *Hendricks*[15] that the provision of treatment was not necessary to justify the involuntary commitment of mentally abnormal sexually violent predators and experience with these commitments suggests that treatment is not of great help because almost no one committed under these schemes is ever released. My conclusion is that until more rigorous data proves the efficacy of treatment for these groups, major resource allocation would not be justified.

Recommendation: Until rigorous data support the efficacy of various psychological treatment methods for prisoners, including special populations such as addicts and sexual offenders, large scale resource allocation for such methods should be limited, especially for methods focused on individual cases.

Although many populations need and deserve services for various problems and money is not limitless, prisoners are entirely under state control and have no alternative means of obtaining care. To the best of my knowledge, there is no rigorously obtained data base that links increased resources and care among prisoners to long-term mental health outcomes. Decency demands, however, that more money should be spent on research concerning prisoners' mental health care and the provision of such care itself, especially appropriate prescription of and follow up for psychotropic medication.

Recommendation: Jail and prison mental health services need to be dramatically improved.

III. Doctrinal and Practice Reforms

In this part of the chapter, I address those aspects of doctrine and practice that seem most in need of reform. For those who wish more information and analysis, in earlier writing, I have treated these issues at vastly greater length.[16]

O. *Criminalization of Mental Disorder*

A particularly vexing problem is the rise of mental disorder among local jail inmates. Many attribute this to the de-

[15] Note ___supra

[16] Stephen J. Morse, *Mental Disorder and Criminal, Law*, 101 J. CRIM. L. & CRIMINOL. 885 (2011).

institutionalization movement that began in the 1960s and that led to the closing of mental hospitals, the reduction in psychiatric hospital beds generally, and the decreased use of involuntary civil commitment. One phrase characterizes the history as a movement from de-institutionalization to trans-institutionalization, with local jail facilities replacing hospitals as the location of first resort for holding people with mental disorders who are presenting public problems. In other words, in the absence of a viable hospitalization alternative, we are now using the misdemeanor public "nuisance" behavior of people with mental disorder to jail rather than to hospitalize them and sometimes use arrest even in the absence of probable cause to believe a misdemeanor has occurred.

Although there is truth to some of the descriptive parts of this argument, e.g., hospitalization has declined and penal incarceration in jails has increased, I think much of the trans-institutionalization claim is misguided. Involuntary hospitalization is a massive intrusion on the liberty of the individual, as the Supreme Court recognized in O'Connor v. Donaldson,[17] and it was often based on inaccurate clinical predictions that the person was going to be danger to himself or to others. Hospitalization is the most expensive form of mental health treatment and there is much evidence to suggest that it is not necessary if proper services are provided in the community. De-institutionalization did not fail. It was never really tried because most communities did not make adequate services available when the hospitals closed. Further, there was good evidence that hospitalization was not cost-benefit effective for mental disorders, although it did remove bothersome people from the community.

Some people with serious mental disorders can seem threatening or be offensive and are often responded to negatively. Petty assaults may result. If people with disorder are poor and homeless, they may commit petty theft and public disturbance can occur. Previously, the police would take such people to a mental hospital emergency room. Although that is still possible, it is much less common for the reasons given. As a result, they are far more likely to be jailed if the police believe they must be taken out of the community. This is particularly unfortunate because jails, especially in big cities, are highly stressful environments and the mental health care available is very poor. We should also note that for more serious criminal behavior, there has been

[17] U.S. (1975).

no "trans-institutionalization." People arrested for such crime have always been responded to by being jailed. No suspected murderer, rapist or armed robber was taken to the mental hospital emergency room as the venue of first resort.

There is undeniably a problem of large numbers of mentally disordered misdemeanants being in jail, but how should it be addressed. A return to large-scale involuntary hospitalization would be unwise for the reasons the system was dismantled in the first place and it would be infeasible to re-create it. One could de-criminalize low level misdemeanors generally, but that, too, would be infeasible. So, assuming that the behaviors resulting in jailing should be criminalized, the most obvious solution has already been addressed in the preceding section: provide sufficient mental health care in the jails. Assuming, too, that most of the jailed inmates with mental disorder are responsible for the criminal behavior that resulted in jail time, they are rightly there and should then be treated properly.

Jailing mentally disordered, low-level misdemeanants seems harsh and inefficient to many, including me. Diversion from the criminal justice system is a much more attractive option in appropriate cases, but the mechanisms now available are problematic. Despite the popularity of specialty problem-solving courts, such as drug courts and mental health courts, there are significant civil liberties concerns about these courts. Also, they have not been terribly rigorously evaluated for efficacy. Finally, they are not used in cases of violent crime, which would include assaultive behavior, but such cases are common among mentally disordered people who are arrested.

Involuntary outpatient commitment is another promising diversion possibility. Without some form of coercion, many mentally disordered people who have been arrested for misdemeanors will not adhere to treatment regimens. Outpatient commitment has been shown to be successful, but only if treatment of sufficient intensity and duration is provided. In either case, effective mechanisms for triggering diversion would have to be adopted. Police officers typically have a fair degree of experience assessing whether a subject is seriously mentally disordered and with training could do even better at making such judgments and interacting successfully with disordered people. When officers arrest misdemeanants, they might be able to make on the spot decisions to call psychiatric emergency teams to trigger outpatient commitment. In the alternative, all misdemeanants placed in jail could be evaluated within 24 hours for their suitability for outpatient

commitment. Both mechanisms—police judgment and in-jail evaluation—might be highly successful in diverting misdemeanants to outpatient treatment rather than jail. In addition to the problems noted above, specialty courts would not provide an efficient diversion mechanism for misdemeanants because invoking this process is time-consuming and jail terms are typically relatively short.

Assuming that an effective and efficient mechanism for diversion could be devised, it is still utterly crucial that sufficient resources for adequate treatment in the community should be provided. If mentally disordered misdemeanant arrestees are diverted to an inadequate treatment environment, little will be gained.

Recommendation: Mentally disordered people arrested for non-violent or minimally violent offenses should be diverted from the criminal justice system to the mental health system. Adequate methods for effective and efficient triggering of diversion must be devised and adequate treatment must be provided in the community to the people diverted. Law enforcement officers should receive special training in dealing with mentally disordered people to enhance diversion and to deal with such people humanely.

B. *Forensic Evaluation and The Right to A Mental Health Expert*

Pretrial forensic evaluations are routine both to determine various competencies and to evaluate legal insanity and the negation of *mens rea*. The results of such evaluations can also have a major impact on sentencing, and, indeed, a forensic evaluation at any time may be useful for sentencing alone even if no competence or defense issue is raised. For example, an defendant with mental disorder who is competent and has no plausible insanity defense or *mens rea* claim may nonetheless have a good argument for mitigation at sentencing. Major issues are whether determinations requiring a forensic evaluation are truly adversarial and whether an indigent defendant should be entitled to a genuinely independent expert to assist him.

In the case of competence evaluations, the defendant seldom has his own expert. State-appointed forensic professionals are virtually always the only experts who examine the defendant and trial judges—this issue is seldom decided by a jury—routinely simply rubber-stamp the state experts' opinions. Much is at stake in competence evaluations. This type of process is unlikely to lead to a full evaluation of the issues. These proceeding should be fully adversarial with experts on both sides.

Recommendation: Competence determinations should be fully adversarial, with experts representing both sides.

Suppose defense counsel suspects that a defense to guilt based on mental disorder is a plausible claim or simply wishes to evaluate whether it is. Or, suppose that the defense counsel believes that although no doctrinal defense based on mental disorder is likely to succeed, counsel believes mitigation at sentencing is appropriate. Anyone with experience in criminal mental health practice understands that mental health experts, typically psychiatrists and psychologists, play a crucial role. Although either the defense or prosecution can succeed with or defeat a claim involving mental disorder without using expert witnesses, as a practical matter it is extremely difficult and perhaps impossible for the defense.[18] This is not a problem for wealthier defendants who can retain a genuinely independent expert, but it is a major problem for indigent defendants. Unless an indigent defendant has access to an expert paid for by the state, the defendant will seldom have a fair chance of succeeding with his or her claims.[19]

In *Ake v. Oklahoma*,[20] the Supreme Court finally recognized the unfairness of not providing the defendant with a mental health expert. It noted that fundamental fairness entitles indigent defendants to an adequate opportunity to present their claims.[21] The Court further held that a mental health expert is necessary for this purpose when the defendant has a significant claim of legal insanity or needs expert assistance at capital sentencing hearings to rebut expert predictions of dangerousness.[22] The Court left the implementation of the right to the states.[23] The decision is correct, but it left open important questions about the extent of the right and how it should be implemented. In particular, it did not decide whether the indigent defendant is entitled to a truly independent expert to represent him. The Court's opinion did not address whether experts also needed to be provided to assist the defendant with other claims concerning the relation of mental disorder to

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[18] ABRAHAM S. GOLDSTEIN, THE INSANITY DEFENSE 124 (1967) ("Though the cases say again and again that expert testimony is not 'essential' to raise the insanity defense, it is clear that a persuasive case is unlikely to be made on lay testimony alone.").

Although a guilty verdict will typically be upheld even if the defense presents unanimous expert testimony that the defendant was legally insane and the prosecution rebuts this testimony only with lay witnesses and cross-examination, such cases are rare at the trial level. *See* WAYNE R. LAFAVE, CRIMINAL LAW 453 (5th ed. 2010) (noting that it is difficult to succeed without expert witnesses, but that appellate courts uphold verdicts based on lay testimony "not infrequently").

[19] *Id.*

[20] Ake v. Oklahoma, 470 U.S. 68 (1985).

[21] *Id.* at 77.

[22] *Id.* at 83–84.

[23] *Id.* at 83.

culpability and sentencing. A majority of states permit defendants to use evidence of mental disorder to negate *mens rea*, although usually with limitations.[24] Mental disorder can also be a mitigating factor at both capital and non-capital sentencing, and expert predictions of dangerousness at non-capital sentencing may need to be rebutted. Even if there is no expert prediction of dangerousness in capital and non-capital sentencing proceedings, there may be a plausible case for mitigation. In all these contexts, the defendant is in peril without expert assistance. It is difficult to understand how these other types of questions involving mental disorder can be distinguished from legal insanity and rebutting expert predictions at capital sentencing. It is true that legal insanity is a complete defense and that death is "different." Nonetheless, *mens rea* is a crucial culpability issue, and in many cases a *mens rea* negation claim may be more important to a defendant than raising legal insanity because the defendant can thereby defeat the prima facie case for higher levels of offense and avoid potentially lengthy post-insanity acquittal commitments. Moreover, sentencing is vitally important to the defendant in all cases, and raising mitigation at capital sentencing is especially important, as the Supreme Court recognized beginning with *Lockett v. Ohio*.[25] Experts should be appointed and paid for in all these cases that so fundamentally affect the defendant's culpability and punishment, but the reach of *Ake* is unclear. Failure to do so is substantially unfair because a defendant with a potentially meritorious claim of innocence or mitigation will not be able to raise it effectively.

Recommendation: A mental health expert should be appointed to assist a defendant with any potential claim based on mental disorder that bears on culpability and punishment.

The more difficult problem is how the right has been implemented in many jurisdictions. *Ake* has not been interpreted to guarantee the defendant a mental health professional that the defense chooses.[26] If a defendant has resources, he can "shop around" to try to obtain a mental health professional who will support his claims, but indigent defendants do not have that ability.[27] If the professional consulted will not render a favorable opinion, the defendant's mental health-based argument will almost certainly fail. In some jurisdictions with a sizeable number of forensic professionals, some experts

[24] Clark v. Arizona, 548 U.S. 735, 800 (2006) (Kennedy, J., dissenting).
[25] Lockett v. Ohio, 438 U.S. 586, 605 (1978).
[26] *E.g.*, United States v. Osoba, 213 F. 3d 913 (6th Cir. 2000).
[27] *Ake*, 470 U.S. at 83.

may have a reputation for being favorable to the defense and the problem may be somewhat alleviated. There is no guarantee, however, that even a favorably inclined forensic professional will reach the expected conclusion, and the possibility of using a predisposed expert may not arise in jurisdictions with fewer forensic specialists. What is worse, in some jurisdictions the defendant may be assigned a mental health professional who is an employee of the state and the prosecution may immediately have access to the report.[28] A state employee inevitably has a conflict of interest. The indigent defendant should be entitled to an independent professional, as some jurisdictions, including a majority of the federal circuits, hold.[29]

There is split among the circuit courts concerning whether *Ake*'s holding requires a genuinely independent mental health evaluation or whether a single expert appointed by the court who makes his findings available to both parties and the court is sufficient. The Supreme Court has granted *certiorari* in a case that squarely raises this issue in a capital case involving mitigation.[30] The Court should rule that the defendant is entitled to a genuinely independent evaluator, but that does not go far enough. The expert should not be an employee of the state. Further, the independent expert's report should not be disclosed to the prosecution unless the defendant decides to go forward with a mental health-based argument. An independent expert's report should be confidential work product unless the claim is raised. The fruits of an evaluation of a potential claim should not be of benefit to the prosecution.

Recommendation: Defendants with a mental health based claim should be entitled to a genuinely independent mental health evaluator and the results of the evaluation should be confidential work product and not disclosed to the prosecution unless the defendant intends to use the evaluation to support a claim.

Should the defense attorney be present when the defendant is clinically examined by the prosecution's expert? Courts have rejected such arguments on the ground that the attorney's presence will undermine the expert's attempt to obtain information and could be otherwise disruptive.[31] For example, the attorney might try improperly to caution or to coach the client during the evaluation. There is some truth to these worries, but I think that they are

[28] Granviel v. Texas, 495 U.S. 963, 963–64 (1990) (Marshall, J., dissenting from denial of certiorari).

[29] PARRY, at 131–32.

[30] McWilliams v. Dunn, *cert. granted* (2017).

[31] United States v. Byers, 740 F.2d 1104 (D.C. Cir. 1984) (rejecting the claim that the State does not need an independent evaluation).

exaggerated and that there is good reason to have the attorney present. The examiner inevitably will be wittingly or unwittingly selective in his report and testimony about which aspects of the examination are focused on. It is all too easy for an expert to succumb to confirmation bias and to ignore contrary evidence. Moreover, inferences from, and conclusions about, particular parts of the examination are subject to subjective interpretation. As the Supreme Court has repeatedly said, psychiatry is not an exact science.[32] Consequently, it would be very helpful to both sides to be able to view the examination of the defendant by the opposing expert or by the sole expert in non-adversarial proceedings. Both attorneys can then have a better sense of whether an evaluation actually supports or is consistent with the testifying expert's inferences and conclusions based on the evaluation. The potential for disruption remains, however, so I suggest that all forensic evaluations should be videotaped. This would not be disruptive and would allow the type of assessment that would be helpful. Indeed, in some cases, the tapes might be shown to the jury guided by the expert testimony about them.

Psychological testing, the other major form of forensic evaluation, need not be taped. It is true that a psychological test can be improperly administered in various ways and there is some evidence that testers tend to interpret results more favorably to the side that retained the expert. It seems, however, that taping will not substantially ameliorate this problem. It will be sufficient if the opposing expert has access to the raw scores on the tests in question so the expert can determine if the test was properly scored and interpreted.

Recommendation: Clinical forensic evaluation interviews should be videotaped and the raw scores of psychological tests should be provided to the opposing side.

In cases involving allegedly civil preventive detention, such as sexual predator commitments, the subject of the potential commitment is not constitutionally entitled to the service of an independent professional and seldom has one unless the subject has independent means. Moreover, the subject does not have the right to remain silent.[33] Great weight will be placed on the testimony of the state-appointed evaluator and the subject's only means of defeating an adverse opinion will be through effective cross-examination. There are no data on this question, but I suspect that judges and juries seldom

[32] *See, e.g.,* Crane, supra note ___

[33] *E.g.*, Allen v. Illinois, 478 U.S. 364, 374 (1986).

find that the subject does not meet the commitment criteria, even if cross-examination is effective. For example, the subjects have typically committed seriously dangerous acts and it is difficult to establish the negative that the subject will *not* commit another dangerous act if released. Most preventive detention commitments associated with criminal justice are potentially indefinite. A subject faced with such a drastic loss of liberty should have a right to the services of an independent mental health professional to defeat the allegation that he should be detained preventively.

Recommendation: In quasi-criminal proceedings, such as those involving the civil commitment of mentally abnormal, sexually violent predators, the person facing commitment should be entitled to a genuinely independent mental health professional to assist him.

C. *Competence to Stand Trial*

Competence to stand trial is the most frequently raised doctrinal issue in the criminal justice system. There is a good argument that many defendants who are incompetent could nonetheless receive a fair trial, thus avoiding some of the negative consequences of a finding of incompetence, but it is settled constitutional doctrine that an incompetent defendant may not be tried.[34] In this section, I shall focus primarily on the restoration of competence.

I suggest that lawyers appointed solely to evaluate trial competence would be better evaluators of a defendant's trial competence than mental health professionals because lawyers comprehend much better what understanding and assistance are necessary. The mental health expert will have a better understanding of why the defendant is allegedly incompetent, and the clinician is certainly better positioned to recommend treatment. Nonetheless, the cause is usually apparent, and why the defendant is incompetent is relevant only to the potential treatment to restore competence. The evaluating professional is virtually never involved in the treatment process, so the treatment evaluation will have to be made independently in any case. For now and for the foreseeable future, however, the evaluations will be done by mental health professionals.

A defendant found incompetent to stand trial will typically be committed to a forensic hospital or forensic unit of a hospital for treatment to restore competence. In the leading precedent, *Jackson v. Indiana*, the Supreme Court

[34] Pate v. Robinson, 383 U.S. 375 (1966); Drope v. Missouri, 420 U.S. 162, 173 (1975). Some refer to *Dusky v. United States* as the crucial precedent, but *Dusky* was simply an interpretation of the federal statute and not a constitutional case. 362 U.S. 402 (1960).

held that due process requires that the nature and duration of the commitment should bear a reasonable relation to its purpose, which is to restore trial competence.[35] The Court did not provide much guidance about the length of these commitments, and they vary substantially among jurisdictions. Thus, although there is only probable cause to believe the defendant has committed the crime, he can be incarcerated without trial in a secure facility for many years—in some cases as long as the sentence for the crime charged—despite the lack of a conviction.[36] Although the time hospitalized is counted towards any criminal sentence ultimately imposed, the hospitalized incompetent defendant is in legal limbo, and incompetence can be used as a tactic by both the prosecution and the defense.[37] To the extent that incompetence commitment is used by the prosecution to preventively detain an accused for whom the case may be weak, this is an abuse of the incompetence procedures. The Supreme Court in *Jackson* also held that a defendant who is irreversibly incompetent to stand trial must be released from the criminal justice system, but state officials clearly have substantial discretion to decide that the incompetence is not irreversible and thus to continue what may be improper preventive detention.[38]

Finally, the Court suggested, but did not require, that pretrial motions, such as to suppress evidence, could be adjudicated, even if the defendant were incompetent to stand trial.[39] In some cases, this might have the effect of ending the prosecution because suppressed evidence is crucial to the prosecution's case, but there are no data about how often such pretrial proceedings are used. In sum, much potential exists for abuse of incompetence to stand trial doctrines and practices. It is time to rethink them. Virtually everything I shall say in what follows has been suggested previously,[40] but the system does not change and abuses are not curtailed.

If the criminal process can be halted by the suppression of evidence or other pretrial proceedings, it should be. An incompetent defendant is presumed innocent and should have available any pretrial action that can halt

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[35] Jackson v. Indiana, 406 U.S. 715, 738 (1972). In some jurisdictions, trial competence treatment can be performed in the local jail. *See* CAL. PENAL CODE § 1369.1(a) (West 2010).

[36] JOHN PARRY, CRIMINAL MENTAL HEALTH AND DISABILITY LAW, EVIDENCE AND TESTIMONY 116 (2009).

[37] NORMAN G. POYTHRESS, RICHARD J. BONNIE, JOHN MONAHAN, RANDY OTTO & STEVEN K. HOGE, ADJUDICATIVE COMPETENCE: THE MACARTHUR STUDIES 49-50 (2002).,

[38] *Jackson*, 406 U.S. at 738. If the examining or treating mental health professionals unanimously conclude that an incompetent defendant cannot be restored, then the state will have to use some other means, such as civil commitment, to restrain a permanently incompetent defendant who is believed to still be dangerous.

[39] *Id.* at 741.

[40] *E.g.*, ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, Standard 7-4.13 (1989); Robert Burt & Norval Morris, *A Proposal for the Abolition of the Incompetency Plea*, 40 U. CHI. L. REV. 66 (1972). I apologize in advance to the many other excellent scholars who have written about this.

the prosecution. The defendant may go free because the constable has blundered, but that is the cost of doing business in a system dedicated to protecting the rights of defendants. If the defendant is still mentally disordered and non-responsibly dangerous as a result, the state can resort to traditional involuntary civil commitment to protect the public. This is an imperfect remedy, but no system of preventive detention can guarantee society's perfect safety and still be consistent with due process concerns. The defendant may not ever be brought properly to justice, but such a commitment is preferable to outright release, which is what would happen if the defendant were competent.

Recommendations: Defendants who are incompetent to stand trial should be permitted without exception to raise pre-trial motions that might end the prosecution.

Intellectual disability and severe mental disorder are the primary abnormalities related to incompetence. Intellectual disability itself cannot be treated, but it is possible through educational techniques to teach a defendant some of the communication or other cognitive skills, such as an understanding of the criminal process, necessary to restore trial competence. If such interventions are provided soon and with reasonable intensity, the treating personnel can discover in a matter of months and perhaps only weeks if the defendant is capable of learning the necessary skills. There is utterly no need for long-term hospitalization and its use is simply a means to reach another, constitutionally impermissible goal in this context, such as preventive detention.

Severe mental disorder, including psychotic states, is more treatable, especially with psychotropic medication. Psychotropic medication is not a panacea, however. A substantial number of patients do not respond, even to the most effective agents. All the drugs have side effects that can be extremely serious and unpleasant, and the drugs do not provide life skills that the person did not formerly possess. Thus, even if the person responds well to psychotropic medication and regains reasonable cognitive control, some educational interventions may also be necessary to prepare the defendant for a criminal trial. Despite the difficulties, medication will be the first treatment of choice for most defendants who are incompetent because they are out of touch with reality. In virtually all cases, a determination can be made within six to nine months that the defendant is or is not treatable. There is no need

for longer commitment to restore trial competence.[41] A conclusion of irreversibility can be reached and further commitment for restoration is once again preventive detention. Thus, all jurisdictions that permit lengthy restoration commitments are in virtually all cases engaged in permitting preventive detention rather than in genuine restoration commitment. [42]

Finally, in many cases, especially those involving non-violent defendants, there may be no need at all for in-patient hospitalization. Community-based treatment may be sufficient either to restore competence or to determine that this is impossible. Community treatment is preferable because it deprives a defendant not yet convicted of less liberty than hospitalization and it is much less expensive.

Recommendation: Long term inpatient commitments to restore trial competence are unnecessary. Short term commitments are adequate to either restore the defendant or to determine that the defendant cannot be restored. In appropriate cases, restoration should be performed in the community.

In *Sell v. United States*,[43] the Supreme Court addressed whether and under what conditions the state could forcibly medicate an incompetent defendant for the purpose of restoring the defendant's competence to stand trial. The Court agreed, as it had previously,[44] that citizens have a strong liberty interest in being free of unwanted medical interventions.[45] The Court nonetheless held that an incompetent defendant could be involuntarily medicated if four conditions were met: the treatment was medically appropriate, the governmental interest was strong because the charges were serious, the treatment would not cause trial prejudice, and less restrictive means of

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[41] Suppose the defendant competently refuses to take psychotropic medication, thus preventing the government from restoring his or her trial competence. It is perfectly possible that a defendant with mental disorder might be incompetent to stand trial but competent to refuse medication. Crazy thinking can be relatively domain-specific, diminishing competence in some areas of functioning and not in others. It is also possible that the defendant will be incompetent to refuse. The law is not entirely clear about the government's right to override an incompetent refusal of a committed person, but I shall argue that the government should have the right to treat defendants incompetent to stand trial whether or not they are competent to refuse treatment.

[42] Most defendants are restored to competence within six months. POYTHRESS ET AL., at 51. Nonetheless, the potential for lengthy commitment remains and can be abused.

[43] Sell v. United States, 539 U.S. 166 (2003).

[44] In *Washington v. Harper*, the Supreme Court decided under what conditions a prisoner could be forcibly medicated with psychotropic drugs. 494 U.S. 210 (1990). The Court noted that everyone has a substantial liberty interest in being free from unwanted medical interventions. *Id.* at 221–22. The Court held, however, that prisoners could be forcibly medicated for their own safety or the safety of others if medication was medically appropriate and the prisoner posed a danger to himself or others. *Id.* at 227. I will discuss *Harper* in greater detail in subpart V.B, *infra*.

[45] *Sell*, 539 U.S. at 178.

restoring competence were not effective.[46] The Court did express a preference for treating the defendant under an independent and less fraught rationale, however, such as the defendant's dangerousness.[47] Not all incompetent defendants will satisfy such an independent rationale for involuntary treatment and trial courts will have to apply the *Sell* criteria.

Three of *Sell*'s conditions are appropriate, but I would go further and argue that the government's interest in trying an accused is sufficiently strong in the case of any felony to justify forcible medication of an incompetent defendant for the purpose of restoring competence. A criminal prosecution is an extremely serious matter. Neither the case nor the prosecution and defense should remain in limbo while an incompetent defendant languishes in a hospital untreated. The incompetence standards and consequences are not meant to be used strategically by either side. What is the point of keeping an incompetent defendant in a hospital to restore competence if restoration is made impossible by treatment refusal? The intrusion of forcible medication is not trivial, to be sure, especially if refusal is based on religious convictions, but neither is it so extensive that it should block the progress of the case. It is not a form of thought control or any other type of unjustifiable intervention. Forcible medication simply tries to restore the person's cognitive control and ability to test reality. Moreover, hospitalization is expensive and should be terminated as soon as possible. Finally, no good alternative presents itself. If the defendant can prevent restoration, rendering him permanently incompetent, then the government must dismiss the charges, presumably with prejudice, and seek involuntary civil commitment. As we have seen, however, this is an imperfect remedy. If the person could be forcibly treated in involuntary civil commitment or in some other way, such as the substitution of judgment by a guardian because the defendant is not competent to refuse, then perhaps trial competence could be restored in those ways.

Recommendation: Forcible medication to restore trial competence should be justified in the case of all felony prosecutions.

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[46] *Id.* at 180–81. Whether the medication will have an adverse effect on the fairness of trial because it alters the defendant's behavior negatively, such as impairing communication abilities, is an important issue. *See id.* at 185–86. Anti-psychotic medication at proper dosage levels typically does not sedate the defendant or otherwise impair a person's abilities. Rather, if effective, it restores cognitive functioning and should enhance the defendant's performance. On the other hand, it may make the defendant appear "normal" to the judge or jury, which might undermine a claim that the defendant was legally insane, or it might alter the defendant's demeanor in a prejudicial way. Such possibilities especially concerned Justice Kennedy. Riggins v. Nevada, 504 U.S. 127, 142–45 (1992) (Kennedy, J., concurring). These potential difficulties could be alleviated by expert testimony and judicial instructions. In an extreme case, however, the *Sell* criteria will not be met.

[47] *Sell*, 539 U.S. at 181–82. The Court expressed a preference for justifying medication according to the *Harper* criteria. *Id.*

Unless the Supreme Court reverses decades of incompetence jurisprudence, it is not possible to try incompetent defendants even in those cases in which they could receive a fair trial. This would solve many of the problems raised by *Sell* or by cases of seeming permanent incompetence, allowing final resolution of the criminal justice process. One may fairly ask how we could be sure that the trial would be fair, but I suggest that this could be resolved at pretrial hearings. Everything depends on how complicated the issues are and whether difficult strategic choices will be necessary in which the defendant would be likely to disagree with the attorney's advice. We could also adopt various prophylactic rules, such as requiring the prosecution to disclose evidence that may not pass the *Brady* threshold of actual innocence evidence, but which arguably favors the defense.[48] In any case, the issue will not arise frequently because most state and federal cases are resolved by plea bargains. Nonetheless, the incompetence process would be rationalized in those cases in which going to trial seems optimal and a fair trial was possible despite incompetence. I recognize that this is a controversial suggestion and the procedural requirements to guarantee fairness would be complex, but, in principle, this is a reform that could work.

D. *Competence to Plead and to Waive Counsel*

In *Godinez v. Moran*,[49] the Supreme Court was asked to impose a standard of competence to plead guilty and to waive the right to counsel, a so-called "reasoned choice" test, that was different from the standard for incompetence to stand trial. The argument for doing so was that pleading is more complicated than going to trial and therefore a different and presumably higher standard was required to satisfy due process. The Court refused to adopt a different test, holding that the competence to stand trial standard was sufficient to protect the defendant's rights as long as the waiver of the right to trial and other constitutional protections was actually knowing and voluntary.[50] After all, a defendant might be competent but might not actually understand what he is doing as a result of confusion, marginal competence, or the like. In my view, the Court missed the theoretical and policy mark although the holding is not self-evidently wrong.

All competence standards are essentially functional rationality tests. The question is what rational understanding and skills are required. Although competence standards generally should be low, what is required can vary

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[48] Brady v. Maryland, 373 U.S. 83 (1963).

[49] 509 U.S. 389 (1993).

[50] *Id*. at 400. In his concurrence in *Godinez*, Justice Kennedy characterized the requirement as "knowing, intelligent, and voluntary." *Id.* at 403 (Kennedy, J., concurring).

according to the context. Consequently, "one size fits all" standards in many contexts make little sense. For example, some trials are complicated and some guilty pleas are not, and vice versa. It is a fantasy to believe that any particular standard, such as competence to stand trial, adequately operationalizes the test. Even if the standard specifies what must be understood, it does not specify how much understanding and of what type is required. Is the ability to accurately recite information previously provided sufficient or must the agent be capable of a process of rational weighing and assessment?

Although different "skills" may in theory be necessary to accomplish different tasks successfully, such as assisting counsel and deciding whether to plead guilty, it is not clear that the allegedly higher standard that the Court rejected, "reasoned choice," would make much difference in practice. Rational understanding and reasoned choice are both vague formulations that provide little guidance. The test should be a functional and context-dependent rationality standard, focusing on what skills are demanded in a particular context, whichever words are used to express the standard. Waiver of distinct constitutional rights implicates distinct rational understandings of each right waived. Thus, a defendant who appears to have general rational understanding may appear on close examination to lack that understanding for a particular trial right. If the trial court makes a careful inquiry concerning whether a particular waiver is knowing and voluntary, the more general and specific inquiries should merge, as the *Godinez* dissent recognized.[51] Once again, however, what is necessary is not a distinct formulation for competence to plead guilty or to waive the right to counsel, but a context-dependent evaluation by the trial court of the defendant's rational capacities necessary in each context. Finally, if a different or higher standard had been imposed, it is not clear that trial courts would have behaved differently, and appellate courts would rarely second-guess a trial court's substantive determination that a defendant was or was not competent.

Requiring deeper or more detailed rational understanding risks parentalism,[52] but requiring less risks an unjust outcome. I have a preference for limiting parentalism as much as possible and perhaps the Court's recognition that the defendant must actually waive his rights knowingly partially remedies the vagueness of the general test. On the other hand, defining knowing or intelligent is as vulnerable to manipulation as defining competence itself. In short, evaluating any competence case is a normatively fraught and difficult enterprise. I have no easy answer, but simply a policy

[51] *See id.* at 409 (Blackmun, J., dissenting).

[52] Parentalism is a gender-neutral synonym for paternalism.

preference for keeping the bar relatively low to let most defendants over it. This will maximize liberty, but the danger is that it will also unduly risk the defendant's ultimate liberty by potentiating the possibility of an irrational outcome.

Recommendation: The test for competence to plead guilty and to waive counsel should be a context-dependent assessment of whether the defendant has the rational skills necessary to meet a generally low standard for competence.

E. *The Right to Proceed* Pro Se

Should a criminal defendant who meets the *Godinez* standard for waiving the right to counsel, which is essentially the competence to stand trial standard, be permitted to proceed *pro se* if he suffers from serious mental disorder? The constitutional right to proceed *pro se* announced by the Supreme Court in *Faretta v. California*[53] does not depend on the defendant's ability to function as an able defense counsel. As long as the defendant understands the consequences of representing himself, he is entitled to do so. Consequently, one would have thought that as long as a defendant with severe mental disorder understood what he was doing, he would be entitled to represent himself.

Nevertheless, in *Indiana v. Edwards*,[54] the Supreme Court held otherwise, unpersuasively distinguishing *Godinez* on the grounds that the issue of self-representation was not raised in the previous case and that *Godinez* involved permitting a defendant to represent himself whereas the instant case involved a state trying to prevent the defendant from doing so. Writing for the majority, Justice Breyer cautioned against trying to apply a unitary competence standard to address two very different questions: whether a represented defendant is capable of going to trial and "whether a defendant who goes to trial must be permitted to represent himself."[55] Instead, Justice Breyer tried to apply a more nuanced understanding of competency that properly considered context. He recognized that a defendant with disorder might be able to assist counsel but might nonetheless be too disabled to perform basic trial tasks at even a minimal level. He therefore worried that an apparently unfair trial could result. Discretion was left in the hands of trial judges to decide if a defendant is competent to represent himself.

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[53] 422 U.S. 806 (1975).

[54] 554 U.S. 164 (2008).

[55] *Id.* at 165.

This is a difficult issue for those like myself who are advocates for the rights of people with mental disorder and who wish to treat them no differently from other people. Let us assume that if the defendant represents himself, the trial will not be a complete sham, especially if back-up counsel or some other prophylactic method is used to try to mitigate the dangers of self-representation. On the one hand, if the defendant understands the perils of self-representation, including how his own mental difficulties will interfere with his performance, why should he not enjoy the usual, constitutionally-protected liberty to represent himself that *Faretta* established? On the other hand, if mental disorder, which affects the defendant's rational capacities, interferes substantially with his abilities fully to understand the peril of self-representation or minimally adequately to represent himself, the risk of an unfair trial is high. It is not clear which approach best balances the rights of the accused with systemic concerns.

I believe the solution lies with a more egalitarian approach to *Faretta*. People might simply be too incompetent to represent themselves for a variety of reasons other than mental disorder,[56] even if they are competent to recognize how badly they will do and wish to represent themselves anyhow. *Edwards* makes clear that this type of restriction can constitutionally be placed on the *Faretta* right, at least in cases involving a defendant with mental disorder, but there seems little reason not to apply an "unreasonable trial incompetence" standard to deny the right to represent oneself to any defendant who wishes to assert it. This will mostly apply to defendants with disorder, but at least it is a cause-neutral standard that does not discriminate against defendants with mental disorder.

F. *Negating* Mens Rea

In some cases, mental disorder may explain why a requisite *mens rea* was not formed, whether or not it actually prevented the defendant from forming it. A defendant who is making such a claim, which is often mischaracterized as the "defense" of "diminished capacity," is not raising a claim of mitigation of responsibility or of excuse; it is simply a denial of the prosecution's prima facie case, which includes the *mens rea* required by the crime charged. I have termed this the "*mens rea* variant" of so-called diminished capacity.[57] For example, in *Clark v. Arizona*,[58] defendant Clark shot and killed a police officer who had pulled the defendant over in his police cruiser and was in full

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[56] *See* Jodi L. Viljoen et al., *An Examination of the Relationship Between Competency to Stand Trial, Competency to Waive Interrogation Rights, and Psychopathology*, 26 LAW & HUM. BEHAV. 481 (2002) (demonstrating that some defendants are incompetent to plead or to stand trial for reasons other than mental disorder).

[57] Stephen J. Morse, *Undiminished Confusion in Diminished Capacity*, 75 J. CRIM. L. & CRIMINOLOGY 1 (1984).

[58] 548 U.S. 735 (2006). All the facts in the following description are taken from the Court's opinion.

uniform. The defendant was charged with the aggravated murder offense of intentionally killing a human being knowing the victim was a police officer. The defendant claimed he lacked the *mens rea* because he did not intend to kill a human being and did not know the victim was a police officer. This claim would have been incredible, of course, except that the defendant was suffering from paranoid schizophrenia and had delusions that space aliens were threatening him. He claimed that he actually believed that the victim was a space alien impersonating a police officer. If he were believed—and there was evidence consistent with the truth of this belief—he did not intend to kill a human being and did not know the victim was a police officer. In this case, the mental disorder produced an irrational belief that is inconsistent with the formation of *mens rea*.

It is also possible that mental disorder explains a failure to form a *mens rea* that is not a result of an irrational belief. Imagine that a severely disordered person is confused and disorganized on the streets of a large city in a deserted neighborhood. It is freezing cold and the person realizes that he cannot find his way home and fears freezing. He therefore breaks into a building simply to keep warm. The police catch him and charge him with burglary on the theory that he intended to commit the felony of larceny in the building. In this case, the defendant was surely capable of forming the intent to commit larceny and there was no rationality problem about what he was doing, but he simply did not form the intent to steal. His disorganization resulting from mental disorder simply helps explain why he broke in just to keep warm.

In most cases, mental disorder does not interfere with the formation of *mens rea*. The primary effect of mental disorder on the mental states required by the definitions of crimes is to give the defendant abnormally irrational reasons for actually forming the requisite *mens rea*. Consider Daniel M'Naghten again. His delusional belief about the Tories motivated him to form the intent to kill Peel. In some cases, however, mental disorder may be the only credible explanation for why a defendant did not form the *mens rea* required by the definition of the offense. If a plausible claim of *mens rea* negation can be made, can the state nonetheless exclude the evidence?

In *Clark*, the Supreme Court addressed precisely this issue and held that the state could constitutionally exclude all non-observational expert evidence of mental disorder that would be introduced to negate *mens rea*.[59] The Court approved Arizona's "channeling" of all such evidence into the issue of legal insanity because so-called mental disorder and capacity evidence bearing on

[59] Clark v. Arizona, 548 U.S. 735, 772 (2006).

mens rea would simply confuse the finder of fact.[60] Judge Morris Hoffman and I have severely criticized the Court's reasoning in *Clark*,[61] but I will not repeat those arguments here. Rather, I will simply go to the heart of why the Court's decision is unfair.

Criminal blame and punishment are the most awesome, painful exercises of state action towards a citizen. In our adversarial system of criminal justice, the defendant is presumed innocent and the prosecution has the burden of proving the defendant's guilt, including the requisite *mens rea*. Criminal liability should not be imposed unless the defendant deserves such treatment. Desert is at least a necessary condition of just punishment, and the fair ascription of criminal culpability thus requires the presence of *mens rea*, which is the indicator of the degree of the defendant's fault. One would think that in such a system of justice, fundamental fairness would require that a criminal defendant should be given every reasonable opportunity to defend against the state's charge with credible and probative evidence.

There are a number of reasons that a jurisdiction might want to reject or limit *mens rea* variant claims, many of which were discussed in the *Clark* opinion. Psychiatric and psychological evidence can admittedly be scientifically and clinically questionable and sometimes of faint legal relevance. I have been a long-term critic of much forensic mental health testimony and remain so.[62] Moreover, even good forensic testimony can be confusing to lay witnesses. Despite these problems—and the Supreme Court has repeatedly acknowledged them, including in *Clark*—mental health testimony is routinely and generously admitted in a wide variety of civil and criminal contexts because it is considered relevant and probative. Indeed, the Court has accepted the admission of expert testimony about the prediction of future dangerousness in capital sentencing proceedings in the face of virtually unanimous professional opinion that such predictions were too inaccurate to

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[60] *Id*. at 774–78.

[61] Stephen J. Morse & Morris B. Hoffman, *The Uneasy Entente Between Legal Insanity and Mens Rea: Beyond* Clark v. Arizona, 97 J. CRIM. L. & CRIMINOLOGY 1071 (2007). The decision was disappointing but not unsurprising after *Montana v. Egelhoff*, 518 U.S. 37 (1966), in which the Court upheld Montana's complete exclusion of admittedly relevant and probative voluntary intoxication evidence to negate *mens rea* on the grounds that the state had valid policy reasons for doing so and that a criminal defendant does not have an absolute right to have relevant and probative evidence admitted. Voluntary intoxication is of course distinguishable from mental disorder because the latter is not the defendant's fault, but the Court's deference to the state rule and justification for it was generalizable.

[62] Morse, *Crazy Behavior* at 600–25; Stephen J. Morse, *Failed Explanations and Criminal Responsibility: Experts and the Unconscious* 68 VA. L. REV. 973 (1982) (providing a detailed critique of psychodynamic psychology and forensic testimony that is based on this theory of behavior); Stephen J. Morse, *The Ethics of Forensic Practice: Reclaiming the Wasteland*, 36 J. AM. ACAD. PSYCHIATRY L. 206 (2008) (claiming that forensic practice is not an ethical wasteland, but recommending major changes to practice). Although there are still major problems with forensic mental health testimony, I believe the situation is much improved since I first addressed this, largely as a result of the creation of specialty boards in both forensic psychology and psychiatry and the general professionalization of the field.

be the basis of a death sentence.[63] The Court held that such weaknesses were matters of weight rather than admissibility and could be exposed through cross-examination and by opposing witnesses.[64] If such prosecution testimony is admissible to put a defendant to death, how can it be fair to prevent the defendant from negating the prima facie case by using credible, relevant, probative testimony that is admissible in every other legal context?

The "channeling" of mental abnormality evidence into legal insanity claims is no remedy for the inconsistency because the *mens rea* variant is a claim entirely distinct from legal insanity, even if the evidence used is similar for both claims. In the former case, the defendant claims, "I didn't do it"; in the latter, the claim is, "I did it, but I'm not responsible." How can it be fair to permit the prosecution to use abnormality evidence to put a defendant to death but to prevent the defendant from using credible and probative evidence that he or she did not commit the crime charged in the first place?

A related rationale for denying or limiting *mens rea* negation is that it "undermines" the insanity defense. It is not clear precisely what this rationale means. Some courts reject the *mens rea* claim because they appear to assume that this claim is a lesser form of legal insanity and thus a mitigating (but not fully excusing) affirmative defense that should be adopted by legislatures rather than by courts,[65] but this is a confusion. Roughly speaking, the insanity defense is based on the premise that the legally insane defendant substantially lacks rational capacity or the capacity to control his or her criminal behavior. The *mens rea* claim does not specifically address either capacity, however. It simply addresses whether the defendant possessed the mental state required by the definition of the crime.

A better argument is that a defendant who successfully raises the *mens rea* variant may negate all *mens rea* and thus would simply be acquitted and freed. In contrast, an insanity acquittee will be involuntarily civilly committed. Moreover, the *mens rea* claim will be easier to establish than the legal insanity claim. Success in the former case requires casting only a reasonable doubt on the prosecutor's case whereas the burden of proof for affirmative defenses like legal insanity may be placed on the defendant, which significantly reduces the defendant's chance of succeeding.[66] Thus, permitting the *mens rea* claim may

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[63] Barefoot v. Estelle, 463 U.S. 880 (1983).

[64] *Id.* at 896–903.

[65] State v. Wilcox, 436 N.E.2d 523, 526–33 (Ohio 1982) (partially conflating the *mens rea* and partial responsibility variants of diminished capacity and suggesting that the legislature and not the court should adopt this "defense") (quoting Bethea v. United States, 365 A.2d 64, 92 (D.C. 1976)).

[66] HENRY J. STEADMAN ET AL., BEFORE AND AFTER HINCKLEY: EVALUATING INSANITY DEFENSE REFORM 84–85, 144–46 (1993). This study found that shifting the burden of persuasion caused a decline in the number of insanity pleas raised and that the presence of a major mental disorder was a necessity for success. It also found, however, that among the very

compromise public safety more than the insanity defense—a point to be addressed immediately below—but this is distinguishable from claiming that the insanity defense is thereby undermined. As we have seen, criminal liability should not be imposed unless the defendant deserves such treatment and a defendant does not deserve blame and punishment for a particular crime unless he possessed the *mens rea* required by the definition of that crime. The defendant can avoid unjust blame and punishment either by negating *mens rea* or by establishing an affirmative defense. *Mens rea* and legal insanity are independent doctrines. Both implicate public safety, but, more fundamentally, they are aimed at doing justice. Permitting the defendant to negate *mens rea* achieves justice independently rather than undermining the justice the insanity defense achieves.

Perhaps the strongest reason for limiting or rejecting the *mens rea* variant is the fear for public safety, a concern that might be the underlying foundation for the claim that the *mens rea* variant undermines the insanity defense. It is true that *mens rea* variant claims present cases in which fair ascriptions of culpability and public safety might conflict. The defendant who lacks the *mens rea* required by the definition of the crime is simply less culpable. But a defendant with a sufficiently severe mental abnormality to negate *mens rea* may also be a serious danger to the public because such severe abnormalities also suggest that the defendant's general capacity for rationality is diminished in situations in which criminal conduct occurs. A defendant who succeeds with a negation of *mens rea* claim will be convicted of a lesser offense that carries lesser penalties or perhaps will be completely acquitted. Consequently, the defendant will be incapacitated by imprisonment for a shorter period than if he or she had been convicted for the offense charged or acquitted by reason of insanity and then civilly committed.

The fear for public safety is genuine but overwrought. As noted, the effect of mental disorder, including severe mental disorder, is seldom to negate the "subjective" *mens rea*s, such as purpose, knowledge, and recklessness, that are part of the definitions of crimes. Mental disorder may give people irrational reasons to form the *mens rea*, but it almost never interferes with formation of that mental state. There are instances in which subjective *mens rea* is entirely negated, but they are few, indeed. Moreover, no defendant can use evidence of mental disorder to negate negligence because failing to recognize a risk the defendant should have recognized because the accused is abnormal is per se unreasonable. There are attempts to "individuate" the

few defendants in New York who did raise the defense, the success rate increased. This seemingly paradoxical effect was almost certainly caused because the defense was probably raised in only the clearest cases after proving insanity became more difficult.

reasonable person standard by endowing the reasonable person with the characteristics of the accused, such as being mentally abnormal, but this abandons objectivity altogether.[67] After all, what does it mean to talk of the "reasonable abnormal" person?

In short, even if a jurisdiction permitted a defendant to negate *mens rea* without any restriction whatsoever, public safety would scarcely be compromised and greater individual justice would be gained. I propose that this is precisely the rule that should be adopted and it is the Model Penal Code rule.[68] There will be occasions in which defendants raise implausible claims about *mens rea* negation based on mental disorder, but these can be limited by pretrial motions to exclude the evidence and similar remedies.

Recommendation: Defendants should be permitted to introduce evidence of mental disorder without limitation to negate any subjective *mens rea* but should not be permitted to use such evidence to negate negligence.

G. *Legal Insanity*

Legal insanity is an affirmative, complete defense to crime. Forty-six states and the federal criminal code have the defense.[69] Most have some variant of the "cognitive" *M'Naghten* standard, which asks whether as a result of mental disorder the defendant did not know the nature and quality of his act or did not know right from wrong.[70] A minority also have an alternative "control" test, which asks whether as a result of mental disorder the defendant could not control his criminal behavior.[71] In *Clark*, the Supreme Court upheld the constitutionality of Arizona's test, which was simply the right/wrong alternative in *M'Naghten*, although it is the narrowest conceivable test.[72] The Supreme Court has never held that the insanity defense is required by substantive due process and in 2015 denied *cert.*in a case that squarely raised the issue.[73] Further, the state supreme courts of four of the five states that

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[67] Stephen J. Morse, *The "New Syndrome Excuse Syndrome,"* 14 CRIM. JUST. ETHICS 3 (1995). For example, H.L.A. Hart has suggested general individuation of reasonable person standards for negligence, but recognized that the individuation would be a matter of mitigation or excuse and not of "subjective justification." HART, PUNISHMENT AND RESPONSIBILITY, at 153–54. The most common doctrinal examples of the attempt to individuate the reasonable person standard are in cases of self-defense and in cases concerning the reduction from murder to manslaughter if the defendant was legally adequately provoked and killed in the heat of passion.

[68] MODEL PENAL CODE § 4.02 (Proposed Official Draft 1962).

[69] Clark v. Arizona, 548 U.S. 735,749–53 (2006) (providing a description of the various rules and the number of jurisdictions that adopt each).

[70] M'Naghten's Case, (1843), 8 Eng. Rep. 718 (H.L.).

[71] *Clark*, 548 U.S. at 749–53.

[72] *Id.* at 742.

[73] Delling v. Idaho.

abolished the defense have upheld the constitutionality of abolition.[74] A compelling constitutional argument could be made for the necessity of the insanity defense,[75] but, as I shall argue presently, abolition is a bad policy even if it is constitutional. First, however, let us address a number of issues that need to be clarified.

Legal insanity is a legal and moral issue, not a medical, psychiatric, or psychological issue. The criteria for finding someone not criminally responsible—for deciding who is a fit subject for blame and punishment—are thoroughly normative. Thus, the claim that a test is "unscientific" is a category mistake. One may believe that certain types of mental states should excuse a criminal who possessed them at the time of the crime and may therefore criticize on moral grounds a test that does not include them, but that is a normative and not a scientific critique. A narrow test may be morally offensive, but it will not be scientifically erroneous.

Mental disorder alone, no matter how severe, is not an excusing condition even if it played a causal role in explaining the defendant's behavior. Causation *per se* is not an excusing condition.[76] The moral basis for the insanity defense is that in some cases mental disorder affects the defendant's capacity to act rationally or to control his behavior. These are the genuinely excusing conditions that the other criteria for legal insanity address. The issue is the defendant's impaired reasoning. Excuse is warranted only in those cases in which the impairment is sufficient, which is a moral and legal question. As a practical matter, the defendant will have to be out of touch with reality to succeed with the insanity defense,[77] but many defendants who are concededly delusional at the time of the crime may be convicted because their reasoning about the crime was nonetheless not sufficiently impaired. For example, Eric Clark was incontrovertibly suffering from paranoid schizophrenia, but the court convicted him because it concluded that Clark did know that what he was doing was wrong.[78]

Much scholarly ink has been spilled and many pixels illuminated about specific issues within *M'Naghten* and its variants, such as whether knowledge of right versus wrong means moral or legal wrong and whether an allegedly broader substitute for knowledge, such as appreciation or understanding, is

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[74] State v. Bethel, 66 P.3d 840 (Kan. 2003); Utah v. Mace, 921 P.2d 1372 (Utah 1996); State v. Cowan, 861 P.2d 884 (Mont. 1993); State v. Winn, 828 P.2d 879 (Idaho 1992). Nevada also abolished the defense, but the Nevada Supreme Court held that abolition was unconstitutional. Finger v. Nevada, 27 P.3d 66 (Nev. 2001).

[75] Stephen J. Morse & Richard J. Bonnie, *Abolition of the Insanity defense Violates Due Process*, 41 J. AM. ACD. PSYCHIATRY & L.488 (2013).

[76] *See supra* .

[77] STEADMAN ET AL., *supra* note, at 85.

[78] *Clark*, 548 U.S. at 745–46.

preferable. I believe that such debates are beside the point. To begin, the test used does not seem to make much difference in the outcome,[79] a result I think is best explained by the jury's rough and ready conclusion that the defendant was or was not sufficiently irrational to deserve to be punished.

To the extent that an outcome might turn on moral versus legal wrong, the former should be preferred because it is more action-guiding and provides a better fit with the underlying rationale for the defense. Note that all crimes for which an insanity defense is typically raised are acts that are also objectively and clearly immoral and illegal. The reason a legally insane offender typically commits the crime is primarily because she believes that she has a sufficient moral or legal justification for what she is doing. Consider Andrea Yates, who delusionally believed that she needed to kill her children while they were still sufficiently pure or they would become corrupted and would be tormented in hell for eternity.[80] Yates knew it was legally wrong to kill her children and she might also have recognized that her neighbors might think it morally wrong to do so. Nonetheless, from her deluded, subjective point of view, she surely thought she was doing the right thing. If the facts and circumstances were as she believed them to be, the balance of evils was positive in this case. Ms. Yates's knowledge of moral and legal wrong is beside the point, however. Although Ms. Yates was instrumentally rational, she deserved to be excused because her actions were deeply irrationally motivated through no fault of her own.

Many critics of cognitive tests believe that the word "know" is too narrow and that other, apparently broader terms should be used that encompass a somehow deeper understanding of what one is doing or that it is wrong.[81] Every lawyer knows, however, that almost any term used can be interpreted more or less broadly to reach the morally preferred result. Consider knowledge itself. Did Ms. Yates know what she was doing? The answer depends on whether one takes a narrow or broad view of such knowledge. Ms. Yates knew that she was killing her children, so she knew what she was doing in the narrow sense. On the other hand, her material motive for action—to save the children from eternal torment—was deluded, so she did not know what she was doing in a broader sense. She thought she was saving the children, but she was not. The same could be said of her knowledge of moral and legal wrong. Either result could be obtained by narrow or broad readings

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[79] SANFORD H. KADISH, STEPHEN J. SCHULHOFER & CAROL S. STEIKER, CRIMINAL LAW AND ITS PROCESSES: CASES AND MATERIALS 884 (8th ed. 2007).

[80] Deborah W. Denno, *Who is Andrea Yates? A Short Story About Insanity*, 10 DUKE J. GENDER L. & POL'Y 1 (2003) (providing a complete account of the case).

[81] *E.g.*, MODEL PENAL CODE AND COMMENTARIES § 4.01, at 166, 169–70 (1985); Douglas Mossman, United States v. Lyons: *Toward a New Conception of Legal Insanity*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 49, 54–57 (1988).

of "understand," "appreciate," or other contenders. Fine-grained parsing of small definitional differences will not be helpful to finders of fact. A legislature can certainly signal by using a term different from knowledge that it wishes to adopt a broader reading of its cognitive test, but juries will still make a rough and ready judgment and the word used has no influence on which expert and lay testimony will be admissible. In practice, the complete clinical picture will be brought to bear whichever word is used.

If a defendant was sufficiently irrational, no separate control test will be necessary to excuse him. Suppose, however, that the defendant was rational according to any ordinary definition, but claims that he could not control himself. Such claims are often associated with sexual disorders, substance disorders, and impulse control disorders generally. These are the cases in which an independent control test is thought to be necessary. In the wake of John Hinckley's acquittal by reason of insanity for attempting to assassinate President Reagan and others, many legislatures abolished a control test for legal insanity. The American Bar Association and the American Psychiatric Association also took positions rejecting the validity of control tests.[82] Although it may seem unfair to blame and punish an otherwise rational agent who cannot control himself, there was good reason to jettison control tests. The primary ground was the inability of either experts or jurors to differentiate the defendant who could not control himself from one who simply did not. The presence of mental disorder is of no help in this regard because criminal conduct is human action, even if it is the sign or symptom of a disease. Concluding that human action is not controllable because it is a sign or a symptom is simply question-begging.[83] An independent demonstration that the conduct could not be controlled is required.

I am an opponent of control tests because I have not encountered a convincing conceptual account of an independent lack of control and an operational definition of such an incapacity that would permit expert or lay testimony to resolve whether a defendant had such a problem.[84] I readily concede that lack of control may be an independent type of incapacity that should mitigate or excuse responsibility, but until a good conceptual and

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[82] AM. BAR ASS'N, CRIMINAL JUSTICE STANDARDS COMMITTEE, ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-6.1 cmt. (1984); Am. Psychiatric Ass'n, *American Psychiatric Association Statement on the Insanity Defense*, *reprinted in* 140 AM. J. PSYCHIATRY 681 (1983).

[83] HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 148–53 (1979).

[84] Morse, Stephen J. Morse, *Against Control Tests*, *in* CRIMINAL LAW CONVERSATIONS 449 (Paul H. Robinson et al. eds., 2009). The latter was a "target" chapter that challenged proponents of control tests to provide the psychological process or mechanism that produced lack of control capacity and that could be the focus of testimony about it. Five critics responded to the chapter, but not one even remotely suggested a mechanism or process.

operational account of lack of control is provided, I prefer to limit the insanity defense to cognitive tests.

Moreover, I believe that virtually all cases in which a control test seems attractive or necessary can be better explained as a cognitive problem. People who are out of touch with reality may have trouble controlling themselves in the sense that they cannot be guided by reason, but irrationality is the problem. For example, people with sexual or substance disorders may not appear irrational, but they do report intense craving and often engage in repetitive actions that can be ruinously costly to them. It seems natural to infer that they somehow cannot control themselves. I suggest that the lack of control arises from the intensity of desire that seems to drown out all the competing considerations that most of us use to control untoward desires. In other words, at times of peak arousal, people with these problems simply cannot be guided by the good reason not to yield to their desires.[85] Even if one accepts a control theory of mitigation or excuse, in most cases the agent can still be held responsible. During those times when arousal is dormant or low, they do have intact rational capacity and recognize that they will yield in the future. It is therefore their duty to take whatever steps are necessary, such as entering treatment, to insure that they do not offend. If they do not take such steps, they are responsible for not avoiding the condition of their own excuse. In other words, even if sexual and substance disorders were to qualify as a sufficient mental abnormality for establishing legal insanity and even if people with these disorders were not rational at the time of the crime, a successful insanity defense might nonetheless be inappropriate in most cases.

Recommendation: All jurisdictions should adopt a cognitive test for legal insanity but should not adopt a control test.

An interesting and important issue that implicates the mental disorder criterion and both the cognitive and control tests is whether psychopathy should qualify as a mental disorder for purposes of legal insanity and whether at least some psychopaths seem to meet either a cognitive or a control test. The issue is important because psychopathy is highly predisposing to criminal behavior, including heightened recidivism,[86] and is common among

[85] *See* Stephen J. Morse, *Addiction, Science and Criminal Responsibility*, *in* THE IMPACT OF BEHAVIORAL SCIENCES ON CRIMINAL LAW 241 (Nita Farahany ed., 2009) (providing a fuller account).

[86] Kevin S. Douglas et al., *Risk for Criminal Recidivism: The Role of Psychopathy*, in HANDBOOK OF PSYCHOPATHY 533, 534 (Christopher J. Patrick ed., 2006) (urging caution on methodological grounds).

prisoners.[87] Psychopaths simply do not get the point of morality or the underlying moral basis of criminal law prohibitions. Criminal punishments are simply prices to them. It may sound as if such people are simply callous and have an unfeeling character, but the dominant understanding today is that they are disordered for reasons not yet well understood.

The Model Penal Code's insanity provisions excluded from the defense a mental disorder "manifested only by repeated criminal or otherwise anti-social conduct."[88] Most courts have interpreted this provision to exclude psychopathy, but the words of the section do not entail this conclusion.[89] Repetitive anti-social and criminal behavior is one factor that can increase psychopathy scores, but the diagnosis is not based on this factor alone. Thus, the language of the various tests for legal insanity permits a reasonable case for inclusion. In brief, the argument for excusing psychopaths, or at least some of them, is that they lack the strongest reasons for complying with the law, such as understanding that what they are doing is wrong and empathic understanding of their victim's plight.[90] Most people can use empathy, conscience, understanding of the reason underlying a criminal law's prohibition, and prudential reasons to guide their behavior. In contrast, as a result of their psychological deficits, psychopaths can be guided only by prudential, egoistic reasons not to be caught and punished. In other words, they cannot grasp or be guided by the good reasons not to offend, which could be expressed either as a cognitive or control defect. And according to the same argument, people with lesser but still substantial psychopathy should qualify for mitigation. In response, most advocates for continuing exclusion of psychopathy as a basis for the insanity defense argue that they are in touch with reality and know the rules and it is sufficient for criminal responsibility that psychopaths can reason prudentially about their own self-interest.[91]

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[87] *See* Thomas A. Widiger, *Psychopathy and DSM-IV Psychopathology*, *in* HANDBOOK OF PSYCHOPATHY 156, 157–59 (Christopher J. Patrick ed., 2006) (noting that there is strong overlap between psychopathy and Antisocial Personality Disorder (APD), but the relation is asymmetric; APD is more prevalent among prisoners and virtually all prisoners who score high on psychopathy meet the criteria for APD, but not the reverse).

As discussed in Part I, psychopathy must be distinguished from APD, which is included in the DSM. APD is diagnosed on the basis primarily of repetitive antisocial conduct. There are only one and perhaps two psychological criteria among the diagnostic criteria, lack of remorse and, arguably, impulsivity, but neither needs to be present to make the diagnosis. Psychopathy, by contrast, always includes psychological criteria. As a result, psychopathy might plausibly be a candidate for a mental disorder that would support an insanity defense, but APD would clearly not qualify.

[88] MODEL PENAL CODE § 4.01(2) (Proposed Official Draft 1962).

[89] Indeed, the Model Penal Code makes clear that its provision did not exclude a mental condition "so long as the condition is manifested by indicia other than repeated antisocial behavior." MODEL PENAL CODE AND COMMENTARIES § 4.01(2), at 164 (1985).

[90] *See* Stephen J. Morse, *Psychopathy and Criminal Responsibility*, 1 NEUROETHICS 205 (2008) (providing a fuller account).

[91] Samuel H. Pillsbury, *The Meaning of Deserved Punishment: An Essay on Choice, Character, and Responsibility*, 67 IND. L.J. 719, 746–47 (1992). For an intermediate position, see Walter Glannon, *Moral Responsibility and the Psychopath*, 1 NEUROETHICS 158 (2008) (arguing that psychopaths are capable of instrumental reasoning and are capable

Finally, in the United States, there is a major practical objection to applying the insanity defense to psychopathic defendants. In all jurisdictions, a defendant acquitted by reason of insanity may be involuntarily committed to a secure hospital facility, a practice that the Supreme Court has held is constitutional and that will be discussed in a later part of the chapter.[92] The term of commitment varies, but the Supreme Court has upheld an indefinite term[93] as long as the acquitted inmate remains both mentally ill and dangerous.[94] It thus appears that this would be a secure form of incapacitation for dangerous psychopaths if psychopathy were accepted as a potentially excusing mental disorder. Despite the initial attractiveness of this solution to the danger psychopathy presents, it is unlikely to be successful. The insanity defense cannot be imposed on a competent defendant who does not wish to raise it,[95] and virtually no psychopath would raise the insanity defense because at present there is no effective treatment for adult psychopathy. Any psychopath acquitted by reason of insanity for any crime would potentially face a lifelong commitment to an essentially prison-like facility. In short, even if American law came to the conclusion that psychopaths should be excused, few psychopaths would be willing to accept such "lenient" treatment and we would still have to rely on a pure criminal justice response. Thus, the only potential solution to the desert-disease gap psychopathy produces would be some special form of involuntary civil commitment similar to sexual predator commitments.[96]

Finally, let us consider proposals to abolish the insanity defense and potential alternatives to it. Abolition of the insanity defense is simply unfair and there is no adequate substitute for it. Some people are so lacking in rational capacity through no fault of their own that it would be as unjust to blame and punish them as it would be to blame and punish young children or people with dementia. The consequential grounds for abolition are unpersuasive,[97] so the only potentially convincing ground must be that it is

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of being guided by moral considerations to some degree, but their cognitive and affective impairments warrant mitigation).

[92] Jones v. United States, 463 U.S. 354 (1983); *see* Part VI.B *infra*.

[93] *Id.*

[94] Foucha v. Louisiana, 504 U.S. 71, 76 (1992).

[95] *E.g.*, United States v. Marble, 940 F.2d 1543 (D.C. Cir. 1991).

[96] Sexual predator commitments are discussed in section . The same conceptual and constitutional concerns would apply if a legislature attempted to create a special form of commitment for some psychopaths.

[97] Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 S. CAL. L. REV. 777, 795–801 (1985) (rejecting various consequential and practical arguments for abolition). It is possible that abolishing the defense will increase social safety because it will deter both some severely mentally ill defendants who would succeed with the defense of legal insanity and some normal defendants who might think that they can fake the defense. *See* HART, PUNISHMENT AND RESPONSIBILITY, at 48–49 (conceding that abolition of all excuses might increase social safety, but arguing that the cost to individual rights would be too high). Such deterrent benefit is entirely speculative, however, and in the case of abolishing the insanity defense, the likelihood of achieving these benefits is tiny.

not unfair to abolish the defense. The late Norval Morris tried to make such an argument on behalf of the American Medical Association, which took a position in favor of abolition in the wake of Hinckley. Professor Morris argued that since poverty is a stronger cause of crime than mental disorder and we think it is fair to blame and punish poor criminals, it follows that it is fair to blame and punish criminals with severe mental disorders. With respect, however, Professor Morris confused causation with excuse. Poor criminals are not excused because they do not have rational or control incapacities. Some offenders with mental disorder do have such incapacities, which is why they are excused.

There is no suitable alternative to legal insanity. The most common alternative is to permit evidence of mental disorder to be admitted to negate *mens rea*, but this will fail to do justice and it can lead to morally and legally bizarre results. As previously discussed, mental disorder, even severe disorder, seldom negates *mens rea*; rather it gives the offender an abnormal, irrational reason to form *mens rea*. In the *Delling* case cited in the beginning of this section, Delling delusionally believed the two victims were sucking his brain out of his skull and would thereby kill him. He carefully planned to kill the victims to save his own life, just like M'Naghten. He clearly formed the intent to kill and was therefore prima facie guilty of premeditated murder, but the trial judge explicitly found that he did not know right fromwrong. Idaho had abolished the insanity defense, however, and thus Delling was convicted of murder. This case and others like it are the clearest confirmation of the insufficiency of the *mens rea* alternative because, even those defendants most out of touch with reality will have no opportunity to raise a defense unless there is a potential insanity defense. Justice Breyer's dissent from the denial of *cert.* in *Delling* explicitly recognized this.[98]

In some cases, a defendant charged with premeditated homicide might use evidence of hallucinations or delusions to cast doubt on whether his intention to kill was premeditated, but then he would still be convicted of a lesser form of intentional homicide. If a defendant has an auditory hallucination of God's voice telling him to kill, conviction of second-degree murder would be unjust because the defendant is not rational. Reconsider the facts in *Clark*.[99] If the defendant actually believed he was killing a space alien who was impersonating a police officer, then he is not guilty of purposeful, knowing, or reckless homicide. He would be convicted of involuntary manslaughter on a negligence theory, however, because his deluded mistake

[98] Delling v. Idaho, (Breyer, J. dissenting)

[99] 538 U.S. 735, 743–44 (2006).

was unreasonable. But this defendant is not negligent in the ordinary sense. He cannot correct the error by being more careful. He is irrational and does not deserve to be punished at all. Conviction of involuntary manslaughter is morally and legally obtuse in such a case of gross lack of rational capacity.[100]

Another alternative deserves brief mention: the verdict of "guilty but mentally ill" (GBMI). This verdict has been adopted in a substantial minority of states in addition to legal insanity, so it is an alternative rather than a replacement. A GBMI verdict does not indicate reduced culpability, it does not require lesser punishment, and it does not provide for hospitalization and treatment that would not otherwise be available to the convict. Essentially, the finder of fact is being asked to make a diagnosis in addition to a guilt determination. It is not different from "guilty but herpes." In short, GBMI is a fraudulent verdict because it does not address any issue relevant to just criminal blame and punishment and it has the potential to deflect juries from proper insanity acquittals because they do not understand the insanity defense or fear that it will cause the release of a dangerous offender.[101] When GBMI is available, jurors may falsely believe that they are "taking account" of the defendant's impairment and thus may improperly return the GBMI verdict when an acquittal of insanity was appropriate. Paradoxically, defendants who raise the verdict may receive even harsher sentences, so there is evidence that its use is declining.[102]

Recommendation: All jurisdictions should adopt an insanity defense to insure that justice is done in appropriate cases and no alternative will equally achieve this result.

Finally, should the jury be informed that the outcome of an acquittal will be a form of involuntary civil commitment with a potentially indefinite term? In *Shannon v. United States*,[103] the Court held that federal trial courts need not

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[100] In addition to the *mens rea* alternative if the insanity defense is abolished, Professor Christopher Slobogin's "integrationist" proposal for abolition should be briefly mentioned because it is the only serious contemporary scholarly proposal and interesting in its own right. CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY 51–60 (2006). This proposal would allow the defendant to use evidence of mental disorder to indicate that he would have been justified or excused if the facts had been as he believed them to be. The proposal depends, however, on adopting a subjectivized view of justification that is unacceptable if the distinction between justification and excuse is to be preserved. It would also fail to acquit many disordered defendants who have substantial rationality defects. Professor Slobogin rejects rationality impairments as the basis for legal insanity, but he then inconsistently uses lesser rationality to argue that juveniles are less responsible than adults. The integrationist proposal has been subject to a great deal of criticism. *See* CRIMINAL LAW CONVERSATIONS, *supra* note, at 173–92; Morse & Hoffman, *supra* note, at 1123–31. No legislature has seriously entertained adopting the proposal.

[101] STEADMAN ET AL., *supra* note, at 102–20 (describing the verdict as a compromise).

[102] *Id.*

[103] 512 U.S. 573 (1994).

instruct the jury about commitment unless the prosecution affirmatively misleads the jury about the consequences. Justice Thomas's majority opinion focused primarily on the traditional assumption that juries should decide whether the defendant is culpable and should not be concerned with the consequences of their verdict.[104] Although this assumption may make sense for the vast majority of cases in which the defendant will be imprisoned or freed depending on the verdict—a fact jurors know—the insanity defense is the only form of exculpation that does not result in the defendant being immediately freed. I recognize that jurors may not fully understand what sentence will follow a conviction, but the insanity defense is *sui generis* because the acquitted defendant is not freed. It would be understandable if a juror voted to convict a legally insane defendant because the juror feared that a disordered and dangerous person might be freed. Similarly, jurors may be far more inclined to reach the just result if they learn that the insanity acquittee will be preventively detained by post-acquittal commitment.[105] Thus, I conclude that the defendant should be entitled to a "consequences" instruction upon request. I would not make it mandatory because, as Justice Thomas recognized, there may be situations when the defendant would think it is not in his interest to have the jury learn of the consequences.

H. *"Guilty But Partially Responsible"*

In 2003, I proposed that the criminal law should include a generic, doctrinal mitigating excuse of partial responsibility that would apply to all crimes, and that would be determined by the trier of fact.[106] This partial excuse would apply in cases in which a defendant's behavior satisfied the elements of the crime charged, but the defendant's rationality was non-culpably and substantially compromised and thus the defendant was not fully responsible for the crime charged.[107] Current Anglo-American criminal law contains no such generic partial excuse. Some doctrines, such as provocation/passion and extreme mental or emotional disturbance for which there is reasonable explanation or excuse, appear to operate in effect as partial

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[104] *Id.* at 579–80, 586–887. In fact, Justice Thomas's entire majority opinion relies on the validity of this assumption.

[105] This form of commitment is discussed in section, *infra*.

[106] Stephen J. Morse, *Diminished Rationality, Diminished Responsibility*, 1 OHIO ST. J. CRIM. L. 289 (2003). I will use the terms "partial responsibility" and "diminished responsibility" interchangeably, but the former should be preferred because there is no extant legal doctrine by that name with which the proposed doctrine could be confused. Diminished responsibility is probably more accurately descriptive, but there does exist a doctrine with which the proposal might be confused. *See* Coroners and Justice Act, 2009, c. 25, § 52 (Eng.) (discussing criteria for "diminished responsibility"). This section came into force on October 4, 2010 as a result of Statutory Instrument No. 2010/816.

[107] The defendant could also plead in the alternative any other mitigating or full affirmative defense, such as legal insanity.

excuses. They typically apply only in limited contexts, however, such as to reduce a homicide that would otherwise be murder to manslaughter.[108]

Criminal law already recognizes the moral importance of "partial responsibility" for determining just punishment. Despite the lack of a generic mitigating excuse and strict limitations on the few doctrines that serve this purpose, the relevance of diminished rationality and diminished responsibility to sentencing is widely and generally accepted. For example, *Atkins v. Virginia*,[109] which categorically prohibited capital punishment of people with retardation on Eighth Amendment grounds, was based precisely on this recognition. The Court wrote,

> Mentally retarded persons frequently know the difference between right and wrong . . . . Because of their impairments, however, by definition they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others . . . . Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability . . . . With respect to retribution—the interest in seeing that the offender gets his "just deserts"—the severity of the appropriate punishment necessarily depends on the culpability of the offender.[110]

The Federal Sentencing Guidelines also explicitly adopt this principle by providing for a reduced sentence if a "significantly reduced mental capacity . . . contributed substantially to the commission of the offense."[111] Although this provision applies only to non-violent offenders, the limitation is based on considerations of public safety, rather than on the belief that violent offenders never suffer from reduced mental capacity or that such incapacity does not affect the culpability of violent offenders. Even a preference for determinate sentencing does not undermine the general acceptance of this view because it is typically motivated primarily by concerns with disparate sentencing, rather than by the belief that impaired rationality is unrelated to diminished responsibility.

I have long argued that the capacity for rationality is the fundamental criterion for responsibility. Young children and some severely disordered

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[108] MODEL PENAL CODE § 210.3(1)(b) (Proposed Official Draft 1962). The English doctrine of "diminished responsibility," which is quite expansive, is likewise limited to reducing murder to manslaughter. *See* Coroners and Justice Act, 2009, c. 25, § 52 (Eng.). *See generally* GEORGE MOUSOURAKIS, CRIMINAL RESPONSIBILITY AND PARTIAL EXCUSES (1998); PARTIAL EXCUSES TO MURDER (Stanley Meng Heong Yeo ed., 1991).

[109] 536 U.S. 304 (2002).

[110] *Id.* at 318–19. Note that these are largely rationality considerations

[111] U.S. SENTENCING GUIDELINES MANUAL § 5K2.13 (2004).

defendants are excused not because they are young or ill, but because youth and disorder, respectively, are inconsistent with or impair the capacity for full rationality.[112] Sentencing reduction based on mental abnormality is premised upon the same basis. Provocation/passion and extreme mental or emotional disturbance as partially excusing mitigating doctrines are best explained by the theory that these conditions non-culpably reduce the capacity for rationality. Finally, the claims for excuses based on newly discovered, alleged syndromes are best justified as irrationality claims. How much rational capacity must be impaired under what conditions to warrant excuse or mitigation is, of course, a moral, political, and legal question.

Present law is unfair because it does not sufficiently permit mitigating claims. Criminal defendants display an enormously wide range of rational and control capacities. In some cases, there may be quite substantial impairments, but such defendants simply have no doctrinal purchase to argue for mitigation at trial or in the plea bargaining process. If criminal punishment should be proportionate to desert, blanket exclusion of doctrinal mitigating claims and treatment of mitigation solely as a matter of sentencing discretion are not fair.

To understand the unjustifiable limitations of current doctrine, consider the impaired rationality doctrines that reduce a murder to manslaughter: heat of passion upon legally adequate provocation, and extreme mental or emotional disturbance for which there is reasonable explanation of excuse.[113] Why should these doctrines be limited to homicide? For example, suppose a defendant acting in the heat of passion intentionally burns the provoker's property on the spur of the moment, rather than killing the provoker. Or suppose that an agent suffering from a non-culpable state of substantially diminished rationality commits arson. Some arsonists and some criminals generally might act with non-culpable, substantially impaired rationality that does not meet the standards for a full legal excuse. Compromised rationality and its effect on culpability are not limited to homicide. Moreover, such a generic mitigating doctrine would be a more just and practical response than either legal insanity or subjectivizing justification for claims of reduced responsibility based on alleged newly discovered psychological syndromes.

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[112] The Supreme Court confirms this in the case of juveniles. *See* Roper v. Simmons, 543 U.S. 551 (2005) (declaring unconstitutional application of capital punishment to juveniles who committed capital murder at the age of sixteen or seventeen). The Court listed those characteristics of adolescents, such as impulsivity, ill-considered action, and susceptibility to peer pressure, as diminishing juveniles' culpability and cited *Atkins* for the proposition that lesser culpability should lead to lesser punishment, at least in the capital punishment context. *Id.* at 569–71. The factors used in both *Atkins* and *Roper* to justify diminished responsibility are best understood, I believe, as rationality considerations. In the case of juveniles, lesser rationality results from developmental immaturity rather than from an abnormality.

[113] The English "diminished responsibility" doctrine operates similarly and is similarly limited. *See* R. v. Golds, [2016] UKSC 61..

Fairness and proportionality require that doctrinal mitigation should be available in all cases in which culpability is substantially reduced.

I therefore propose the adoption of a new verdict, "guilty but partially responsible" (GPR), that would apply to all crimes and that would be adjudicated at trial (or would be a new variable in plea bargaining). This would be a true mitigating affirmative defense. I am not wedded to any particular set of criteria for this doctrine. Any formula, such as the Model Penal Code's "extreme mental or emotional disturbance,"[114] that captures the essence would be acceptable. I would require that the impairment would have to be substantial, as does the MPC. The consequence of this verdict would be a legislatively mandated reduction in punishment for the crime. I am not committed to any particular reduction scheme, but considerations of public safety would have to play a large role in determining how much reduction would be possible for various crimes. This proposal has been called a "punishment discount," and so it is. But substantially impaired or coerced defendants deserve to pay a lesser price. There are various practical problems that adopting this verdict might create, but I argued in the original paper and still believe that these can be solved. It is certainly worth trying the experiment in the interest of justice.

Recommendation: Legislatures should adopt a generic verdict of "guilty but partially" responsible that would reduce the defendant's sentence in cases in which the defendant's rationality was substantially compromised.

I. *Forcible Medication and Transfer to Hospital*

In *Harper*, the Supreme Court held that prisoners have a liberty interest in avoiding unwanted psychotropic medication, but the state's interest in the safety of the prisoner and others would justify forcible psychotropic medication if it were medically appropriate and the prisoner would otherwise be a danger to himself or others as a result of mental disorder.[115] I believe that the case is properly decided. Prisons are a particularly difficult environment and interests of institutional and personal safety are paramount. There are a few difficulties, however. Psychotropic medications can be used as instruments of pure social control, which is not justified. This could occur if the prisoner were dangerous and mentally disordered, but there was no

[114] MODEL PENAL CODE § 210.3(1)(b) (Proposed Official Draft1962).

[115] *Harper*, 494 U.S. at 225–29.

relation between the two. *Harper* criteria should explicitly include a connection between the mental disorder and the potential for danger.

Recommendation: Prisoners should be forcibly medicated under a *Harper* rationality only if the prisoner's dangerousness is a result of his disordered state of mind.

The second problem is the nature of *Harper* hearings. The Supreme Court approved Washington's process, which permitted all the personnel involved, including the prisoner's adviser, to be employed by the institution.[116] This creates an inevitable conflict of interest, much akin to a non-independent evaluator appointed under *Ake*. It is understandable that these hearings need not be fully adversarial with the full panoply of criminal justice procedural protections because this would be unduly burdensome for the state. The prisoner is facing the loss of an important liberty right, however, and some independent check on the institution should be provided. There are many ways this might be reasonably accomplished without undermining the efficiency of the process, such as providing counsel from a public defender's office or a panel of community attorneys, or an independent advisor or mental health professional from another institution.

Recommendation: Prisoners facing a *Harper* hearing should be represented by an advisor, preferably an attorney, who is independent of the prison or mental health system in the jurisdiction.

If a prisoner's mental disorder renders him unmanageable in the prison, *Vitek v. Jones*[117] held that the prisoner can be transferred to a hospital after a hearing at which the prisoner has a right to be heard and the right to an advisor (although not a lawyer). The Court recognized that the prisoner has an interest in avoiding the stigmatization associated with mental hospitalization and the possibility of forcible treatment. This is a sensible decision that reasonably balances individual and governmental interests as long as the hearings provide the defendant with a genuine chance to contest the transfer. It would be better if the prisoner were represented by adversarial counsel rather than by an appointed adviser who will typically be a prison employee and therefore subject to conflict of interest. Providing counsel would not be unduly burdensome in this context and it would provide greater fairness. Although

[116] *Id.* at 233–36; *see also id.* at 250–55 (Stevens, J., dissenting).
[117] 445 U.S. 480 (1980).

Vitek does not compel the government to provide adversary counsel, it should do so in the interest of justice.

J. *Sentencing*

The issue in all types of sentencing, capital and non-capital, is the role mental disorder should play for both mitigation and aggravation. Sentencing schemes vary substantially across the United States, but I shall assume for the purpose of argument that the judge has the authority to use mental disorder as a sentencing factor. I should say at the outset that if the offender has a colorable mitigation claim based on mental disorder or if the prosecution will introduce mental disorder evidence to support enhancement, as argued in Part III.B., the state should provide an independent mental health professional to aid the offender with sentencing. As people with criminal justice experience know, for many offenders the length of time that they will spend in prison is more important than whether they are convicted. All sentencing, not just capital sentencing, is vital to the offender and the process will not be fair unless he has the assistance of a mental health professional in appropriate cases.

Recommendation: In all capital and non-capital sentencing proceedings in which the defendant has a colorable mitigation claim based on mental disorder, the defendant should have the right to an independent mental health professional to assist him with the claim.

Let us begin with mitigation. If the guilty but partially responsible mitigation I proposed above were adopted, then the defendant would have two chances to have his mental abnormality short of legal insanity considered. If the jury accepted the GPR claim, then there would be no need for the judge to consider mental abnormality evidence at sentencing because a reduction would be automatic. For now, however, using mental disorder to mitigate will be almost entirely a matter of judicial discretion at sentencing.

In *Graham v. Florida*,[118] the Supreme Court held that the Eighth and Fourteenth Amendments prohibited imposing sentences of life without the possibility of parole (LWOP) on juveniles who committed non-homicide crimes because juveniles were less responsible than adults and did not deserve such severe sentences even for heinous non-homicide crimes. The Court's conclusion about diminished responsibility followed its reasoning in *Atkins*,[119] which excluded people with retardation from receiving death sentences for

[118] 130 S. Ct. 2011 (2010).

[119] Atkins v. Virginia, 536 U.S. 304 (2002).

capital crimes, and in *Roper*,[120] which exempted sixteen- and seventeen-year-old capital murderers from capital punishment. The ground for diminished responsibility was essentially that these defendants suffered from diminished rationality.[121] *Graham* was the first occasion that the Court used a diminished desert rationale based on diminished rationality to insist on what is in effect mitigation for a term of years sentence.[122]

The reasoning of *Graham* or the arguments I have made about guilty but partially responsible generalize perfectly to using evidence of mental disorder at the time of the crime for sentencing mitigation generally. Defendants do not deserve mitigation solely because they were disordered, but they do deserve it if the disorder impaired the rationality of their practical reasoning about the criminal offense. Such rationality impairments can range along a long continuum, however, and thus fine-grained differences in responsibility are possible in principle. At present, however, we lack the conceptual and moral capacity to respond in a fine-grained manner and the result will be inevitable, unwitting abuses of discretion and unjustified disparities in sentencing. Principled, finely-calibrated sentencing is impossible. In such circumstances, greater justice will be done if we recognize the inevitable limitations on fine-grained individualization and try to achieve proportionate equality within limited bounds.

In a few cases, mental disorder evidence might also tend to show that the defendant is less dangerous because it renders the defendant disorganized, ineffective, or the like. If this were the case, there would be grounds for mitigating a sentence on consequential grounds as well. Again, diminished dangerousness would be a continuum, but we lack the empirical resources to make such distinctions and predictions accurately.

There should be a legislatively-mandated mitigation if the judge finds that substantial diminished rationality existed at the time of the crime. The amount of reduction could be a uniform percentage or might vary by crime to adjust for social safety concerns, but the sentencing judge would have no power to individualize beyond the mandated reduction. Such one-size-fits-all

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[120] Roper v. Simmons, 543 U.S. 551 (2005).

[121] In *Graham*, the Court explicitly relied on the *Roper* factors discussed *supra* , and also reemphasized that juveniles were not yet fully mature and might change as normal maturation occurred. Nonetheless, lack of rational capacity was the primary ground. *Graham*, 130 S. Ct. at 2026–227.

[122] In *Graham*, the majority relied on *Roper*'s conclusion that adolescents are relevantly different, but cited amicus briefs for the proposition that the adolescent brain was not yet fully mature. *Id.* at 2026. This has produced irrational exuberance among those who want courts to take more account of neuroscience evidence. The Court referred generally to neuroscience to support its conclusion that nothing in the science of adolescent development in the intervening five years changed the *Roper* conclusion, but no one had argued to the contrary. Arguments in support of juvenile LWOP in non-homicide cases were based entirely on other normative and empirical arguments, and thus, I submit, the neuroscience was dictum.

approaches risk unfair lumping and "cliff effects,"[123] but the overall effects will be positive. Most desert and danger criteria cannot be reliably measured, but instead require rougher retributive judgments and often speculative empirical assessments. Further, given the limits on human judgment and the greater reliability of judgments with fewer categories, everyone can understand the need for bright-line rules that risk some disparity at the margins. Less injustice will be produced by this approach than the inequality flowing from the unreliability of judgments involving more numerous categories.

Recommendation: Legislatures should adopt a mandated scheme of mitigation if the sentencing judge finds that substantial diminished rationality existed at the time of the crime. The amount of reduction could be a uniform percentage or might vary by crime to adjust for social safety concerns, but the sentencing judge would have no power to individualize beyond the mandated reduction.

Evidence of mental disorder can also be used for enhancement within the authorized sentence range if it is a risk factor for future antisocial conduct. For example, substance abuse and psychopathy are both serious risk factors for future crime.[124] Mental abnormality is thus a knife that cuts both ways in sentencing. Although the relevance to both mitigation and aggravation is true in theory, the empirical basis for the alternatives of mitigation and aggravation is asymmetrical. Despite the problems with mental abnormality evidence, establishing that the defendant had a substantial mental abnormality at the time of the crime and therefore deserves mitigation is reasonably possible. It is a very fact-based issue that turns on the defendant's mental states. Evaluation of such states is a bread and butter issue in criminal (and civil) cases. Predictions are of course based on facts, but even if the facts are established, the accuracy of such predictions is weak, even if mechanical techniques or semi-structured interviews are used. The level of acceptable accuracy is of course a normative question that cannot be "read off" from Eighth Amendment jurisprudence. Despite the Supreme Court's willingness to accept admittedly inaccurate predictions in *Barefoot*,[125] one would hope

[123] I borrow this term from the economic literature on enforcement, which notes that equal punishments for crimes of different seriousness produces crimes of greater seriousness. *See* George J. Stigler, *The Optimum Enforcement of Laws*, 78 J. POL. ECON. 526, 527 (1970).

[124] For a discussion of substance abuse, see JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE 94 tbl.5.1, 141 (2001). For psychopathy, see *id.* at 65–72; Douglas et al., *supra*, at 534; Widiger, *supra* , at 157–59.

[125] Barefoot v. Estelle, 463 U.S. 880 (1983).

than an extremely high level of accuracy would be required before increasing a sentence or putting a capital offender to death on the basis of a dangerousness prediction.

After *Barefoot*, there is no constitutional bar to introducing weak prediction evidence, but sentencing enhancements should be rationalized to achieve justice. To the extent one is doing evidence-based sentencing and is using reliable and valid diagnostic techniques and adequate databases, using mental disorder as a risk factor seems reasonable. As mentioned previously, mechanical (actuarial) methods and semi-structured interview techniques are state of the art and should be required.[126] The difficulty is that too many claims for enhancement based on predictions do not use the best techniques and data despite large improvements in the technology of prediction.

Our ability to make valid, fine-grained predictions about future danger are quite limited at present, so I would limit enhancement to one grade of enhancement if the defendant meets a legislatively mandated threshold of heightened risk beyond the "average" case at the core of the penalty range. I would also require that the sentencing judge should insist that the prosecution should demonstrate that the risk evaluation and prediction methods it uses are state of the art. Although the Constitution may require considerably less, the defendant's freedom is at stake and justice demands that we use the best evidence before depriving it further.

Recommendation: In non-capital cases, mental disorder may be used as an enhancement factor but only if the most accurate methods of predicting future behavior have been used and indicate a very substantial risk, but the amount of enhancement should be limited.

Capital sentencing, the most extreme form of crime and danger prevention, like sentencing generally, raises the issue of the role of mental disorder as both a mitigating and aggravating factor. The considerations are similar, but so much more is at stake. Death is different.

Beginning in 1978 with *Lockett v. Ohio*,[127] the Supreme Court has made clear that the defendant can introduce any potentially mitigating evidence at capital sentencing proceedings, whether or not it supports a statutorily authorized mitigating factor. It is universally accepted that mental disorder is a mitigating factor, and many jurisdictions specifically list mental abnormality

[126] Jennifer L. Skeem & John Monahan, *Current Directions in Violence Risk Assessment*, 20 CURRENT DIRECTIONS PSYCHOL. SCI. 38, 39 (2011), *available at* http://ssrn.com/abstract=1793193.

[127] 438 U.S. 586 (1978).

as a mitigating factor, using language similar to the Model Penal Code's "extreme mental or emotional disturbance" criterion or a similar partial responsibility standard.[128] Although only a minority of states makes "dangerousness" per se a statutorily aggravating factor, dangerousness is incorporated implicitly or explicitly in other listed factors, and, as just discussed, purely clinical mental health testimony is used to predict future dangerousness, despite the empirical weaknesses of clinical predictions.

There are no constitutional means to exclude abnormality evidence for the purposes of mitigation. The states should nonetheless be free to exclude aggravating predictions because they are too inaccurate to be the basis for imposing the death penalty, but, as a practical, political matter, I suspect that no jurisdiction would do this. I therefore recommend again, as I have before in this chapter, two less "extreme" prophylactic measures. First, the state should require use of the most empirically validated prediction methods rather than clinical evaluations or responses to hypothetical questions. Mechanical (actuarial) methods and semi-structured interview techniques are state of the art and should be required.[129] Second, the defendant must have access to an independent mental health professional to help him prepare mitigation evidence and to defend against aggravation evidence of future dangerousness. Of course, if the defendant does not raise mental abnormality, then, consistent with *Estelle v. Smith*,[130] a defendant cannot be compelled to undergo a psychiatric examination whose results will be used at capital sentencing, unless the defendant consents to such use. In that case, the state would have to rely on the answers to hypothetical questions, which my proposal would bar.

K. *Competence to be Executed and Forcible Restoration of Competence*

At common law, a prisoner sentenced to death could not be executed if he was incompetent because he did not understand what penalty was being imposed or why. The Supreme Court finally held[131] and reaffirmed[132] that the common law practice has constitutional status under the Eighth Amendment. In *Ford*, the first Supreme Court case to so hold, the Court noted that the reasons for this uniform common law rule are less certain and uniform than the rule itself.[133] The Court then considered a number of historical rationales

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[128] MODEL PENAL CODE § 210.3(1)(b) (Proposed Official Draft 1962).

[129] Skeem & Monahan, *supra* , at 39.

[130] 451 U.S. 454 (1981).

[131] Ford v. Wainwright, 477 U.S. 399, 409–10 (1986).

[132] Panetti v. Quarterman, 551 U.S. 930, 958 (2007).

[133] *Ford*, 477 U.S. at 407.

that might support the doctrine, but, in short, the rationale is that executing incompetent offenders is simply cruel and that society must protect the defendant and protect the dignity of society.

In *Panetti*, the Court appeared to adopt a primarily retributive rationale, suggesting that the incompetent offender could not recognize the gravity of his crime and that executing him would not allow the community to affirm its judgment that the prisoner's culpability was so serious that he deserved death.[134] The Court therefore rejected a narrow reading of the substantive requirements for competence to be executed. Panetti was concededly delusional and the Court held that a reading of the test that would permit execution of an offender who simply understood or was aware, rather than *rationally* understood, the fact of execution and why he was being executed, was inconsistent with the rationale and language of *Ford*.[135] The Court wrote:

> Gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose. It is therefore error to derive from *Ford*, and the substantive standard for incompetency its opinions broadly identify, a strict test for competency that treats delusional beliefs as irrelevant once the prisoner is aware the State has identified the link between his crime and the punishment to be inflicted.[136]

It is clear that, unlike in *Godinez*, in which the Court rejected an allegedly higher "reasoned choice" test for competence to plead guilty and to waive counsel,[137] in this context a higher standard is required. Death is indeed different.

For purposes of discussion, we must assume that the defendant was competent to be tried, was properly convicted, was competent to be sentenced, and was properly sentenced to death. There is much reason to question these assumptions, despite the many procedural protections Justice Powell noted in his *Ford* concurrence.[138] It is possible, of course, that the offender was not suffering from substantial disorder at the earlier stages of the criminal process, and only became severely disordered in prison. Nonetheless, the most common age of onset for psychotic ideation of the type that might undermine competence, which is usually a symptom of schizophrenia, is from late

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[134] *Id.* at 958–59.
[135] *Id.* at 958.
[136] *Id.* at 960.
[137] 509 U.S. 389, 398 (1993).
[138] *Ford*, 477 U.S. at 420 (Powell, J., concurring).

adolescence to the early 30s, although late-onset cases do occur.[139] Therefore, many people later found incompetent to be executed were probably suffering from substantial mental problems at the time of the crime and during trial and sentencing—problems that were not sufficiently addressed or properly considered. Consequently, many such offenders should not have been sentenced to death in the first place because, at the least, mental abnormality should have mitigated punishment at sentencing. Dementia associated with aging might be a counter-example to the foregoing considerations, especially given the often lengthy process before prisoners are actually executed. Again, however, let us assume that the process was sufficiently fair.[140]

It is not clear whose interests are being protected by the bar on executing incompetent offenders. Executing incompetent prisoners might seem to support individual or state interests we endorse. For example, a prisoner who does not fully apprehend what is happening might be less fearful. The community might be indifferent to the mental state of the prisoner at the time of the execution and satisfied both that the defendant deserved death for his conduct at the time of the crime and that the state must fulfill its obligation to impose that sentence. Professor Richard Bonnie, influenced by Justice Powell, suggests that the only sound rationale for this bar is respect for the dignity of the condemned prisoner, who has a right to be treated as a subject worthy of respect and not simply as an object to vindicate the state's promise.[141] If the offender does not realize what is happening to him, he will not be able to exercise the few choices left to him that preserve his autonomy, agency and dignity.[142] I have been persuaded by Professor Bonnie's argument, but it does leave open precisely how much rational understanding is necessary to vindicate the condemned's dignity. Because death is different, I would insist that a high standard should be imposed. A just society should insure that it substantially increases the risk of error in favor of the prisoner.

Recommendation: The standard for competence to be executed should be very high.

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[139] DSM notes that the typical onset of schizophrenia occurs between the late teens and mid-thirties, but that late onset is also possible. DSM, *supra* note, at 102

[140] I confess that I am deeply ambivalent about the issues in this section. I oppose capital punishment and one part of me wants to make any argument possible to abolish it. Another part, however, recognizes that it has constitutional status and I therefore try to make arguments in light of that status.

[141] Richard J. Bonnie, Panetti v. Quarterman: *Mental Illness, the Death Penalty, and Human Dignity*, 5 OHIO ST. J. CRIM. L. 257, 277 (2007).

[142] *See id.*

In *Ford* and *Panetti*, the Court did not hold that the decision about competence to be executed must be made by a judge. Instead, and again following Justice Powell's *Ford* concurrence,[143] it is apparently sufficient if there is some type of impartial hearing officer or board that can receive arguments and evidence from the prisoner.[144] *Panetti* made clear, however, that the offender is entitled to use his own experts to rebut the State's evidence.[145]

For a decision of such importance, only a judicial hearing is sufficient to protect the prisoner's rights. Any other type of decision maker, especially if it is an individual, will appear less formally rigorous or independent and will in fact probably be less rigorous and independent. Moreover, the prisoner should be entitled to the services of a genuinely independent mental health practitioner if the prisoner is too poor to hire his own. As a practical matter, anti-capital punishment advocates will surely insure that such services are provided, but it ought to be the prisoner's right.

Recommendation: Competence to be executed should be decided by a judicial hearing.

Suppose the concededly incompetent capital prisoner could potentially be restored to competence by taking medically appropriate psychotropic medication, but refuses to do so. The Supreme Court has not decided this issue, but it has reached both a state supreme court, *State v. Perry*, which decided that the prisoner could not be medicated unless the death penalty was commuted,[146] and a federal circuit court, *Singleton v. Norris*, which held that the state's interest was sufficiently strong to permit forcible medication.[147] This is a fearsomely difficult issue. In contrast to *Harper*,[148] in this case the prisoner must undergo not only the liberty deprivation of forcible medication, which is not insignificant in itself, but also the ultimate deprivation of death as a result. On the other hand, the meaning of a capital sentence is that society has decided that the prisoner no longer has a right to live. It is forfeit.

Singleton held that forcible medication would be permissible if the state had a sufficiently strong interest, if the medication was the least intrusive way

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[143] 477 U.S. 399, 425–27(1986) (Powell, J., concurring).

[144] Panetti v. Quarterman, 551 U.S. 930, 949–50 (2007).

[145] *Id*. at 950, 958 (requiring that the prisoner must be able to offer his own psychiatric testimony as a counterweight to the State's evidence).

[146] 610 So. 2d 746, 770 (La. 1992).

[147] 319 F.3d 1018, 1026 (8th Cir. 2003).

[148] 494 U.S. 210 (1990).

of restoring competence, and if it was medically appropriate.[149] Let us assume that the state's interest in imposing capital punishment is strong, as it surely is, and that medication is necessary to restore competence, as it will be in most cases. Dementia may again be a counter-example because there may be no treatment that can restore competence in advanced cases. The issue is how to think about whether the medication is medically appropriate. Therapy of the disorder may ameliorate it, but if so, it will enable execution. As a result, it is claimed that it is not in the prisoner's medical interest to be medicated so that he may be killed.[150]

With respect, the petitioner's undoubted interest in continuing his life is a moral and legal issue independent of his medical interests. His medical interest is in alleviating serious illness. His personal interest in remaining alive is the same legal interest any citizen has in life, except that in this case it is forfeit. An analogy may help make this clearer. Suppose the condemned prisoner suffers from an illness that can cause loss of contact with reality or other dementia-like states and suffering. Suppose, too, that medication to control the disorder can cease to be fully effective unless the dosage is increased. If the prisoner's illness became uncontrolled as execution neared and he lost touch with reality and was suffering, it would be medically inappropriate *not* to treat the defendant. Or suppose the prisoner suffered a stroke and was in coma in the emergency room. Should the doctors fail to treat? I suggest that all physicians would believe it is their duty to treat the prisoner. These cases can be distinguished, of course, but is there a distinction that makes a principled difference or is the desire to avoid capital punishment at all costs driving the argument?

In *Washington v. Glucksberg*,[151] the Court rejected the argument that people have a due process right to physician-assisted suicide. In the course of reaching that decision, the Court noted the state's interest in upholding the ethics of the medical profession as one ground for affirming the state's constitutional right to ban this practice.[152] Almost certainly the overwhelming majority of American physicians would probably oppose forcible psychotropic medication to restore trial competence unless the death penalty was commuted. Surely, however, there are a few physicians who do not oppose it and who would administer the medication either because they do not think it is wrong or because they think it is their distasteful duty, but a duty

[149] 319 F.3d at 1027.
[150] *See id.* at 1025–27.
[151] 521 U.S. 702 (1997).
[152] *Id.* at 731.

nonetheless if they work for the state.[153] In a sense, this case is the reverse of *Glucksberg*. There, the patient wanted treatment that most doctors oppose.[154] Here, the prisoner does not want treatment that most doctors think it is wrong to impose unless capital punishment is commuted. Nonetheless, the Court might uphold banning forcible medication on the ground that permitting it undermines medical ethics. States will certainly have the right to ban the practice of forcible medication to restore execution competence, even if the Supreme Court ultimately decides that the Constitution does not absolutely prohibit it.

If the Supreme Court does permit this practice, a particularly difficult question is whether, when an execution date is set, competence flowing from medication justified by *Harper*[155] should be sufficient to let execution proceed. This would permit the state to avoid the harder issue presented by using forcible medication solely to restore competence to be executed. The prisoner may continue to be a threat to his own safety or the safety of others. Nonetheless, the prisoner on death row can probably be managed without medication because the circumstances are very different from those of prisoners in the general population. I propose that as the execution date approaches, the medication should be reduced or withdrawn to determine if the prisoner is rendered incompetent to be executed. If so, then the state must confront directly whether it is willing to medicate this prisoner solely for the purpose of executing him. The state should be forced to decide this rather than to be permitted to comfort itself with an independent rationale that is much less problematic. It is not enough to demonstrate that the *Harper* medication is genuinely independently motivated and justified and that competence restoration is simply a side benefit. It might be argued that because the prisoner's life is already forfeit, society owes no such obligation to set up potential roadblocks that compel the state to clear-sighted recognition of the immensity of its proposed action. Perhaps so, but a civilized society should demand this.

Recommendation: Competence to be executed that is achieved by forcible medication administered under a *Harper* rationale should not be sufficient. The state should be compelled decide whether forcible medication solely to restore competence is justifiable independent of a *Harper* rationale.

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[153] A state could surely permit an employee without a medical degree but with the proper training to administer the drugs.

[154] 521 U.S. at 710.

[155] Washington v. Harper, 494 U.S. 210 (1990).

In conclusion, resolving in general and in individual cases the immensely difficult issues presented by incompetence to be executed is another one of the many costs and controversies capital punishment produces that abolition would avoid.

L. *Mentally Abnormal Sexual Predator Commitment*

A substantial minority of states have adopted a special form of involuntary civil commitment if four criteria are met: a charge or conviction of a sexual offense, the presence of a mental abnormality or a personality disorder, predicted future dangerousness, and serious difficulty controlling the sexually violent conduct. Although civil, these forms of commitment are usually accorded heightened procedural due process by legislation, such as the necessity of proving the criteria beyond a reasonable doubt. They may be imposed at the end of a full prison term for the sexual crime of conviction, and the term of confinement is indefinite but includes periodic review.

In *Kansas v. Hendricks*,[156] the Supreme Court upheld this type of commitment against a claim that it violated substantive due process. The Court noted that the requirement of a mental abnormality satisfied a classic due process justification for civil commitment because it indicated that the subject could not control his offending sexual behavior.[157] Thus, for this and other reasons, the Court held that the commitment was genuinely civil and not criminal punishment.[158] Just five years later, in *Kansas v. Crane*, the Court again addressed the criteria for these commitments to decide whether the justifying rationale of lack of control had to be proven independently.[159] The Court held that it did, but noted that the presence of a mental abnormality did not have to render the defendant completely unable to control his conduct.[160] Justice Breyer wrote for the majority:

> [W]e did not give to the phrase "lack of control" a particularly narrow or technical meaning. And we recognized that in cases where lack of control is at issue, "inability to control behavior" will not be demonstrable with mathematical precision. It is enough to say that there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness,

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[156] 521 U.S. 346 (1997).

[157] *Id.* at 360.

[158] *Id.* at 365–66. The statutes provide that these commitments may be triggered simply by a charge of a sexual offense or incompetence to stand trial for such an offense, but in practice they are imposed post-conviction and sentence.

[159] 534 U.S. 407 (2002).

[160] *Id.* at 411–12.

abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case.[161]

Sexual predators fall into the gap between criminal and civil confinement that desert-disease jurisprudence creates. Sexual offenders are routinely held fully responsible and blameworthy for their behavior because they almost always retain substantial capacity for rationality, they remain in touch with reality, and they know the applicable moral and legal rules. Consequently, even if their sexual violence is in part caused by a mental abnormality, they do not meet the usual standards for an insanity defense.[162] For the same reason, they do not meet the usual and implicit non-responsibility standards for civil commitment and could not be restrained civilly after they finish a prison term.[163] In other words, their rationality and control capacities do not indicate that they are sufficiently non-responsible to justify the preventive detention involuntary civil commitment imposes. Moreover, in most cases in which civil commitment is justified, a majority of states no longer maintain routine indefinite involuntary civil commitment but instead tend to limit the permissible length of commitment. Without these special forms of commitment, most "sexual predators" could not be preventively detained at the end of their prison term unless they committed a new crime.

I have frequently and severely criticized the statutes authorizing allegedly civil commitment for sexual predators and both *Hendricks* and *Crane*.[164] My argument is that the gap-filling is impermissible because the mental abnormality criterion the Court approved is not a definition of abnormality and the control criterion is vague and not operationalizable. Together these two criteria do not entail that the agent is non-responsible. The differential responsibility requirement for criminal conviction and civil sexual predator commitment is unjustified, and adequate prediction does not exist. Moreover, in practice, these commitments do not offer treatment programs designed to

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[161] *Id.* at 413.

[162] Consider the remarks of Justice Owen Dixon of Australia in *King v. Porter*:

> [A] great number of people who come into a Criminal Court are abnormal. They would not be there if they were the normal type of average everyday people. Many of them are very peculiar in their dispositions and peculiarly tempered. That is markedly the case in sexual offenes [sic]. Nevertheless, they are mentally quite able to appreciate what they are doing and quite able to appreciate the threatened punishment of the law and the wrongness of their acts, and they are held in check by the prospect of punishment.

(1933) 55 CLR 182, 187 (Austl.).

[163] The implicit non-responsibility standard is the lack of rational (or control) capacity. *See supra* subpart II.B (discussing the general rationale for treating people with mental disorder specially). Moreover, professionals do not prefer to treat dangerous people who are not obviously suffering from a major disorder.

[164] *E.g.*, Stephen J. Morse, *Fear of Danger, Flight from Culpability*, 4 PSYCHOL., PUB. POL'Y, & L. 250 (1998); "Uncontrollable Urges and Irrational People," 88 VIRGINIA LAW REVIEW 1025 (2002)

let the inmate progress and eventually be released. In liberal Minnesota, for example, as of 2015 there was no genuine treatment program and no one had ever been released.[165]

Rather than repeat the arguments I've made in other writings, I will simply say conclusorily that the criteria in the Kansas statute that help establish non-responsibility, personality disorder, and mental abnormality, are over-inclusive, and the definition of mental abnormality is both obscure and virtually incoherent. The causal link standard that ties abnormality to loss of control is not a non-responsibility standard. The criteria for these commitments cannot conceivably limit them only to those potential predators who cannot control themselves and are, thus, not responsible for their potential sexual violence. Using such criteria, virtually every predator would be both convictable and committable.

Even if one accepted independent, functional non-responsibility criteria, however, serious control difficulty still fares poorly as a non-responsibility standard because it is so poorly understood and cannot be operationalized adequately. This standard is an invitation for conclusory, morally-grounded expert opinions offered as if they were based on sound scientific or clinical standards and measurements, but they are not. Justice Breyer's suggestion that considering the nature of the diagnosis or the severity of the disorder will not help if the abnormality criterion has no meaning and if there is no necessary relation between these factors and lack of control.[166] Once again, lack of control must be proved independently.

The criminal justice system is the appropriate mechanism for control of responsible predators. Agents who are not responsible for their predatory sexual violence may properly be confined involuntarily, but such a massive deprivation of liberty should be inflicted only on those predators who are genuinely not responsible. Even if a state seems to impose a genuinely independent, serious lack of control problem criterion, as *Crane* requires, the definition of such a problem is so inevitably amorphous that this criterion will impose no practical limit on abnormal sexual predator commitments.[167]

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[165] Karsjens v. Jesson, ___F. Supp. 3d___ (2015).

[166] *Crane.* at 413.

[167] In his dissent in *Crane*, Justice Scalia scolded the majority for the vagueness of the control standard it adopted. He conceded that the mental abnormality or personality disorder criterion and the resulting propensity for violence criterion were both coherent and, with the assistance of expert testimony, within the capacity of a normal jury to determine. But he chided the majority's control standard as being so vague that it will give trial judges "not a clue" about how to charge juries. *Id.* at 423 (Scalia, J., dissenting). He speculated that the majority offered no further elaboration because "elaboration . . . which passes the laugh test is impossible." *Id.* Justice Scalia wondered whether the test was a quantitative measure of loss-of-control capacity or of how frequently the inability to control arises. In the alternative, he questioned whether the standard was "adverbial," a descriptive characterization of the inability to control one's penchant for sexual violence. *Id.* at 424. The adverbs he used as examples were "appreciably," "moderately," "substantially," and "almost totally." *Id.* According to Justice Scalia, none of these could provide any guidance. He was correct.

Mental health professionals will have no difficulty adjusting their expert testimony to support the conclusion that virtually any sexually violent offender meets the serious lack of control standard. Moreover, there is nothing in the language of *Hendricks* and *Crane* that would permit an appellate judge to overturn a jury verdict of serious loss of control, except, perhaps, in extreme, obvious cases.[168] Loss of control as an independent non-responsibility condition simply will not suffice on conceptual, scientific, and practical grounds.

Note that the standards for non-responsibility differ in the criminal and civil justice systems because the sexual predator is responsible for his sexual crimes but sufficiently non-responsible to warrant involuntary commitment based on the same behavior. It is paradoxical, to say the least, to claim that a sexually violent predator is sufficiently responsible to deserve the stigma and punishment of criminal incarceration, but that the predator is not sufficiently responsible to be permitted the usual freedom from involuntary civil commitment that even very predictably dangerous but responsible agents retain because we wish to maximize the liberty and dignity of all citizens. But Leroy Hendricks and Michael Crane had no realistic chance of succeeding with an insanity defense. Even if the standards for responsibility in the two systems need not be symmetrical, it is difficult to imagine what adequate conception of justice would justify blaming and punishing an agent too irresponsible to be left at large. An agent responsible enough to warrant criminal punishment is sufficiently responsible to avoid preventive detention. If a state seriously believes that any mental disability sufficiently compromises responsibility to warrant civil preventive detention, then such disability should be part of the criteria for the insanity defense. When a defendant is charged with an offense, it is an occasion when the citizen has the most to lose and therefore deserves the most consideration.

Finally, we have previously considered the difficulties with predictive accuracy concerning future behavior. There are mechanical techniques for evaluating the risk of future sexual predation, but none has better than modest success[169] and clinical predictions, which will be used all too often, are

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[168] Such cases would probably be marked by an alleged predator's history that is entirely inconsistent with a colloquial control problem and by patently deficient expert testimony. I assume, however, that such cases would be rare, especially if there were a history of sexual predation.

[169] *See* Dana Anderson & R. Karl Hanson, *Static-99: An Actuarial Tool to Assess Risk of Sexual and Violent Recidivism Among Sexual Offenders*, *in* HANDBOOK OF VIOLENCE RISK ASSESSMENT 251, 255–260, 262 (Randy K. Otto & Kevin S. Douglas eds., 2010) (reviewing the most widely used sexual recidivism instrument and finding an average "medium to large" effect size by conventional standards, but noting that absolute recidivism rates are unknown and that there is large variability in the effect size among the studies, and recommending caution in cases in which accurate probability estimates are needed).

notoriously unreliable.[170] A sexual predator commitment is potentially for life. The context in which the prediction will be made is a maximum security institution in which the subject has been incarcerated: first prison and then a secure hospital. The context of validation is the community. It will be difficult to predict community behavior accurately based on behavior in maximum security. Moreover, gatekeepers, including the state mental health professionals who evaluate the alleged predator, will have a natural incentive to be conservative. The subjects are sexual criminals and thus not sympathetic people. It will seem better, and safer, from the evaluator's career standpoint, to err on the side of caution than to err by releasing someone who may commit a heinous crime. Although *Ake* does not require the provision of a mental health professional in the civil context,[171] the state should provide the potential subject of a sexual predator commitment with an independent expert to help him defeat the State's case.

Recommendation: The state should provide an independent mental health professional to help indigent people subject to a mentally abnormal sexual predator commitment oppose the commitment.

Constitutional limitations on the state's power to confine citizens based on our concern for liberty inevitably mean that the protection of social safety cannot be seamless and that security will be compromised. Some dangerous but responsible agents must remain free until they commit a crime or until they become non-responsible for their potential danger. As a result, our justifiable, appropriate fear of the harms such people may cause creates strong incentives to devise means to confine them preventively. Pure preventive detention on grounds of dangerousness alone is an anathema in a free society, however, and we should not loosen the standards of non-responsibility to sweep into civil confinement responsible agents who should more appropriately be incapacitated by criminal sentences. As Justice Anthony Kennedy warned in his concurrence in *Hendricks*, and as all the Justices in *Crane* apparently agreed, civil commitment should not be used to impose punishment or to avoid the effects of deficiencies in the criminal justice system, such as improvident plea bargains, which might cause the legally required but objectionably early release of dangerous criminals.[172] I and most

[170] *See* Skeem & Monahan, *supra* note.

[171] Ake v. Oklahoma, 470 U.S. 68 (1985) (applying the right to the assistance of a mental health professional in the criminal justice process).

[172] Kansas v. Crane, 534 U.S. 407, 411 (2002); Kansas v. Hendricks, 521 U.S. 346, 373 (1997) (Kennedy, J., concurring). Indeed, Crane himself was sentenced to a relatively brief term of imprisonment as a result of a plea bargain

other academic commentators believe, however, that this is precisely the motivation for sexual predator commitments. They are a way of filling the desert-disease gap using punishment by other means and they should be abolished.

Recommendation: Mentally abnormal sexual predator commitment laws should be repealed.

States could, of course, achieve essentially indefinite confinement through the criminal justice system by imposing life sentences on sexual offenders. Almost certainly, there would be no constitutional objection under current proportionality jurisprudence,[173] and many would accept that such sentences would be deserved. Thus, perhaps we should not worry about the potentially extensive reach of various control criteria for the civil commitment of sexual predators because sexually violent offenders will remain incarcerated for very long periods in any case. But this would be an unacceptably skeptical, consequential approach to the danger sexual predation presents.[174] The law sets moral standards and should be clear about which agents are responsible. Moreover, if sexual dangerousness were treated virtually exclusively within the criminal justice system, legislators would be forced to confront and to defend the sentences they are willing to impose on sexual offenders, rather than sweeping this morally fraught question under the psychiatric rug. Finally, prosecutors would be forced to straightforwardly evaluate the strength of their cases and would not be able to rely on allegedly civil commitment to remedy the effects of weak cases or improvident plea bargains.

M. *Commitment After Acquittal By Reason of Insanity*

In all jurisdictions, a defendant acquitted by reason of insanity may be automatically civilly committed, either for an evaluation that will be followed by formal civil commitment, or by formal commitment itself without a prior evaluation.[175] Although not punishment for crime—the defendant has been acquitted after all—these civil commitments have been justified because the defendant is allegedly still dangerous and not responsible for the

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under circumstances that might otherwise have justified a prison term of thirty-five years to life. *In re* Crane, 7 P.3d 285, 287 (Kan. 2000).

[173] *See* Ewing v. California, 538 U.S. 11, 20 (2003) (holding that the Eighth Amendment contains only a narrow proportionality principle applied to term-of-years sentences).

[174] This objection also bears a stunning resemblance to past claims that the insanity defense should be abolished because defendants acquitted by reason of insanity are incarcerated in any case. *See* Joseph Goldstein & Jay Katz, *Abolish the "Insanity Defense"—Why Not?*, 72 YALE L.J. 853, 864–70 (1963). These claims were misguided for the same reasons that it is important to distinguish responsible from non-responsible sexual predators.

[175] *See* Parry, at 168–70.

dangerousness. The terms of such possible commitments vary across jurisdictions, but in some jurisdictions the term may be indefinite with periodic review. In *Jones v. United States*,[176] the Supreme Court upheld both an automatic commitment for evaluation and the potentially indefinite commitment of a defendant acquitted by reason of insanity for shoplifting a leather jacket. The Court argued that, based on an insanity acquittal, it is rational to presume that the subject was still mentally disordered and dangerous.[177] The Court was unwilling to equate "dangerousness" with violence. It claimed that the legislative purpose to confine was the same for violent and nonviolent offenses and that the former often led to the latter.[178] Moreover, for this type of commitment, the Court was willing to accept a lesser burden of persuasion than the constitutionally-imposed standard civil commitment standard of clear and convincing evidence.[179] Post-insanity commitments are different, the Court claimed, because the defendant himself raised the issue of mental disorder, and so the risk of error is decreased.[180] Finally, the Court approved potentially indefinite confinement on the ground that such confinement did bear a rational relation to the purpose of the commitment, which is to confine dangerous, non-responsible agents. The defendant was acquitted so the length of the confinement need not be limited by the deserved punishment. The subject is properly confined as long the defendant remains disordered *and* dangerous and need not be released until either condition is no longer met. This might happen at any time, or never.[181] In *Foucha v. Louisiana*,[182] the Court affirmed that a post-insanity commitment must end if the subject is no longer mentally ill, even if he is still dangerous.[183]

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[176] 463 U.S. 354 (1983).

[177] *Id.* at 365.

[178] *See id.* at 365 n.14.

[179] *Id.* at 367–68; *see also* Addington v. Texas, 441 U.S. 418, 431–33 (1979).

[180] *Jones*, 463 U.S. at 367.

[181] *Id.* at 368–69.

[182] 504 U.S. 71 (1992).

[183] *Id.* at 81. Justice O'Connor partially concurred. She noted that an insanity acquittee had been found to have committed the prima facie case beyond a reasonable doubt. She then wrote cryptically, as follows:

> It might therefore be permissible for Louisiana to confine an insanity acquittee who has regained sanity [sic] if, unlike the situation in this case, the nature and duration of detention were tailored to reflect pressing public safety concerns related to the acquittee's continuing dangerousness . . . . [A]cquittees could not be confined as mental patients absent some medical justification for doing so; in such a case the necessary connection between the nature and purposes of confinement would be absent.

Id. at 87–88 (O'Connor, J., concurring). Justice O'Connor also noted that the seriousness of the crime should also affect whether the state's interest in continued confinement would be strong enough. *See id.* at 88.

If the subject is no longer mentally disordered and therefore no longer non-responsible, it is hard to imagine what possible "medical justification" there could be for continuing civil commitment to protect the public. It is not clear from the O'Connor concurrence if she would require some finding of mental abnormality, as did the statute upheld in *Kansas v. Hendricks*, to make the commitment analogous to traditional civil commitment. 521 U.S. 346, 355 (1997). If not, however, then five Justices of the Supreme Court, the four *Foucha* dissenters and Justice O'Connor, would have been

I think that the Court was correct to decouple the potential length of the civil commitment from the sentence for the crime charged. The defendant has been acquitted and the usual justifications for a sentence length do not apply. Roughly, the legislature sets sentences that are proportionate to culpability and that reflect an ordinary, rational offender's dangerousness. The insanity acquittee is neither culpable nor dangerous in the ordinary manner, however. If the basis for the commitment is non-responsible dangerousness, the commitment can justifiably continue until these conditions are no longer met. Although this is true as a theoretical matter, it seems useless to have lengthy commitments for non-violent offenders. They do not present much danger and the risk that they will be erroneously held longer than necessary is substantial. I would have limited terms of confinement for non-violent acquittees. These could be longer than ordinary involuntary civil commitment terms because the acquittee was prima facie guilty of a criminal offense, which is seldom the case in involuntary civil commitment and never required.[184] Nonetheless, the terms of post-insanity commitment for non-violent offenders should be short. If the subject has a clean disciplinary record in the hospital, he should be released at the end of the short term or the state can seek ordinary involuntary civil commitment. Another possibility is conditional or probationary release.[185] If the acquittee has an unproblematic probationary period in the community, the commitment should end. In short, the principle of least restrictive means should be applied to the treatment of insanity acquittees.

Recommendation: Post insanity acquittal commitments should be subject to the least restrictive means principle, including compelled treatment in the community.

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willing to countenance pure preventive detention, at least of a person who had committed a crime without being responsible and who continued to be dangerous.

For an attempt to apply Justice O'Connor's suggestion, see *State v. Randall*, 532 N.W.2d 94, 109 (Wis. 1995) (permitting continued confinement if there were a medical justification and the subject was still dangerous, but limiting the term to the maximum sentence for the crime charged). Needless to say, I believe that this practice is simply criminal punishment by other means. The "medical justification" criterion is a transparent and fraudulent attempt to bring this type of commitment within the disease justification for preemptive confinement. The limitation on the term of the commitment to the maximum term for the crime charged is simply a salve to the legislative conscience and a signal that the continued commitment is punitive.

[184] *See* PARRY, *supra* note, at 476–77 (discussing the criteria for commitments for dangerousness, which do not include a finding of prima facie guilt for a criminal offense or the equivalent thereof). Parry notes that the trend in standard involuntary civil commitments for dangerousness is away from requiring overt, recent acts and threats and towards more purely predictive criteria. In practice, however, commitment is common for threatening behavior, including verbal threats. Less serious assaults and thefts may also lead to civil commitment, although they are often processed through the criminal justice system. In my experience, seriously violent conduct is virtually always processed through the criminal justice system. Moreover, traditional civil commitment requires only the lower, clear and convincing burden of persuasion. Addington v. Texas, 441 U.S. 418, 431–33 (1979).

[185] *See* CAL. PENAL CODE § 1026.2(e)–(f) (West 2010).

The Court in *Jones* never noted that the mental disorder and dangerousness had to be linked to insure that the subject was not responsible for his dangerousness.[186] After all, non-responsibility for the legally relevant behavior, in this case dangerousness, is necessary to justify involuntary commitment. It is possible for a person to be independently disordered and bad, with no link between them that suggests that the defendant's dangerousness is irrational. For example, a paranoid defendant may have an excuse if he attacks another because he delusionally believes that the victim is a wrongful assailant, but there will be no excuse if he robs a bank. There probably will be such a link in most cases of insanity acquittal, but it cannot be taken for granted empirically.

More important, there is reason to doubt the Court's presumption of continuing mental disorder and dangerousness. By definition, the defendant must have been sufficiently rational to be competent to stand trial. If that state of rational capacity continues, then it is not clear that he continues to be mentally ill for the purpose of involuntary commitment. Moreover, to the extent that the mental disorder played a causal role in the practical reasoning that accompanied the offense, it is perfectly possible that the defendant is no longer dangerous either. This will be especially possible if the prosecution bears the burden of persuasion on legal insanity and the defendant only needs to cast a reasonable doubt about his sanity. Even if the defendant bears the burden of persuasion, as is commonly the case at present, the considerations just adduced apply.

My suggestion, therefore, is that all post-acquittal commitments should be for evaluation only and should not be for full commitment. There is little need to deprive the defendant of more liberty to protect the public. Preventive commitment should occur only if the evaluation indicates that the criteria for commitment are met at present. The evaluations need not last more than a few weeks. That is more than sufficient for the state's mental health professionals to reach a conclusion. I once again think that a subject facing potentially indefinite commitment and those facing substantial limited terms should be entitled to the services of an independent mental health professional to help defend against the commitment. Without such help, they have essentially no chance if the state's professional recommends commitment. These forms of commitment are more onerous than ordinary involuntary commitment and fairness requires that insanity acquittees should have a chance to avoid long-term incarceration in secure forensic facilities. For the

[186] Jones v. United States, 463 U.S. 354, 363–65 (1983) (discussing the need for a showing of both mental disorder and dangerousness to justify these commitments and apparently assuming that the fact of an insanity acquittal supplies a link between the two criteria, but not explicitly requiring the causal link at the time of commitment).

same reason, the State should have to prove the commitment criteria by the higher, clear and convincing standard that *Addington* imposed for ordinary involuntary commitment to avoid imposing too much risk of error on the individual.[187]

Recommendation: An insanity acquittal should be followed by a brief evaluation period rather than involuntary commitment to determine if the acquittee is still dangerous because his mental disorder continues. If the state then wishes to commit the acquittee, there should be a judicial hearing and the acquittee should have the right to an independent mental health professional to assist him to contest the commitment.

N. *Expert Testimony*

In section III.B. I suggested that all forensic evaluations should be videotaped. This would have an immensely salutary effect on determining the accuracy of the evaluation for the reasons given above, not least of which would be aiding cross-examination of the testifying evaluator, and I want to repeat this recommendation.

There are two questions we should ask of mental health expert opinions and testimony. Is it clinically and scientifically sound and is it genuinely relevant to the legal question in issue. All too often, alas, expert testimony that does not meet these criteria. In particular, experts too often conflate mental health and legal criteria. For example, a "broken" brain is not an excusing or mitigating condition *per se*, no matter how broken the brain appears to be. Expert testimony on such matters is legally relevant only if the abnormality produces acts and mental states that meet the legal criteria. The expert should be able to show precisely—no hand waving allowed—how the expert data helps answer the legal question. If it is not obviously directly relevant, the expert should be able to show the chain of inference that establishes its relevance.

In particular, we should ask whether a diagnosis ever answers a legal question independent of the underlying behavioral criteria (broadly defined as in section I above) upon which diagnosis is based. I submit that it does not and it distracts the legal decision maker and leads to question-begging about responsibility and competence. In almost all contested cases, there will be a conflict about the appropriate diagnosis. Rather than ask the decision maker to decide under which shell the diagnostic pea may be found, the experts should testify only about the underlying behavior, which will be much easier

[187] *Addington*, 441 U.S. at 425–33.

to assess than whether a specific diagnosis is warranted. Because all diagnostic categories can be met by very heterogeneous behavior, the diagnosis indicates nothing very specific about the defendant's behavior. The underlying data is far more helpful.

Barring testimony about diagnosis is not the law anywhere, although Congress did strongly consider imposing this limitation as part of the Insanity Defense Reform Act. Nonetheless, it would be a salutary change because it would produce greater clarity and it would not prevent experts from offering data and opinions on the underlying data that are relevant. Moreover, when decision makers hear "disease terms," they tend to think that responsibility or competence is affected, but this is a mistake.

In nearly all jurisdictions, experts are allowed to offer an opinion on the "ultimate legal issue," such as whether a defendant is competent or legally insane. In Federal criminal cases, however, the Insanity Defense Reform Act of 1984 bars experts from offering an ultimate opinion on whether the defendant possessed the requisite *mens rea* for the crime charged or was legally insane. In my opinion, the federal rule is correct and should be widely adopted and expanded to include all ultimate issue testimony. The ultimate issue is a legal issue and mental health experts have no particular expertise about them. When they offer such opinions, they are doffing their white coats and simply stepping into the jury box as the 13th lay juror. It is sufficient if they present the underlying data relevant to the legal issue and let the judge or jury decide if those data meet the standard in issue.

Recommendation: Expert witnesses at any stage of the criminal justice process should be prohibited from offering an opinion on the ultimate legal issue in question.

IV. Conclusion

Mental disorder plays a very large role in criminal justice at every step in the process. Virtually all doctrines and practices would benefit from substantial reforms to further justice, humanitarian and systemic goals. This chapter has made an enormous number of recommendations. I hope that some begin serious discussion and come to fruition. Most importantly, however, better mental health services, including addiction treatment, should be more widely available in the community and in the criminal justice system.

APPENDIX: List of Recommendations

Recommendation: Readers interested in the role of mental disorder in the criminal justice system should also consult the ABA Criminal Justice Mental Health Standards.

Recommendation: When predicting future behavior, the most accurate type of prediction method available should be used. If actuarial or structured clinical judgment methods are available for the type of prediction in question, they should always be preferred to purely clinical prediction.

Recommendation: Race should not be considered as a variable when predicting future behavior.

Recommendation: Non-physician health care providers in jails and prisons, especially psychologists, psychiatric social workers, and psychiatric nurses, who have received adequate training in prescribing psychotropic medication should be permitted to prescribe psychotropic medication.

Recommendation: Until rigorous data support the efficacy of various psychological treatment methods for prisoners, including special populations such as addicts and sexual offenders, large scale resource allocation for such methods should be limited, especially for methods focused on individual cases.

Recommendation: Jail and prison mental health services need to be dramatically improved.

Recommendation: Mentally disordered people arrested for non-violent or minimally violent offenses should be diverted from the criminal justice system to the mental health system. Adequate methods for effective and efficient triggering of diversion must be devised and adequate treatment must be provided in the community to the people diverted. Law enforcement officers should receive special training in dealing with mentally disordered people to enhance diversion and to deal with such people humanely.

Recommendation: Competence determinations should be fully adversarial, with experts representing both sides.

Recommendation: A mental health expert should be appointed to assist a defendant with any potential claim based on mental disorder that bears on culpability and punishment.

Recommendation: Defendants with a mental health based claim should be entitled to a genuinely independent mental health evaluator and the results of the evaluation should be confidential work product and not disclosed to the prosecution unless the defendant intends to use the evaluation to support a claim.

Recommendation: Clinical forensic evaluation interviews should be videotaped and the raw scores of psychological tests should be provided to the opposing side.

Recommendation: In quasi-criminal proceedings, such as those involving the civil commitment of mentally abnormal, sexually violent predators, the person facing commitment should be entitled to a genuinely independent mental health professional to assist him.

Recommendations: Defendants who are incompetent to stand trial should be permitted without exception to raise pre-trial motions that might end the prosecution.

Recommendation: Long term inpatient commitments to restore trial competence are unnecessary. Short term commitments are adequate to either restore the defendant or to determine that the defendant cannot be restored. In appropriate cases, restoration should be performed in the community.

Recommendation: Forcible medication to restore trial competence should be justified in the case of all felony prosecutions.

Recommendation: The test for competence to plead guilty and to waive counsel should be a context-dependent assessment of whether the defendant has the rational skills necessary to meet a generally low standard for competence.

Recommendation: Defendants should be permitted to introduce evidence of mental disorder without limitation to negate any subjective *mens rea* but should not be permitted to use such evidence to negate negligence.

Recommendation: All jurisdictions should adopt a cognitive test for legal insanity but should not adopt a control test.

Recommendation: All jurisdictions should adopt an insanity defense to insure that justice is done in appropriate cases and no alternative will equally achieve this result.

Recommendation: Legislatures should adopt a generic verdict of "guilty but partially" responsible that would reduce the defendant's sentence in cases in which the defendant's rationality was substantially compromised.

Recommendation: Prisoners should be forcibly medicated under a *Harper* rationality only if the prisoner's dangerousness is a result of his disordered state of mind.

Recommendation: Prisoners facing a *Harper* hearing should be represented by an advisor, preferably an attorney, who is independent of the prison or mental health system in the jurisdiction.

Recommendation: In all capital and non-capital sentencing proceedings in which the defendant has a colorable mitigation claim based on mental disorder, the defendant should have the right to an independent mental health professional to assist him with the claim.

Recommendation: Legislatures should adopt a mandated scheme of mitigation if the sentencing judge finds that substantial diminished rationality existed at the time of the crime. The amount of reduction could be a uniform percentage or might vary by crime to adjust for social safety concerns, but the sentencing judge would have no power to individualize beyond the mandated reduction.

Recommendation: In non-capital cases, mental disorder may be used as an enhancement factor but only if the most accurate methods of

predicting future behavior have been used and indicate a very substantial risk, but the amount of enhancement should be limited.

Recommendation: The standard for competence to be executed should be very high.

Recommendation: Competence to be executed should be decided by a judicial hearing.

Recommendation: Competence to be executed that is achieved by forcible medication administered under a *Harper* rationale should not be sufficient. The state should be compelled decide whether forcible medication solely to restore competence is justifiable independent of a *Harper* rationale.

Recommendation: The state should provide an independent mental health professional to help indigent people subject to a mentally abnormal sexual predator commitment oppose the commitment.

Recommendation: Mentally abnormal sexual predator commitment laws should be repealed.

Recommendation: Post insanity acquittal commitments should be subject to the least restrictive means principle, including compelled treatment in the community.

Recommendation: An insanity acquittal should be followed by a brief evaluation period rather than involuntary commitment to determine if the acquittee is still dangerous because his mental disorder continues. If the state then wishes to commit the acquittee, there should be a judicial hearing and the acquittee should have the right to an independent mental health professional to assist him to contest the commitment.

Recommendation: Expert witnesses at any stage of the criminal justice process should be prohibited from offering an opinion on the ultimate legal issue in question.