A Jail by Any Other Name: *Youngberg v Romeo* and the Grant of On-Grounds and Off-Grounds Passes to Insanity Acquittees

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INTRODUCTION

John Hinckley Jr shot Ronald Reagan yet never went to prison. Instead, a jury found him not guilty by reason of insanity (NGRI), and he was subsequently committed to St. Elizabeths Hospital.[1] The public was infuriated that Hinckley escaped conviction.[2] To the extent most Americans believed he should have been punished,[3] his commitment would be less punitive than they may have desired. For example, on one occasion the hospital gave Hinckley permission to leave the grounds for a holiday dinner with his family.[4] According to the DC Circuit, not only could the hospital grant such a pass, they could do so without court approval.[5]

The hostile reaction to the shooting reflected many of the public's misperceptions regarding the insanity defense. Although the vast majority of Americans believe that the defense is an easy "loophole that allows too many guilty people to go free,"[6] insanity pleas are actually exceptionally rare and mostly unsuccessful.[7] Respondents in one survey estimated that the insanity defense is invoked forty-one times more often than it actually is and that the

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1 *Hinckley v United States*, 163 F3d 647, 648 (DC Cir 1999).

2 Valerie P. Hans and Dan Slater, *John Hinckley, Jr. and the Insanity Defense: The Public's Verdict*, 47 Pub Op Q 202, 202 (1983) ("No verdict in recent history has evoked so much public indignation. . . . [T]hree-quarters of the Americans surveyed felt justice had not been done.") (quotation marks omitted).

3 One survey found that 59.5 percent of Americans believed Hinckley should receive both punishment and treatment, while another 26.4 percent believed he should receive punishment alone. See id at 206.

4 See *Hinckley*, 163 F3d at 648.

5 Id at 656.

6 See Eric Silver, Carmen Cirincione, and Henry J. Steadman, *Demythologizing Inaccurate Perceptions of the Insanity Defense*, 18 L & Hum Behav 63, 64 (1994).

7 According to one study, only 0.9 percent of indictments result in an insanity plea, and of those only 26 percent succeed. Id at 67.

rate of success is almost twice as high as the real figure.[8] Furthermore, while the public views the insanity defense as a get-out-of-jail-free card, the consequences to the defendant can actually be devastating, as the average NGRI patient is confined almost twice as long as he would have been if found guilty.[9] And while Hinckley's holiday dinner might have upset some, passes of that nature often serve an essential role in the treatment of the mentally ill.[10]

Given that backdrop, this Comment examines the due process rights that are implicated in the denial of passes. These passes include various on-grounds and off-grounds privileges, the nature of which can vary significantly. They might include anything from a walk around a hospital to a trip lasting several days. Some passes allow unsupervised privileges, while others do not. Because these passes affect treatment and reduce bodily restraint, this Comment argues that they are protected, under certain circumstances, by *Youngberg v Romeo*.[11] In that case, the Supreme Court held that involuntarily committed patients have liberty interests, protected under the Due Process Clause of the Fourteenth Amendment, to safe living conditions and freedom from bodily restraint.[12] The Court also held that there is a right to treatment that is "minimally adequate" to ensure that the interests in safety and freedom from restraint are protected.[13] However, patients do not have absolute rights to these interests,[14] so *Youngberg* requires that courts defer to professional judgment in suits against hospital administrators.[15] Only a small number of courts have considered *Youngberg* claims with regard to passes. Most have rejected those claims, arguing that *Youngberg* does not apply to this issue at all,[16] that there are no protected interests at stake,[17] or that categorically banning passes does not violate the

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8 Survey respondents estimated that 44 percent of these pleas result in acquittal. The actual figure is 26 percent. Id.

9 Michael L. Perlin, *"Wisdom Is Thrown into Jail": Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness*, 17 Mich St U J Med & L 343, 356 (2013). One study has suggested that those found NGRI of nonviolent crimes in California are confined on average nine times longer than those convicted. See id.

10 See, for example, *In re Williamson*, 564 SE2d 915, 917 (NC App 2002) (discussing a patient who "could not achieve further therapeutic gains until [ ] passes were authorized").

11 457 US 307 (1982).

12 See id at 315–16.

13 Id at 319.

14 Id at 319–20.

15 See *Youngberg*, 457 US at 321–22.

16 See *Laney v State*, 223 SW3d 656, 668–69 (Tex App 2007).

17 See *Williamson*, 564 SE2d at 919.

professional judgment standard.[18] This Comment argues that there are several instances in which a patient seeking a pass would have a valid *Youngberg* claim.

Part I of this Comment discusses the law governing passes, the *Youngberg* decision, and the cases that have already considered due process claims in this context. Part II argues that *Youngberg* is the appropriate standard in cases involving passes and explores how to apply that standard to decisions made by hospital staff. Part III argues that two common practices—categorical bans on all passes in all cases and broad trial court discretion over granting passes—should be considered unconstitutional.

I. PASSES, *YOUNGBERG*, AND DUE PROCESS

This Part discusses acquittal and commitment processes, the role of passes in mental health treatment, state law governing the decision to grant a pass, the Supreme Court's decision in *Youngberg*, and subsequent decisions that have applied that case. Finally, it briefly evaluates the potential link between mental illness and criminal behavior.

A. Acquittal, Commitment, and Passes

When the prosecution can prove its case beyond a reasonable doubt, a criminal defendant has a complete defense in most jurisdictions if he can prove insanity by a preponderance of the evidence.[19] After acquittal, the defendant is transferred to a mental hospital, where the state may constitutionally hold him until he proves that he is either no longer mentally ill or no longer dangerous.[20]

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[18] See *Laney*, 223 SW3d at 669–70.

[19] The traditional formulation of the insanity defense requires the defendant to show that, as a result of a mental disorder, he did not understand "the nature and quality of the act he was doing" or did not understand that it was wrong. See *M'Naghten's Case*, 8 Eng Rep 718, 722 (HL 1843). For a modern example, see 720 ILCS 5/6-2(a) ("A person is not criminally responsible for conduct if at the time of such conduct, as a result of mental disease or mental defect, he lacks substantial capacity to appreciate the criminality of his conduct."). Four states do not recognize insanity as an affirmative defense, but defendants in those states may introduce evidence of mental illness to disprove an element of an offense. See Idaho Code § 18-207(1), (3); Kan Stat Ann § 21-5209; Mont Code Ann § 46-14-102; Utah Code Ann § 76-2-305(1)–(2).

[20] See *Jones v United States*, 463 US 354, 368 (1983) ("The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous."); *O'Connor v Donaldson*, 422 US 563, 575 (1975) ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will. . . . [T]here is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.").

Rather than focusing on the acquittal process itself, this Comment addresses the constitutional rights of NGRI patients while committed.[21] In understanding the scope of these rights, the fact that the patient was found not guilty is significant.[22] In *Bell v Wolfish*,[23] the Court held that it is unconstitutional to punish a detainee without an adjudication of guilt.[24] Therefore, state NGRI policies must always be "rationally related to a legitimate nonpunitive governmental purpose."[25]

More specifically, this Comment considers how due process rights are affected when states decide whether to grant on-grounds and off-grounds passes. The nature of these passes can vary significantly, from brief walks around the hospital facility to excursions lasting several days.[26] To understand the due process implications, it is important to recognize that these passes are not always mere privileges but are often important in advancing a patient's treatment program.

Medical and forensic experts have "long recognized the clinical necessity of a transitional period between the forensic inpatient setting and the long-term goal of unconditional release of insanity acquittees into the community."[27] While research often focuses on the role of conditional releases, therapeutic passes can also be effective, and even essential, in this transition period.[28] In

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[21] The total number of involuntarily committed patients in the United States has declined dramatically in the last half century. While there were 559,000 psychiatric inpatients in 1953, that number fell to 30,000 by the end of the century. Megan Testa and Sara G. West, *Civil Commitment in the United States*, 7 Psychiatry (Edgemont) 30, 32–33 (Oct 2010).

[22] Twelve states have an additional "guilty but mentally ill" (GBMI) verdict. See Perlin, 17 Mich St U J Med & L at 355 (cited in note 9). Because those individuals are found guilty, they would not benefit from this Comment's arguments, because the nonpunitive nature of NGRI confinement is an essential component of a potential *Youngberg* claim. For competing views on the GBMI verdict, contrast generally Ira Mickenberg, *A Pleasant Surprise: The Guilty but Mentally Ill Verdict Has Both Succeeded in Its Own Right and Successfully Preserved the Traditional Role of the Insanity Defense*, 55 U Cin L Rev 943 (1987) (describing the positive effects of the GBMI verdict), with Christopher Slobogin, *The Guilty but Mentally Ill Verdict: An Idea Whose Time Should Not Have Come*, 53 Geo Wash L Rev 494 (1985) (counseling against adoption of the GBMI verdict).

[23] 441 US 520 (1979).

[24] See id at 535–36. See also *Jones*, 463 US at 369 ("As [an insanity acquittee] was not convicted, he may not be punished.").

[25] *Bell*, 441 US at 561.

[26] See *County of Hennepin v Levine*, 345 NW2d 217, 220 (Minn 1984). See also, for example, 730 ILCS 5/5-2-4(b) (allowing treatment plans to include "unsupervised on-grounds privileges, off-grounds privileges (with or without escort by personnel of the Department of Human Services), home visits and participation in work programs").

[27] Stephen A. Young, et al, *Commitment versus Confinement: Therapeutic Passes in the Management of Insanity Acquittees*, 30 J Am Acad Psychiatry & L 563, 566 (2002).

[28] See id at 566–67.

fact, "[p]roviding individuals greater access to passes and privileges as they gradually improve is widely accepted as an integral component of treatment plans for individuals with a mental disability who have been placed in an institution."[29] For example, in one case, *In re Williamson*,[30] a hospital's director of forensic treatment testified that his patient "could not achieve further therapeutic gains until [ ] passes were authorized."[31]

Experts recognize that a complete treatment plan for mentally ill patients generally requires more than medication alone,[32] and passes help fill that gap. For instance, in the psychosocial rehabilitation model, patients maintain close ties to their community, friends, and family as part of their treatment.[33] As a result, "suspension of [ ] pass program[s]" under this model can "severely restrict the treatment staff's ability to implement a treatment plan."[34] The therapeutic gains are particularly important toward the end of a patient's treatment program, as the staff begins to consider whether discharge is possible. One physician testified that passes "are the most important part of [our] program, particularly as we reach the point of having to assess whether the patient can safely readjust to life in the community. It's the single most important thing."[35]

B. Judicial Review of Passes

States vary considerably as to whether their NGRI statutes even mention passes, but some states have provisions that explicitly allow for them. For instance, an Illinois statute explicitly allows treatment plans to include on-grounds and off-grounds privileges, "but only where such privileges have been approved by specific court order."[36] The courts making these decisions have a

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29 Thomas L. Hafemeister and John Petrila, *Treating the Mentally Disordered Offender: Society's Uncertain, Conflicted, and Changing Views*, 21 Fla St U L Rev 729, 837 (1994).

30 564 SE2d 915 (NC App 2002).

31 Id at 917.

32 See generally, for example, Marcelo Valencia, et al, *The Beneficial Effects of Combining Pharmacological and Psychosocial Treatment on Remission and Functional Outcome in Outpatients with Schizophrenia*, 47 J Psychiatric Rsrch 1886 (2013).

33 See *Levine*, 345 NW2d at 221.

34 Id.

35 Id at 220.

36 730 ILCS 5/5-2-4(b). Ohio provides another example. See Ohio Rev Code Ann § 2945.401(D) (describing the conditions that apply to the grant of passes).

great deal of flexibility. As one Illinois court noted, "The clear language of [the statute] giv[es] the trial court wide discretion in granting and tailoring passes."[37]

However, many states' statutes do not explicitly address passes, and their courts have treated that absence in a number of ways. Some of these states also vest the discretion to grant passes in trial courts. California's NGRI statute, for example, does not mention on-grounds passes.[38] In *In re Cirino*,[39] a California appellate court determined that, because the statute gives courts discretion over whether patients should be released from confinement,[40] and because on-grounds passes should be considered a question of "confinement," a court's duty extends to this area.[41] As a result, California trial courts have the discretion to deny on-grounds passes against the recommendation of the patient's treatment team.[42] While this decision dates to 1972, the rule remains good law.[43] Georgia courts have reached a similar result.[44]

Other states have read the absence of a clear provision more restrictively. In *Laney v State*,[45] a Texas appellate court found that NGRI patients were governed by the Texas Code of Criminal Procedure, which, unlike the Texas Mental Health Code, did not have a provision for passes and furloughs.[46] Therefore, the court categorically held that NGRI patients "are not permitted passes

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37 *People v Bethke*, 6 NE3d 348, 352 (Ill App 2014).

38 See Cal Penal Code §§ 1026–1026.6.

39 28 Cal App 3d 1009 (1972).

40 See id at 1014. While this case is from 1972, the statute's wording remains essentially the same. Compare id with Cal Penal Code § 1026(b).

41 *Cirino*, 28 Cal App 3d at 1014 ("The word 'confine' means 'To restrain within limits; to limit; . . . to shut up; imprison; to put or keep in restraint . . . to keep from going out.'") (ellipses in original).

42 See id at 1014–16.

43 See, for example, *People v Michael W.*, 32 Cal App 4th 1111, 1116 (1995), citing *Cirino*, 28 Cal App 3d at 1014 ("Section 1026 does not expressly refer to grounds pass issues. However, it confers jurisdiction on the court which committed the defendant to make release decisions. . . . Thus, the court's authority does not end with the commitment of the defendant.").

44 See *O'Neal v State*, 365 SE2d 894, 896 (Ga App 1988) (holding that "a committing court has the authority to allow an insanity acquittee to pursue treatment, educational or other goals outside of the confines of the treating facility" and that "[t]he [committing] court is entirely free to reject the recommendation of the staff of the institution" regarding these goals) (brackets in original).

45 223 SW3d 656 (Tex App 2007).

46 See id at 670.

or furloughs."[47] In *State v Hudson*,[48] a South Carolina court similarly read the absence of an explicit provision to categorically ban certain off-grounds passes.[49] The court found that a patient with an off-grounds pass could not be deemed "committed" within the meaning of the statute, and therefore the court concluded that the state legislature did not intend such a result.[50]

At the opposite end of the spectrum is the Minnesota Supreme Court's decision in *County of Hennepin v Levine*.[51] Minnesota's NGRI statute also lacks an explicit provision concerning passes.[52] The county argued that passes constituted a "provisional discharge" under the statute, which would require approval by a special review board.[53] The patient argued that such passes constituted merely "a form of partial institutionalization," which would not require approval.[54] The court agreed with the latter viewpoint and held that passes are "beyond the ambit of special review board jurisdiction."[55] The court emphasized the value of passes in treatment programs, reasoning that "[t]o require special review board approval of issuance of passes would tie the hands of the treating physician and eviscerate the physician's discretion necessary for treatment of patients."[56] Thus, rather than categorically banning some types of passes or placing the discretion to grant passes in judges as many other states do, Minnesota gives hospital staff the discretion to grant passes without judicial review.

The most recent comprehensive analysis of state policies was in 2002, a few years after the Hinckley episode. Researchers contacted practitioners in all fifty states and found that off-grounds passes were completely unavailable in eight states,[57] and that judicial approval was required in an additional twenty-two states.[58]

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[47] Id.

[48] 519 SE2d 577 (SC App 1999).

[49] Id at 582.

[50] See id.

[51] 345 NW2d 217 (Minn 1984).

[52] See Minn Stat § 253B.15.

[53] See *Levine*, 345 NW2d at 221.

[54] Id at 222.

[55] Id at 223.

[56] Id (quotation marks omitted).

[57] These states are Arkansas, California, Iowa, Kansas, Kentucky, Oklahoma, Pennsylvania, and South Carolina. See Young, et al, 30 J Am Acad Psychiatry & L at 567 (cited in note 27). Since 2002, Texas has interpreted its NGRI statutes to ban passes as well. See *Laney*, 223 SW3d at 670.

[58] These states are Alabama, Alaska, Colorado, Delaware, Georgia, Illinois, Louisiana, Maine, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North

C. *Youngberg* and the Rights of the Involuntarily Committed

Before examining how the Due Process Clause affects passes, this Section turns to *Youngberg*, the leading case on the rights of the involuntarily committed. At thirty-three years old, Nicholas Romeo had the mental capacity of an eighteen-month-old child.[59] When his father died, his mother was no longer able to care for him, so she committed him to a state-run hospital on a permanent basis.[60] While in the hospital, Romeo suffered numerous injuries, sometimes resulting from his own violence and sometimes inflicted by other patients.[61] On one occasion, he broke his arm, and as a result the doctors physically restrained him for a prolonged period of time.[62]

Romeo's mother filed a complaint against the hospital's staff alleging that the "officials knew, or should have known, that Romeo was suffering injuries and that they failed to institute appropriate preventive procedures, thus violating" his due process rights under the Fourteenth Amendment.[63] Amended complaints "alleg[ed] that the defendants were restraining [Romeo] for prolonged periods on a routine basis" and that they "fail[ed] to provide him with appropriate treatment or programs for his mental retardation."[64]

First, the Court recognized that there are protected liberty interests under the Due Process Clause to both safe conditions and freedom from bodily restraint when in state custody—those rights survive criminal convictions, so they must also survive involuntary commitment.[65] These rights are particularly sensitive here because the involuntarily committed may not be punished.[66]

Romeo's third claim—asking for appropriate treatment—proved to be more difficult. While his mother could have pressed

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Carolina, Ohio, Rhode Island, South Dakota, Tennessee, Washington, West Virginia, and Wyoming. See Young, et al, 30 J Am Acad Psychiatry & L at 567 (cited in note 27).

59 *Youngberg*, 457 US at 309.

60 Id.

61 Id at 310.

62 Id at 310–11.

63 *Youngberg*, 457 US at 310.

64 Id at 311 (quotation marks omitted). The complaint originally asked for both injunctive relief and damages. Id at 310. However, Romeo was part of a separate class action seeking injunctive relief, so those claims were dropped before trial. Id at 311. While patients can claim either form of relief in a *Youngberg* action, professionals will have "good-faith immunity" from damages if their behavior was the result of budgetary constraints. Id at 323.

65 Id at 315–16.

66 See id.

for a general right to treatment in and of itself, she chose not to.[67] Instead, the claim was narrower in scope: she asked only for treatment that would temper her son's aggressive behavior, the cause of many of his injuries.[68] On that narrower question, the Court held that Romeo had a right to treatment that was "minimally adequate or reasonable [ ] to ensure safety and freedom from undue restraint."[69]

That, of course, still left unresolved the question of what is "minimally adequate." The Court was clear that the interests in safe conditions, freedom from restraint, and minimally adequate treatment are not absolute.[70] After all, the right to safe conditions and the right to freedom from bodily restraint are often in conflict, as hospitals will often have to restrain patients to ensure that they are safe from themselves and others.[71] The Court therefore held that the Constitution requires treatment that is "reasonable in light of [the need to protect the patient's] liberty interests."[72] Because the Court was reluctant to create a standard that would interfere with the internal operations of state institutions, it held that courts must defer to professional judgment in determining what is "reasonable."[73] A professional's decision is "presumptively valid,"[74] so his action will be shielded from liability unless his decision "is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that [he] actually did not base the decision on such a judgment."[75]

The result is a two-part test.[76] First, a plaintiff must show that some protected liberty interest was infringed.[77] Second, a plaintiff must show that the restriction of that interest was not

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[67] See *Youngberg*, 457 US at 318–19 & n 23.

[68] See id at 318.

[69] Id at 319.

[70] Id at 319–20.

[71] See *Youngberg*, 457 US at 320.

[72] Id at 322.

[73] Id.

[74] Id at 323.

[75] *Youngberg*, 457 US at 323.

[76] See id at 324 (explaining that the Court will ask first whether liberty interests exist, and second whether those interests were infringed in the given case).

[77] See *C.J. v Department of Human Services*, 771 NE2d 539, 549 (Ill App 2002) ("Under the two-part test articulated in *Youngberg*, plaintiffs in this case must demonstrate, first, that their liberty interest in freedom of movement was restricted by the Department.").

based on professional judgment.[78] The Supreme Court has not revisited this standard in the intervening years, so the test remains untouched.[79]

D. Previous Applications of *Youngberg* to Passes

While *Youngberg* has been the controlling law on the subject of the rights of involuntarily committed patients for over three decades, only a small number of cases have discussed those rights in the context of NGRI passes. One of the earliest relevant challenges was *Johnson v Brelje*.[80] The patients in that case were committed to the hospital after being found unfit to stand trial—thus, at that time, they had not yet been convicted of any crime.[81] The patients' complaint alleged that two practices—locking the patients indoors at almost all times and locking them in their rooms during the staff's mealtimes—violated their rights under the Due Process Clause.[82] The Seventh Circuit cited *Youngberg* in deciding that "[t]he Constitution only requires us to make certain that in deciding to restrict the movements of the plaintiffs, a *professional judgment* was exercised."[83] The court concluded that the practice of confining the patients indoors at almost all times was unconstitutional under *Youngberg* because it had no basis in professional judgment, but the decision to confine patients during mealtimes was valid because it was "based on a professional judgment concerning how best to operate [the facility]."[84]

Several decades later, an Illinois court directly applied *Youngberg* to the issue of passes in *C.J. v Department of Human*

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78 See id ("Under the second prong of the *Youngberg* test, when a decision to restrict liberty is made, it must be shown that professional judgment was used to balance the plaintiffs' liberty interest against the State's interest in restricting liberty.").

79 See *Evans v Fenty*, 701 F Supp 2d 126, 152 (DDC 2010) ("In the almost 30 years since *Youngberg* was decided, the Supreme Court has not revisited the daunting task of explicating the constitutional rights of the involuntarily-committed developmentally disabled. . . . Thus, there is no controlling precedent, other than *Youngberg*, and there is no consensus among the courts regarding [its] interpretation.").

80 701 F2d 1201 (7th Cir 1983). An unrelated part of the opinion, which discussed a right to "treatment in the least restrictive environment," was later superseded by statute. See id at 1205–07; *Maust v Headley*, 959 F2d 644, 648 (7th Cir 1992) ("We therefore hold that ICCP § 104–17 had the statutory effect of eliminating a [ ] protectible liberty interest . . . to being confined in the least restrictive environment. To the extent that it conflicts with our holding today, our earlier decision in *Johnson v. Brelje* is no longer viable.").

81 See *Johnson*, 701 F2d at 1204.

82 See id at 1208.

83 Id at 1209.

84 Id at 1209–10.

Services.[85] Under a policy enacted by the Illinois Department of Human Services, no NGRI patients were able to obtain unsupervised on-grounds passes.[86] The court applied the two-part *Youngberg* test, first finding that the "plaintiffs' liberty interest in freedom of movement was restricted" by such a policy.[87] In determining whether that restriction was reasonable—the second prong of the *Youngberg* test—the court emphasized the categorical nature of the ban and therefore "affirm[ed] the trial court's conclusion that the Department violated due process by failing to exercise professional judgment in restricting plaintiffs['] liberty interest in freedom of bodily movement."[88] The scope of this case's holding is measured. It did not hold that all NGRI patients should be given on-grounds passes, but instead struck down a policy under which no patient would ever be considered for passes.[89] The court concluded: "Plaintiffs are not seeking injunctive relief requiring the Department to allow NGRI patients to roam or wander the facility grounds unsupervised. Plaintiffs are seeking, consistent with fundamental principles of substantive due process, that the Department exercise professional judgment in restricting the plaintiffs' liberty interest in freedom of movement."[90]

Some courts in other states have been less sympathetic to due process claims regarding passes. For instance, in *Williamson*, a North Carolina court quickly rejected the idea that the grant of on-grounds passes involved any protected liberty interest without discussing *Youngberg* at all.[91] In *Laney*, the Texas decision categorically banning off-grounds passes, the court addressed the *Youngberg* claim more carefully, though also ultimately rejecting it.[92]

The plaintiffs in *Laney* argued, relying on *Youngberg*, that courts must always accept the decision of a professional to grant a pass, unless it is shown that the decision was a substantial departure from accepted standards.[93] The *Laney* court determined

[85] 771 NE2d 539 (Ill App 2002).

[86] Id at 543.

[87] Id at 551. Illinois's case law is not entirely consistent on this point. See *People v Cross*, 684 NE2d 135, 143 (Ill App 1997) ("[N]o due process liberty interest is involved when a defendant seeks pass privileges; the defendant is not challenging his commitment to the State facility, but rather seeks privileges subject to the court's approval, to modify his treatment plan during his commitment status.").

[88] *C.J.*, 771 NE2d at 554.

[89] See id at 555.

[90] Id.

[91] See *Williamson*, 564 SE2d at 919.

[92] See *Laney*, 223 SW3d at 666–70.

[93] Id at 668.

that *Youngberg* does not apply to this question at all,[94] relying in part on two Supreme Court cases, *Jones v United States*[95] and *DeShaney v Winnebago County Department of Social Services*.[96] The court argued that *Jones* stood for the proposition that NGRI patients are a distinct class that the state can treat differently than civil committees.[97] It then reasoned that *DeShaney* narrowed *Youngberg*'s scope by characterizing that opinion's holding "as standing 'only for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.'"[98] *Laney* concluded that even if *Youngberg* did apply, the claim would still fail because the patient was receiving "minimally adequate" treatment without the passes, emphasizing the various medications and services that were already available.[99]

Although there has been little litigation on the exact question presented in this Comment, this does not reflect a lack of seriousness or legitimacy of the claims. Instead, it likely reflects the inadequacy of legal resources available to NGRI patients.[100] Resources are particularly scarce for test cases pressing for new precedent,[101] so it is not surprising that few patients have attempted this relatively novel claim.

In total, only a few courts have addressed the application of *Youngberg* to passes. Several have rejected the claims outright, while others have been more sympathetic. The courts that upheld claims relied on concerns regarding freedom from bodily restraint, without considering *Youngberg*'s requirement of minimally adequate treatment.

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94 See id at 668–69.

95 463 US 354 (1983).

96 489 US 189 (1989).

97 *Laney*, 223 SW3d at 668, citing *Jones*, 463 US at 370 (referencing the Court's holding in *Jones* that a state can commit an insanity acquittee to a hospital without ordinary commitment proceedings, even though the burden of proof at trial is lower than would otherwise be required).

98 *Laney*, 223 SW3d at 669, quoting *DeShaney*, 489 US at 199–200.

99 See *Laney*, 223 SW3d at 669.

100 See Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 L & Hum Behav 39, 43 (1992) ("The record of the legal profession in providing meaningful advocacy services to mentally disabled persons has been grossly inadequate. . . . In one case study, counsel was so inadequate that a patient's chance for release was actually greater if there was no lawyer present.").

101 See id at 49 ("[R]epresentation is rarely available in a systemic way in law reform or test cases.").

E. Public Safety Concerns

In light of the public's negative view of the insanity defense, there will likely be pushback against any proposal to expand access to passes, especially off-grounds passes. But expanding pass availability and protecting the public need not be mutually exclusive policy aims. As this Section discusses, the state's security concerns are less substantial than one might think, and providing better treatment could enhance, rather than detract from, public safety goals.

While mental illness receives much of the blame for violence in our society,[102] mentally ill individuals actually pose a much smaller threat than one might expect.[103] Studies do show some link between mental illness and violence,[104] but most research shows that the correlation is small.[105] This is especially true when controlling for other risk factors. One study found that while individuals with both schizophrenia and a substance abuse problem are much more likely to commit a violent act than the general population, the relationship is relatively weak for individuals with schizophrenia alone.[106] Another study by many of the same researchers found similar results when studying individuals with

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[102] See Lydia Saad, *Americans Fault Mental Health System Most for Gun Violence* (Gallup, Sept 20, 2013), online at http://www.gallup.com/poll/164507/americans-fault-mental-health-system-gun-violence.aspx (visited Feb 20, 2016) (Perma archive unavailable) (reporting that 48 percent of Americans think that the "[f]ailure of the mental health system to identify individuals who are a danger to others" is "a great deal to blame" for mass shootings in the United States, a higher percentage than for any other factor listed in the survey, including drug use and access to guns).

[103] See John Junginger, et al, *Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses*, 57 Psychiatric Serv 879, 882 (2006) ("Unless it can be shown that factors unique to serious mental illness are specifically associated with behavior leading to arrest and incarceration, the [hypothesis that mental illness is associated with arrest and incarceration] should be reconsidered in favor of more powerful risk factors."); Perlin, 17 Mich St U J Med & L at 343, 349–53 (cited in note 9) (discussing the widespread reduction in the number of psychiatric beds in the 1970s and 1980s and concluding that criminalization is not the "inevitable by-product" of deinstitutionalization).

[104] See, for example, Edward P. Mulvey, *Assessing the Evidence of a Link between Mental Illness and Violence*, 45 Hospital & Community Psychiatry 663, 663 (1994) ("Mental illness appears to be a risk factor for violence in the community. . . . About 20 percent of individuals appearing in psychiatric emergency rooms have been found to have some history of violent behavior.") (emphasis omitted).

[105] See id at 664 (describing a study of the link between symptoms of mental illness and violent behavior, which placed the correlation coefficient around 0.20).

[106] See Seena Fazel, et al, *Schizophrenia, Substance Abuse, and Violent Crime*, 301 J Am Med Assoc 2016, 2020 (2009) (finding that 27.6 percent of those who had both schizophrenia and a substance abuse problem had committed a violent offense, compared to 8.5 percent of those with just schizophrenia and 5.3 percent of the control group).

bipolar disorder.[107] In total, those diagnosed with a mental illness were responsible for less than 5 percent of all gun homicides in the United States between 2001 and 2010,[108] and the mentally ill as a whole account for "only a small proportion of the violence in our society."[109]

Furthermore, the effective treatment of NGRI acquittees will have a positive effect on public safety. Preventing escape is one important interest, but ensuring that patients are safe to others when they eventually reenter the community is equally important.[110] Experts recognize that there is a need for a transitional period toward the end of a patient's confinement,[111] and passes can be extremely important in determining whether a patient is ready to be released,[112] so much so that some patients cannot continue to make therapeutic gains without passes.[113] Studies show that conditional release programs can be effective at reducing recidivism rates.[114] When authorities retain the ability to monitor patients for some period of time and, in difficult cases, revoke

[107] See Seena Fazel, et al, *Bipolar Disorder and Violent Crime: New Evidence from Population-Based Longitudinal Studies and Systematic Review*, 67 Arch Gen Psychiatry 931, 936 (2010) (finding "that the risk of violent crime in individuals with bipolar disorder was confined to those with comorbid substance use" and that "no increased violence risk in patients having bipolar disorder without substance abuse comorbidity").

[108] See Jonathan M. Metzl and Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 Am J Pub Health 240, 241 (2015).

[109] Mulvey, 45 Hospital & Community Psychiatry at 664 (cited in note 104) (finding "that the absolute risk of violence among the mentally ill as a group is still very small and that only a small proportion of the violence in our society can be attributed to persons who are mentally ill").

[110] Evaluations of similar programs sensibly focus on reductions in recidivism rates. See Michael J. Vitacco, et al, *Evaluating Conditional Release in Not Guilty by Reason of Insanity Acquittees: A Prospective Follow-Up Study in Virginia*, 38 L & Hum Behav 346, 346–47 (2014) (describing common metrics for evaluating the success of conditional release programs). See also, for example, Grant H. Morris, *Placed in Purgatory: Conditional Release of Insanity Acquittees*, 39 Ariz L Rev 1061, 1069–71 (1997) (discussing the success of conditional release programs at reducing recidivism rates in Oregon).

[111] See Young, et al, 30 J Am Acad Psychiatry & L at 566 (cited in note 27) ("The forensic literature has long recognized the clinical necessity of a transitional period between the forensic inpatient setting and the long-term goal of unconditional release of insanity acquittees into the community.").

[112] See *Levine*, 345 NW2d at 220 (quoting a doctor who described passes as "the single most important thing," particularly in "assess[ing] whether the patient can safely readjust to life in the community").

[113] See, for example, *Williamson*, 564 SE2d at 917.

[114] See, for example, Morris, 39 Ariz L Rev at 1069–71 (cited in note 110) (discussing studies of conditional release programs in Oregon, which found that during a nine-year period around 15 percent of conditionally released patients were charged with new crimes).

their release status before their condition reaches dangerous levels, the result is less crime.[115] An effective pass program would give hospital staff similar flexibility to monitor patients, well before conditional release is under consideration. Because passes are so important in treatment and, more importantly, in assessing whether a patient is actually safe to reenter the community, the public safety gains could outweigh the costs associated with the risk of escape.

With that said, public safety may not even be the controlling motivation in the first place. Comparing pass policies in the civil commitment context provides some insight on this point. While NGRI patients in Texas are categorically prohibited from obtaining passes,[116] patients who are committed through ordinary proceedings can still obtain them.[117] Similarly, the Illinois statute that grants courts such wide discretion specifically applies to NGRI patients, not involuntary civil committees.[118] But, before any patient—NGRI or not—is committed to a hospital against his will, the Constitution requires a finding of dangerousness.[119] Not only that, but an involuntary committee, like an NGRI patient, is entitled to release as soon as he is no longer considered dangerous.[120] Thus, both NGRI patients and civil committees are found to be presently dangerous, yet one group has wider access to passes. States may not need to have identical policies for the two populations,[121] but given that the Constitution requires a finding of dangerousness for both groups, the justification for having different policies ought to rest on different grounds.

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[115] See id at 1071 ("The low criminal recidivism rate was attributed to the [ ] ability to revoke conditional release status before a patient's problems developed into criminal activity.").

[116] See *Laney*, 223 SW3d at 666.

[117] See Tex Health & Safety Code Ann § 574.082.

[118] See 730 ILCS 5/5-2-4.

[119] See *O'Connor*, 422 US at 575 ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will. . . . [T]here is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.").

[120] See id at 574–75. See also *Jones*, 463 US at 368 ("The purpose of commitment following an insanity acquittal, like that of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness. The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous.").

[121] See *Jones*, 463 US at 370 (allowing for different commitment procedures between the two groups).

II. *YOUNGBERG* CHALLENGES TO DECISIONS BY HOSPITAL STAFF

This Part argues that there are valid due process claims in those scenarios that mirror *Youngberg* most closely—when the hospital staff itself denies minimally adequate treatment without exercising professional judgment. First, it considers, and dismisses, the argument that *Youngberg* is not the correct standard in these cases. Then it discusses the liberty interests at stake, which include freedom from bodily restraint and treatment that is minimally adequate to ensure that freedom. Finally, it discusses what the professional judgment standard should look like in these cases. While there is some scholarship on state laws governing passes,[122] as well as commentary on *Youngberg*,[123] there is none applying that standard to passes.

First, imagine a hypothetical patient, Tybalt. He is charged with a nonviolent crime, and the state can prove each element of the offense beyond a reasonable doubt. Tybalt suffers from a severe mental illness, and, despite the fact that pleading insanity will most likely result in a much longer confinement,[124] he decides to attempt the defense anyway. Because his condition is severe, this is one of the few insanity defenses that actually succeed.[125] As a result, he is committed to a state hospital indefinitely.

Several years later, Tybalt's treatment program stalls, and he stops progressing toward eventual release. His family wants him to have an on-grounds pass so that he can walk around the hospital. The family members have done enough research and consulted enough experts to know that, in his circumstances, the denial of a pass would be a substantial departure from accepted professional judgment because, without a pass, Tybalt would no

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[122] See, for example, Hafemeister and Petrila, 21 Fla St U L Rev at 837–40 (cited in note 29) (discussing cases reviewing the grant of passes); Young, et al, 30 J Am Acad Psychiatry & L at 566–67 (cited in note 27) (discussing the availability of passes with a particular emphasis on treatment).

[123] See generally Jeremy Y. Weltman, Roderick MacLeish, and Jacquelyn E. Bumbaca, *Deference ≠ Abdication: Application of* Youngberg *to Prolonged Seclusion and Restraint of the Mentally Ill*, 26 Stan L & Pol Rev 239 (2015) (discussing *Youngberg*'s application after the fallout of the deinstitutionalization movement); Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication under the Professional Judgment Standard*, 102 Yale L J 639 (1992) (discussing *Youngberg*'s application to a variety of civil rights cases).

[124] See note 9 and accompanying text (noting that the average NGRI patient is confined twice as long as someone convicted of the same crime).

[125] Less than 1 percent of felony indictments result in an insanity plea, and among those who actually attempt it, only 26 percent succeed. Silver, Cirincione, and Steadman, 18 L & Hum Behav at 67 (cited in note 6).

longer progress in his treatment. The family also knows that the hospital's security is relatively good and that, with an on-grounds pass, Tybalt would pose little danger of escape. When the family goes to the hospital staff, the administrators decide not to grant it to avoid the inconvenience.

Tybalt is indistinguishable from Romeo. He has constitutionally protected interests in safe conditions and freedom from bodily restraint; convicted criminals have those interests, so he does too.[126] He similarly has the right to minimally adequate treatment to ensure those two interests.[127] To secure that freedom, Tybalt claims he needs the pass. The question, then, is whether the denial of passes is "such a substantial departure from accepted professional judgment . . . as to demonstrate that the person responsible actually did not base the decision on such a judgment."[128]

A. Whether *Youngberg* Is the Correct Standard

The first question is whether *Youngberg* directly controls Tybalt's case in the first place. The Supreme Court has announced several standards governing substantive due process claims, and there is some confusion among the lower courts as to which standard is appropriate and when,[129] something the Supreme Court itself has struggled with.[130] The standard announced in *Estelle v Gamble*[131] and *County of Sacramento v Lewis*[132] is the most plausible alternative to *Youngberg*.

In *Estelle*, an inmate sued prison officials over an injury sustained during a work assignment when a bale of cotton fell on

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[126] See *Youngberg*, 457 US at 315–16 ("If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed—who may not be punished at all—in unsafe conditions.").

[127] See id at 319.

[128] Id at 323.

[129] See Rosalie Berger Levinson, *Wherefore Art Thou* Romeo*: Revitalizing* Youngberg*'s Protection of Liberty for the Civilly Committed*, 54 BC L Rev 535, 561–69 (2013) (discussing how different circuits have applied the professional judgment and the deliberate indifference standards).

[130] Contrast *Washington v Glucksberg*, 521 US 702, 720–22 (1997) (applying a standard based on fundamental rights, history, and tradition, and explicitly rejecting the approach advocated by Justice David Souter in his dissent), with *County of Sacramento v Lewis*, 523 US 833, 846–53 (1998) (Souter) (applying a "shocks the conscience" test). See also *Lewis*, 523 US at 860–62 (Scalia concurring in the judgment) (lamenting the discrepancy between the two cases).

[131] 429 US 97 (1976).

[132] 523 US 833 (1998).

him.[133] The Court, applying the Eighth Amendment,[134] held that the plaintiff must show that the prison officials exhibited deliberate indifference, a higher standard than negligence.[135] In *Lewis*, a young man's parents brought a substantive due process claim against a police officer after a high-speed chase resulted in their son's death.[136] The Court held that the plaintiffs must show that the conduct shocks the conscience.[137] Under the *Lewis* standard, as in *Estelle*, negligence is not sufficient.[138] The Court also noted that because deliberate indifference to medical needs shocks the conscience in Eighth Amendment cases, it must also be sufficient in the due process context, such as in the treatment of pretrial detainees.[139]

The relationship between the professional judgment standard and the deliberate indifference standard is not clear. Some circuits now apply *Lewis* in the context of the involuntarily committed, either in addition to *Youngberg* or on its own, primarily on the grounds that the two standards are more or less the same.[140] Other circuits have rejected the notion that the deliberate indifference standard has any place in this context and have continued to apply *Youngberg* alone.[141] To the extent these standards might actually differ—in that "deliberate indifference" includes a

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133 *Estelle*, 429 US at 98–99.

134 In *Youngberg*, the Court rejected an argument that the Eighth Amendment was the proper standard for liability. See *Youngberg*, 457 US at 325.

135 See *Estelle*, 429 US at 104–06.

136 *Lewis*, 523 US at 836–37.

137 See id at 846–47.

138 See id at 849–50.

139 See id at 850.

140 See *Battista v Clarke*, 645 F3d 449, 453 (1st Cir 2011) (reasoning that *Youngberg* was controlling, but that it was "not all that far apart" from the deliberate indifference standard); *Beck v Wilson*, 377 F3d 884, 889–90 (8th Cir 2004) (citing *Youngberg* favorably, but applying the deliberate indifference test); *Benn v Universal Health System, Inc*, 371 F3d 165, 175 (3d Cir 2004) (holding that a decision based on professional judgment did not shock the conscience); *Collignon v Milwaukee County*, 163 F3d 982, 988 (7th Cir 1998) (finding that the professional judgment standard is at least as demanding as the deliberate indifference standard, but declining to find that it is *more* demanding).

141 See *Ammons v Washington Department of Social and Health Services*, 648 F3d 1020, 1029 (9th Cir 2011) (rejecting the deliberate indifference standard because *Youngberg* does not require a finding that "officials were subjectively aware of the risk posed to the patient") (quotation marks omitted); *Bolmer v Oliveira*, 594 F3d 134, 143–45 (2d Cir 2010) (affirming a lower court's reliance on a professional judgment test rather than a deliberate indifference test); *Lanman v Hinson*, 529 F3d 673, 684 (6th Cir 2008) (noting that *Youngberg*, not the deliberate indifference standard, controls cases involving professional decisionmakers); *Patten v Nichols*, 274 F3d 829, 838 (4th Cir 2001) (applying *Youngberg* and rejecting the deliberate indifference standard in a case involving an involuntarily committed patient).

subjective component whereas "professional judgment" does not—some recent scholarship argues for the continuing vitality of *Youngberg*.[142]

There are three principal reasons to apply *Youngberg* to this issue. First, the Court in *Lewis* reasoned that different situations will give rise to different due process requirements,[143] and it explicitly cited *Youngberg* for the proposition that greater care is required in custodial environments.[144] Second, the deliberate indifference standard derives from the Eighth Amendment *Estelle* case,[145] and the Constitution's prohibition of "cruel and unusual punishments"[146] has no bearing in an NGRI case, in which there can be no punishment at all.[147] Third, there are good arguments for using an objective standard in this context. For instance, Professor Rosalie Berger Levinson argues that a subjective standard is ill-suited to solving administrative questions that involve budgetary constraints, whereas the *Youngberg* standard is cognizant of the need for injunctive relief in cases in which a constitutional violation was premised on a lack of funds.[148] Additionally, a subjective standard imposes a burden on the patient to prove a custodial

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142 See, for example, Levinson, 54 BC L Rev at 569–77 (cited in note 129) (noting that *Lewis*, rather than overturning *Youngberg*, cited it as persuasive authority and discussing the many advantages of an objective test in this area). See also Andrea Koehler, Comment, *The Forgotten Children of the Foster Care System: Making a Case for the Professional Judgment Standard*, 44 Golden Gate U L Rev 221, 250–56 (2014) (claiming that *Youngberg* is the preferable standard in the context of foster care cases); Mark Strasser, *Deliberate Indifference, Professional Judgment, and the Constitution: On Liberty Interests in the Child Placement Context*, 15 Duke J Gender L & Pol 223, 233–34 (2008) ("Certainly, there are benefits and drawbacks to the use of either standard. Use of the . . . professional judgment standard would create an incentive for those responsible for placing children in foster care to pay close attention and discover the relevant information."). For an argument for limiting *Youngberg* on the grounds that it does not sufficiently protect patient rights, see Weltman, MacLeish, and Bumbaca, 26 Stan L & Pol Rev at 251 (cited in note 123) (concluding that, "[i]n light of . . . the devastating effects of solitary confinement," the best solution is to reject *Youngberg* in cases involving seclusion and restraint).

143 See *Lewis*, 523 US at 850 ("Deliberate indifference that shocks in one environment may not be so patently egregious in another.").

144 See id at 852 n 12, citing *Youngberg*, 457 US at 319–25 ("The combination of a patient's involuntary commitment and his total dependence on his custodians obliges the government to take thought and make reasonable provision for the patient's welfare."). See also Levinson, 54 BC L Rev at 569 (cited in note 129) ("[*Lewis*] cited *Youngberg* as having recognized that, in the context of civil commitment, substantive due process is violated when state personnel fail to exercise professional judgment.").

145 See text accompanying note 135.

146 US Const Amend VIII.

147 See *Bell*, 441 US at 535. See also *Youngberg*, 457 US at 312 n 11 (explicitly rejecting *Estelle* in this context because it involved the Eighth Amendment).

148 See Levinson, 54 BC L Rev at 573–76 (cited in note 129).

decisionmaker's state of mind that will often be prohibitively high.[149]

One plausible counterargument is that *Youngberg* does not apply to cases concerning passes because the decision to grant a pass is not a treatment decision at all. In 2012, the Seventh Circuit rejected a *Youngberg* claim because "[not] *all* decisions that have an impact on detainees are treatment decisions."[150] The Seventh Circuit found that decisions about security or budgetary allocations, among other things, are not treatment decisions and therefore need not satisfy *Youngberg*'s professional judgment standard.[151]

This argument, while tempting, lacks a basis in *Youngberg* itself. Any given decision can affect both an individual's liberty and the state's interests in security and administration, and the Court's standard explicitly requires that courts balance both.[152] Most security decisions will affect treatment, and most treatment decisions will affect security. "[T]o protect [patients] as well as others from violence,"[153] the Court established a single standard that balances these different considerations. To the extent it would be possible to isolate treatment and security decisions, the Court did not choose to do so.

The second plausible counterargument is that *Youngberg* should not apply here because that case concerned civil committees, and NGRI patients are a distinct group with unique needs. Whereas the first counterargument rested on the type of claim,

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149 See id at 571, quoting *Wendy H. v City of Philadelphia*, 849 F Supp 367, 374 (ED Pa 1994) ("The Eighth Amendment's requirement that officials actually know that inmates face a serious risk of harm provides insufficient protection to the civilly committed. . . . '[To require knowledge of harm] would be to endorse neglect by government officials.'").

150 *Lane v Williams*, 689 F3d 879, 882–83 (7th Cir 2012).

151 See id ("Many policies and practices at a facility . . . reflect what the state can afford . . . and what security requires; the fact that such policies and practices may frame opportunities for treatment does not make them treatment.").

152 See *Youngberg*, 457 US at 321 ("[W]hether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests."). See also *Beaulieu v Ludeman*, 690 F3d 1017, 1033–35, 1037–41 (8th Cir 2012) (allowing hospital staff to seize televisions and restrict telephone access in light of the state's security interests); *Bee v Greaves*, 744 F2d 1387, 1395–96 (10th Cir 1984) (applying *Youngberg* and balancing "a [pretrial] detainee's interest in freedom from unwanted antipsychotics" against the state's interests in security); *Bell*, 441 US at 546–47 (holding that, in the context of pretrial detainees, "maintaining institutional security and preserving internal order and discipline are essential goals that may require limitation or retraction of the retained constitutional rights. . . . [E]ven when an institutional restriction infringes a specific constitutional guarantee . . . the practice must be evaluated in the light of the central objective of . . . safeguarding institutional security").

153 *Youngberg*, 457 US at 320.

this argument attempts to distinguish the parties. While there is some isolated language in *Jones* indicating that the two groups are different, the decision, when taken as a whole, suggests that they should not be distinguished in this situation. *Jones* did find that its "holding accords with the widely and reasonably held view that insanity acquittees constitute a special class that should be treated differently from other candidates for commitment."[154] However, the distinction was far more limited than this isolated statement suggests. At issue was whether insanity acquittees are entitled to the same burden of proof as involuntary civil committees before being committed.[155] The Court found that they are not so entitled, because the risk of error is far lower when one voluntarily pleads insanity at a criminal trial.[156]

While the *Jones* Court distinguished NGRI patients and civil committees for this reason, it limited its holding to the commitment context, noting that "the basic standard for release is the same under either civil commitment or commitment following acquittal by reason of insanity."[157] Passes have nothing to do with commitment procedures, so *Jones* provides no basis for distinguishing Tybalt from Romeo.

Furthermore, the Court's discussion in *DeShaney* provides additional support for the contention that *Youngberg* applies equally to both groups.[158] Admittedly, the *DeShaney* court stated that *Youngberg* stood "only for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being."[159] But the Court was merely saying that a state actor has an affirmative duty to care for someone *in its custody*, like Romeo, but no general duty to care for citizens *not in its custody*.[160] Because the child in *DeShaney* was not a ward of the state, the state had no affirmative duty to protect him from his abusive father, and

[154] *Jones*, 463 US at 370.

[155] See id at 362.

[156] See id at 367–68.

[157] Id at 363 n 11.

[158] *DeShaney*, 489 US at 199–200. This was the second case *Laney* relied on in distinguishing *Youngberg*. See *Laney*, 223 SW3d at 668–69, citing *DeShaney*, 489 US at 199–200.

[159] *DeShaney*, 489 US at 199–200.

[160] See id at 201. See also *Youngberg*, 457 US at 317 ("As a general matter, a State is under no constitutional duty to provide substantive services for those within its border. When a person is institutionalized—and wholly dependent on the State—it is conceded by petitioners that a duty to provide certain services and care does exist.") (citations omitted).

therefore no valid *Youngberg* claim existed.[161] Because NGRI patients are wards of the state, *Youngberg* applies. While *DeShaney* may place limitations on the ability of *voluntary* committees seeking relief,[162] that would not provide a basis for distinction in the NGRI context.

Finally, attempts to instead resolve this question on equal protection grounds—that is, to argue that there is not a rational basis for treating NGRI patients differently than civil committees—run counter to the treatment of equal protection claims in *Jones*. The petitioner had raised both equal protection and due process claims,[163] but the Court decided to answer only the due process question.[164] It reasoned that the equal protection inquiry would be duplicative—if there were reason to deny the due process claim, there would necessarily be reason to treat NGRI patients differently—and therefore proceeded to resolve the case on due process grounds.[165] Passes present the same question: if there is reason to reject the due process claim, there is obviously reason to treat the groups differently. Because it is therefore appropriate to analyze this in terms of due process, *Youngberg* is the most appropriate case for analyzing patients' rights in this context.

B. The Liberty Interests at Stake

As discussed in Part I.C, *Youngberg* is a two-part test. This Section discusses the first prong, which asks whether there is a protected liberty interest at stake. As noted in Part I.A, passes are extremely valuable as treatment. However, to have a valid claim to treatment, that treatment must be minimally adequate to ensure other protected liberty interests.[166] At *Youngberg*'s core is its recognition that patients committed to state hospitals have

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[161] See *DeShaney*, 489 US at 201.

[162] See Levinson, 54 BC L Rev at 544, 547–56 (cited in note 129) (noting that "the growing consensus among federal courts after *DeShaney* is that the involuntary nature of Romeo's admission gave rise to substantive due process protection," but arguing that voluntarily committed patients should in fact receive the same protection).

[163] See *Jones*, 463 US at 361–62.

[164] See id at 362 n 10.

[165] See id.

[166] See *Youngberg*, 457 US at 316–19.

protected interests in both safe conditions and freedom from bodily restraint.[167] In some circumstances, then, there might be a constitutional claim to a pass based solely on freedom from bodily restraint, without having to prove the pass's value as treatment.

In *Youngberg*, the bodily restraints at issue were actual shackles,[168] but the protected interest is much broader, reaching less invasive restraints.[169] In fact, institutionalization itself is a restraint on one's liberty, implicating the Due Process Clause.[170] In *Thomas S. v Morrow*,[171] the Fourth Circuit upheld a court order to place a patient in a community residential program.[172] The plaintiff in this case had alleged that the patient's "hospitalization imposed a degree of restraint on his liberty,"[173] and therefore the decision not to place him in the residential program raised due process concerns.[174] *C.J.*, the Illinois case that struck down a categorical ban on passes, did so because it found that the denial of passes, regardless of what value they have as treatment, infringes on patients' freedom from bodily restraint.[175] This makes sense: the ability to walk around a hospital or leave it under supervision is necessarily a question of how much restraint the state is imposing, so the grant or denial of a pass will always implicate this interest. That is not to say that the denial of a pass always

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[167] See id at 316. The interest in freedom from bodily restraint is so fundamental that it even extends to prisoners. See id ("This interest survives criminal conviction and incarceration."). See also *Wolff v McDonnell*, 418 US 539, 594 (1974) (Douglas dissenting in part and concurring in the result in part) ("Every prisoner's liberty is, of course, circumscribed by the very fact of his confinement, but his interest in the limited liberty left to him is then only the more substantial.").

[168] *Youngberg*, 457 US at 310 & n 4.

[169] See *Reno v Flores*, 507 US 292, 315 (1993) (O'Connor concurring) ("Freedom from bodily restraint means more than freedom from handcuffs, straitjackets, or detention cells.") (quotation marks omitted). See also *Clark v Cohen*, 794 F2d 79, 87 (3d Cir 1986) (finding a violation of a patient's freedom from bodily restraint when the patient was not placed in a community living arrangement, despite her doctors' recommendations). But see *Society for Good Will to Retarded Children, Inc v Cuomo*, 737 F2d 1239, 1247 (2d Cir 1984) ("The 'freedom from restraint' with which *Youngberg* was concerned was Nicholas Romeo's freedom from being unnecessarily shackled. We are unwilling to extend *Youngberg* to apply to situations in which the state has done nothing to place undue physical restraints on individuals.").

[170] See *DeShaney*, 489 US at 200 ("In the substantive due process analysis, it is the State's affirmative act of restraining the individual's freedom to act on his own behalf—through incarceration, institutionalization, or other similar restraint of personal liberty—which is the 'deprivation of liberty' triggering the protections of the Due Process Clause.").

[171] 781 F2d 367 (4th Cir 1986).

[172] See id at 374, 376.

[173] See id at 373.

[174] See id.

[175] See *C.J.*, 771 NE2d at 550–51.

rises to constitutional levels—that depends on the second part of the test, the professional judgment standard, which the next Section will consider.

An NGRI patient seeking a pass might win relief solely on the claim that the denial of the pass is a bodily restraint without a basis in professional judgment. However, there is a second argument as well. Passes could constitute a treatment that is minimally adequate to ensure freedom from bodily restraint, in the sense that patients might not progress toward release otherwise. *Parham v J.R.*[176] held that individuals have "a substantial liberty interest in not being confined unnecessarily for medical treatment."[177] Given this interest, a patient has a limited right to a pass if he would stop progressing toward release without it[178]—either because there is no way to assess a patient's readiness for release or because the treatment plan cannot move forward. Again, not every case in which passes are valuable as treatment will rise to constitutional levels. The answer depends on the second part of the test, the professional judgment standard.

C. The Professional Judgment Standard

The interests *Youngberg* protects are not absolute.[179] As the Court stated, "The question then is not simply whether a liberty interest has been infringed but whether the extent or nature of the restraint or lack of absolute safety is such as to violate due

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[176] 442 US 584 (1979).

[177] Id at 600. See also *Addington v Texas*, 441 US 418, 425 (1979) ("This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.").

[178] See *Sharp v Weston*, 233 F3d 1166, 1172 (9th Cir 2000) ("[T]he Fourteenth Amendment Due Process Clause requires states to provide civilly-committed persons with access to mental health treatment that gives them a realistic opportunity to be cured and released."). Even before *Youngberg*, a number of courts recognized an interest in treatment required to progress towards release. See *Ohlinger v Watson*, 652 F2d 775, 778 (9th Cir 1980) ("Adequate and effective treatment is constitutionally required because, absent treatment, appellants could be held indefinitely as a result of their mental illness."); *Wyatt v Stickney*, 325 F Supp 781, 784 (MD Ala 1971):

> When patients are [ ] committed for treatment purposes they unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition. . . . [A]bsent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense.

(quotation marks omitted).

[179] See *Youngberg*, 457 US at 319–20.

process."[180] To answer that question, one must balance the interests of both the state and the individual.[181] The Court emphasized that medical professionals are better trained and situated to make these decisions than judges are.[182] As a result, the test is extremely deferential: "[L]iability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[183] This professional judgment standard has been difficult for courts to define precisely,[184] but several points are worth emphasizing in applying it to the question of passes: professionals will generally be allowed to choose between multiple alternatives, and they will be expected to balance the individual's liberty interests with relevant state interests.

1. Professionals may choose between available alternatives.

First, it is important to understand that the standard announced in *Youngberg* did not create an absolute affirmative right to whatever treatment a patient wants, so long as it is supported by some professional. As the Second Circuit articulated two years later, "*Youngberg* did not hold that constitutional norms are to be determined by the professional judgment of experts at trial. Rather, it held that constitutional standards are met when the professional who made a decision exercised professional judgment at the time the decision was made."[185] So the professional judgment standard has more to do with defining when courts will not find professionals liable for failing to give treatment, rather than defining the circumstances in which a patient will have an affirmative right to that treatment. In other words, an exercise of professional judgment operates as a shield for the professional, rather than as a sword for the patient.

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[180] Id at 320.

[181] See id at 321–22. See also notes 152–56 and accompanying text.

[182] See *Youngberg*, 457 US at 322–23 ("[T]here certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions."). See also *Bell*, 441 US at 544 ("[Courts] should not second-guess the expert administrators on matters on which they are better informed.") (quotation marks omitted).

[183] *Youngberg*, 457 US at 323.

[184] See Stefan, 102 Yale L J at 644 (cited in note 123) ("[C]ourts have broadened the applicability of the *Youngberg* doctrine with little regard for what professional judgment and the professional judgment standard might actually mean.") (quotation marks omitted).

[185] *Society for Good Will*, 737 F2d at 1248 (quotation marks omitted).

As a result, courts generally do not find liability when a professional makes a choice between several reasonable alternatives.[186] This has a clear basis in *Youngberg*'s statement that "[i]t is not appropriate for the courts to specify which of several professionally acceptable choices should have been made."[187] As an illustration, several patients brought an unsuccessful *Youngberg* claim in the 1990s when they were moved from one treatment facility to a more restrictive one.[188] The court held that the level of care available in the first facility was irrelevant to the question whether the standard of care in the second was sufficient, arguing, in this case, it was "not in a position to enjoin the transfer of patients from one professionally-accepted treatment program to another."[189]

Therefore, if the claim is based on the pass's treatment value, courts should not find that a patient has a constitutional right to the pass if it is merely one of several available treatment alternatives. It should find the hospital staff liable only when the pass is the sole option that is minimally adequate to ensure the protected interest. So if passes, medication, and therapy would each independently be minimally adequate, the staff should not be held liable for choosing the medication or the therapy.

That is a high standard, but some cases will meet it. Recall the clinical necessity of a transitional period in the treatment plans of NGRI patients, and the integral role that passes play in the latter stages of the confinement.[190] As noted earlier, at least one case has acknowledged that passes were the only available option for ensuring protected interests; doctors testified in *Williamson* that the patient "could not achieve further therapeutic gains until such passes were authorized."[191]

2. Professionals should balance liberty interests with the state's interests.

When professionals exercise judgment, what factors must they consider? Courts have often found that decisions based on

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[186] See, for example, *Jackson v Fort Stanton Hospital and Training School*, 964 F2d 980, 992 (10th Cir 1992) ("The choice of alternatives within the universe of constitutionally acceptable choices is to be left to the states and their 'qualified professionals.'").

[187] *Youngberg*, 457 US at 321.

[188] See *Jeffrey v St. Clair*, 933 F Supp 963, 966 (D Hawaii 1996).

[189] Id at 968.

[190] See text accompanying notes 27–35.

[191] *Williamson*, 564 SE2d at 917.

budgetary constraints will not satisfy the professional judgment standard,[192] at least in actions for injunctive relief.[193] However, some of the language in *Youngberg* suggests that there is still a role for nonmedical factors in applying this standard:

> In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance the liberty of the individual and the demands of an organized society. In seeking this balance in other cases, the Court has weighed the individual's interest in liberty against the State's asserted reasons for restraining individual liberty.[194]

Therefore, in defining the scope of the constitutional right at stake, an acceptable exercise of professional judgment should balance the state's interests with those of the individual. Because passes come in a wide variety of forms, different passes might entail different state interests. If some passes involve greater security risks or greater benefits to the individual, professionals should take that into consideration when balancing interests.

In conclusion, an NGRI patient will have a valid *Youngberg* claim against hospital staff when he can show the denial of a pass was not based on professional judgment, which will often be true in cases in which the pass is the only available option for the patient to continue making therapeutic gains. Additionally,

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[192] See, for example, *Baldridge v Clinton*, 674 F Supp 665, 670 (ED Ark 1987) ("[W]hat is appropriate care, treatment and placement must be determined by a qualified professional based upon medical and psychological criteria, not upon what resources are available."); *Lelsz v Kavanagh*, 629 F Supp 1487, 1495 (ND Tex 1986) ("In determining whether community placement is proper, the professional judgment must be based on what is *appropriate* not what is *available*."); *Clark v Cohen*, 613 F Supp 684, 704 (ED Pa 1985) ("[T]he decision has to be one based on medical or psychological criteria and not on exigency, administrative convenience, or other non-medical criteria."); *Thomas S. v Morrow*, 601 F Supp 1055, 1059 (WD NC 1984) ("Lack of funding or of established alternatives is not a factor which may be considered in determining the scope of this constitutional right."). See also Stefan, 102 Yale L J at 696 (cited in note 123) ("The majority of courts have affirmed that professional judgment may not be controlled by availability of resources or budgetary considerations.").

[193] Financial considerations do matter when determining whether damages may be recovered. See *Youngberg*, 457 US at 323 ("In an action for damages against a professional in his individual capacity, however, the professional will not be liable if he was unable to satisfy his normal professional standards because of budgetary constraints; in such a situation, good-faith immunity would bar liability."). See also *Thomas S.*, 781 F2d at 375 ("*Youngberg* points out that lack of funds is an absolute defense to an action for damages brought against a professional in his individual capacity. But the Court did not apply this precept to prospective injunctive relief.") (citation omitted).

[194] *Youngberg*, 457 US at 320 (quotation marks and citation omitted).

Youngberg protects hospital staff from liability when they exercise judgment by reasonably balancing the state's interests against the patient's.

III. UNCONSTITUTIONAL STATE PRACTICES

The previous Part considered situations in which the hospital staff themselves made the decision to deny a pass. Unfortunately, many states have policies that prevent the hospital staff from making the decision to grant or deny the pass in the first place. This Part addresses constitutional challenges to those policies. Given the existence of valid claims challenging decisions made by hospital staff, this Part argues that two common state practices are unconstitutional. Part III.A addresses state policies that make passes categorically unavailable, while Part III.B addresses regimes that give trial courts broad discretion to deny passes in the face of uncontested expert testimony. While Part II.C discussed the narrow circumstances in which a patient can successfully challenge a decision by the hospital not to grant a pass—for instance, if passes are the sole available option—changes to statewide policies would benefit a larger spectrum of patients. Lifting categorical bans and restricting judicial review would ensure that the cases that would be clear under Part II's analysis result in passes, but it would also create more opportunities for passes in harder cases. For instance, doctors could have more room to recommend passes when they are the best, though not the only, option.

A. Categorical Bans

Consider a variation of the hypothetical in Part II. Imagine that all of the facts are the same, and that Tybalt retains the same need for a pass in order for his treatment to progress. This time, though, the hospital staff wants to grant the pass. However, Tybalt lives in a state where passes are categorically unavailable, so the pass will not be granted regardless of what the treatment team recommends. As noted in Part I.B, off-grounds passes are categorically unavailable in a number of states.[195] This Section argues that such policies are unconstitutional under *Youngberg*. To be clear, the Constitution does not compel a state to provide passes to all patients. Rather, it prevents states from denying

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[195] See note 57 and accompanying text.

passes to patients in all cases and instead requires them to make these decisions on an individualized basis.

The central problem discussed in Part II remains: the liberty interests at stake derive from the Constitution itself,[196] so a state legislature cannot infringe on these rights any more than a state-run hospital can.[197] Therefore, for a categorical ban to satisfy the *Youngberg* standard, a court would have to hold that a blanket decision not to provide for passes is itself an exercise of professional judgment. But *Youngberg* strongly suggests that the Fourteenth Amendment requires an individualized exercise of professional judgment, rather than a general exercise at the policymaking stage, to shield a state actor from liability. When articulating the appropriate standard, the Court repeatedly directed its language toward the treatment of individuals, not populations: "[I]t is necessary to balance the liberty of the *individual* and the demands of an organized society";[198] "[i]n seeking this balance in other cases, the Court has weighed the *individual's* interest in liberty against the State's asserted reasons for restraining *individual* liberty";[199] "we weighed the liberty interest of the *individual* against the legitimate interests of the State."[200] This language suggests that patients are entitled to an individualized exercise of professional judgment, rather than a broad judgment about what all patients need.[201]

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196 See *Youngberg*, 457 US at 318, quoting *Romeo v Youngberg*, 644 F2d 147, 176 (3d Cir 1980) (Seitz concurring) ("[T]he plaintiff has a *constitutional* right to minimally adequate care and treatment.") (emphasis added). See also *Baldridge v Clinton*, 674 F Supp 665, 670 (ED Ark 1987) ("The obligation of the defendants to eliminate existing unconstitutionalities cannot depend upon what the Governor or the Legislature may do. Rather, if [a state] is going to operate a state hospital system, it is going to have to be one countenanced by the constitution of the United States."); *Lelsz v Kavanagh*, 629 F Supp 1487, 1494–95 (ND Tex 1986) (finding that "[i]f professional judgment dictates that community placement is necessary in the best interest of the individual, then the individual has a constitutional right to such placement, and continued confinement in the institution constitutes undue restraint").

197 See US Const Art VI, cl 2 ("This Constitution . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.").

198 *Youngberg*, 457 US at 320 (quotation marks omitted and emphasis added).

199 Id (emphases added).

200 Id at 321 (emphasis added).

201 See James A. McClure IV, Note, *Psychiatric Boarding in New Hampshire: Violation of a Statutory Right to Treatment*, 14 U NH L Rev 197, 206 (2015) ("The consensus [regarding *Youngberg*] is that the right to treatment generally entails a humane environment, adequate staffing, and individualized treatment plans."); *Case Law Developments*, 30 Mental & Physical Disability L Rptr 678, 681 (2006) (discussing *Youngberg* and the "individualized nature of all substantive due process inquiries"); Eric S. Janus and Wayne A. Logan, *Substantive Due Process and the Involuntary Confinement of Sexually Violent*

Youngberg's language comports with a long history of Fourteenth Amendment decisions. The Court has clearly stated that "[t]he rights created by the first section of the Fourteenth Amendment are, by its terms, guaranteed to the individual,"[202] which draws on the Amendment's repeated use of the phrase "any person."[203] This principle is particularly prominent in the Court's equal protection jurisprudence. For instance, in *McCabe v Atchison, Topeka & Santa Fe Railway Co*,[204] the Court discussed an Oklahoma statute that allowed railways to provide sleeping and dining cars to one race but not another.[205] The defendants argued that the statute was reasonable because the legislature had determined that there was no market for such accommodations among African Americans.[206] The Court soundly rejected the idea that a state legislature can violate the rights of an individual so long as its general policy is based on reasonable findings: The argument "makes the constitutional right depend upon the number of persons who may be discriminated against, whereas the essence of the constitutional right is that it is a personal one. . . . It is the individual who is entitled to the equal protection of the laws."[207] The Court has applied this principle repeatedly in segregation cases.[208] Analogously, legislatures cannot broadly determine that, in their professional judgment, no individuals will need passes. It is an individual right, and patients are entitled to individualized assessments, a conclusion supported by *Youngberg*'s individualized language.

Predators, 35 Conn L Rev 319, 359 (2003) ("[The right to treatment] is an individualized right that is predicated on efficacy."); Sandra Anderson Garcia and Holly Villareal Steele, *Mentally Retarded Offenders in the Criminal Justice and Mental Retardation Services Systems in Florida: Philosophical, Placement, and Treatment Issues*, 41 Ark L Rev 809, 838 n 150 (1988) (invoking *Youngberg* to support the proposition that "[m]inimum conditions for habilitation include a humane psychological and physical environment, qualified staff in numbers sufficient to administer adequate treatment, and individualized treatment plans").

[202] *Shelley v Kraemer*, 334 US 1, 22 (1948).

[203] US Const Amend XIV, § 1 ("[N]or shall any State deprive *any person* of life, liberty, or property, without due process of law; nor deny to *any person* within its jurisdiction the equal protection of the laws.") (emphases added).

[204] 235 US 151 (1914).

[205] See id at 161.

[206] See id.

[207] Id at 161–62.

[208] See, for example, *Shelley*, 334 US at 22 ("The rights established are personal rights. . . . Equal protection of the laws is not achieved through indiscriminate imposition of inequalities."); *Gaines v Canada*, 305 US 337, 351 (1938) ("It was as an individual that he was entitled to the equal protection of the laws, and the State was bound to furnish him within its borders facilities for legal education . . . whether or not other negroes sought the same opportunity.").

A requirement for individualized assessments is still a workable solution that leaves ample room for broad legislative policymaking in appropriate areas. Possible legislation in the NGRI context can be divided into three categories. The first category includes legislation that does not implicate any of *Youngberg*'s protected interests. Because *Youngberg* does not apply, the state has free rein to legislate broad, categorical rules. This allows the state to regulate most treatment options without limitation. *Youngberg* created a right to treatment when it is necessary to ensure protected liberty interests, but not a right to treatment in and of itself.[209] As a result, if a treatment merely improves a patient's condition, without protecting any liberty interest, it falls in this first category.[210]

The second category includes legislation that might affect protected interests, but for which there is a compelling justification to create categorical rules. *Youngberg* does require individualized assessment, but, even under the strictest scrutiny, some constitutional rights must occasionally yield when a law is narrowly tailored to achieve a compelling state interest.[211] This category may be small,[212] but there are some instances in the NGRI context in which it would be functionally impossible to make

[209] See *Youngberg*, 457 US at 317–19. See also *Clark v Cohen*, 794 F2d 79, 95 (3d Cir 1986) ("*Youngberg* dealt exclusively with training related to physical restraints; the Court expressly stated that it was neither considering nor ruling on any broader right to habilitation."). In addition to declining to answer whether there is a per se right to treatment, *Youngberg* left unresolved the question whether there is a right to treatment that is necessary to prevent a patient's condition from declining. See *Youngberg*, 457 US at 327–29 (Blackmun concurring) (arguing that the Fourteenth Amendment guarantees a right to treatment that would prevent a patient's condition from deteriorating); *P.C. v McLaughlin*, 913 F2d 1033, 1042 (2d Cir 1990) (relying on Justice Harry Blackmun's standard to deny a right to the least restrictive environment); *Society for Good Will to Retarded Children, Inc v Cuomo*, 737 F2d 1239, 1250 (2d Cir 1984) (agreeing with Blackmun's standard).

[210] See *Society for Good Will*, 737 F2d at 1250 ("Where the state does not provide treatment designed to improve a mentally retarded individual's condition, it deprives the individual of nothing guaranteed by the Constitution; it simply fails to grant a benefit of optimal treatment that it is under no constitutional obligation to grant.").

[211] See, for example, *Adarand Constructors, Inc v Pena*, 515 US 200, 237 (1995) ("When race-based action is necessary to further a compelling interest, such action is within constitutional constraints if is satisfies the 'narrow tailoring' test this Court has set out in previous cases."); *National Association for the Advancement of Colored People v Button*, 371 US 415, 438 (1963) ("The decisions of this Court have consistently held that only a compelling state interest in the regulation of a subject within the State's constitutional power to regulate can justify limiting First Amendment freedoms.").

[212] See Gerald Gunther, *The Supreme Court, 1971 Term—Foreword: In Search of Evolving Doctrine on a Changing Court; A Model for a Newer Equal Protection*, 86 Harv L Rev 1, 8 (1972) (describing strict scrutiny as "'strict' in theory and fatal in fact").

unique assessments for each individual. For instance, some decisions regarding infrastructure and facilities must be made before the state knows anything about the specific individuals. In order for the mental health system to function, the state will have to make uniform decisions in these areas. If the result is constitutionally insufficient in any given case, an individual will always be able to challenge the conditions in an action against the hospital after the fact.[213]

This Comment's proposal affects the state's ability to legislate in a categorical manner only in a third category: when protected interests are at stake and when there is no compelling justification for categorical rules. In this category, *Youngberg* requires individualized assessments. Part II established that protected interests are at stake when passes are denied, and that some patients will have winning *Youngberg* claims. And, in contrast to the second category, it is practical to provide individualized assessments.[214] Absent such a justification for categorical rules, the Due Process Clause requires an exercise of professional judgment at the individual level. Again, this does not mean that all patients get passes or that patients will get passes whenever their doctors recommend them. Professionals may still deny them, subject to the limitations in Part II, and legislatures may still give judges discretion to reverse professionals' decisions, subject to the limitations in Part III.B. Furthermore, the state could regulate within this category in any way that does not infringe on any patient's constitutional rights. For instance, Part II.C discussed the narrow circumstances in which *Youngberg* would require that a professional grant a treatment. So long as the state allows for individualized assessments, it could limit the professional's discretion to grant passes to those narrow circumstances. This follows from the principle that *Youngberg* does not grant patients an affirmative right to whatever treatment their doctors recommend.

In one case, *C.J.*, a court adopted the view that categorically banning passes violates *Youngberg*. At the time of that decision, no NGRI patients at the facility were able to obtain unsupervised

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213 See, for example, *Jeffrey v St. Clair*, 933 F Supp 963, 966 (D Hawaii 1996) (describing a suit under *Youngberg* in which plaintiffs challenged the constitutionality of the conditions in a new facility).

214 As evidence, Minnesota has, for three decades, placed the decision to grant passes entirely in the hands of the hospitals, without any judicial oversight. See *Levine*, 345 NW2d at 222–23.

on-grounds passes.[215] The court found that the denial of passes directly restricted the liberty interest in freedom from bodily restraint.[216] Turning to the second prong of the *Youngberg* test, the court found that the policy, because it was categorical, did not use professional judgment to balance the state's and the patients' interests.[217] The court upheld an injunction that required the state to "exercise professional judgment, based on accepted standards and practices, in considering whether to recommend any NGRI patient for an unsupervised on-grounds pass."[218]

States such as Texas and South Carolina might argue that there is, in fact, a compelling justification for a categorical ban on some kinds of passes: public safety. Their laws are different than those considered in *C.J.* in that they categorically ban *off*-grounds passes, as opposed to *on*-grounds passes. Those states might allege that the security risk is higher and that the risk is a compelling reason for a categorical ban.

As discussed in Part II.C.2, security may be a good justification to deny some passes. But, for the purposes of this three-part classification, the question is not whether there is a compelling reason to deny a pass, but whether there is a compelling reason to deny *all* passes by creating categorical rules at the expense of the individualized assessments *Youngberg* requires. Because security can be addressed on a case-by-case basis, there is no pressing need for broad rules. It is plausible that, given the risks and benefits, professionals will choose to grant off-grounds passes in far fewer cases than they grant on-grounds passes, or to grant few of either. While states might have legitimate concerns about these risks, they are fortunately already built into the *Youngberg* analysis.

For the sake of argument, imagine that *Youngberg* did not require an individualized exercise of professional judgment. Even then, one should still be skeptical about whether the state is equipped to make these decisions in the first place. *Youngberg* emphasizes that professional judgment is the appropriate standard because there "is no reason to think judges or juries are better

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[215] See *C.J.*, 771 NE2d at 550.
[216] See id at 551.
[217] See id at 553.
[218] Id at 555.

qualified than appropriate professionals in making such decisions."[219] A legislature may be better at fact finding than judges,[220] but there is still no reason to think they are better qualified than medical professionals to make medical decisions. Additionally, doctors may be less likely than state legislatures to have punitive motivations. State legislatures are representatives of the people, and the people are generally hostile toward insanity acquittees.[221] Remember that *Laney* categorically banned passes on the grounds that NGRI patients, unlike civil committees, are governed by the Texas Code of Criminal Procedure, not the Texas Mental Health Code.[222] While that alone does not demonstrate a punitive motivation,[223] one might be skeptical of a decision to deny passes to all NGRI patients, who have not been convicted of a criminal offense, on the grounds that they are governed by the criminal code and are therefore not entitled to the same rights as those governed by the mental health code.[224]

On the other hand, it is possible that medical professionals are less equipped than legislatures to balance state interests such as security, or, alternatively, that they have fewer incentives to consider such interests. If the state lacks the ability to ban passes categorically, and if patients are always entitled to an individualized assessment by a medical professional, will security considerations fall to the wayside as doctors prescribe passes to patients

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219 *Youngberg*, 457 US at 323.

220 Christopher P. Banks, *The Constitutional Politics of Interpreting Section 5 of the Fourteenth Amendment*, 36 Akron L Rev 425, 469 (2003) ("[T]he legislature has the institutional competence to study complex problems of policy through the open deliberative process of many (instead of the opinion writing proclivities of the few in closed chambers)."). But see John O. McGinnis and Charles W. Mulaney, *Judging Facts Like Law*, 25 Const Commen 69, 71 (2008) ("[T]he judiciary would appear to be a superior fact-finder both because of its institutional capacity and because of its relative lack of bias.").

221 See notes 6–8 and accompanying text.

222 See *Laney*, 223 SW3d at 670.

223 Unless Texas explicitly admitted to a punitive purpose, the due process inquiry would center on whether there is an alternative purpose that is legitimate. See *United States v Salerno*, 481 US 739, 747 (1987), quoting *Schall v Martin*, 467 US 253, 269 (1984) ("Unless Congress expressly intended to impose punitive restrictions, the punitive/regulatory distinction turns on 'whether an alternative purpose to which [the restriction] may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned [to it].'") (brackets in original); *Bell*, 441 US at 538 (holding that, "[a]bsent a showing of an expressed intent to punish on the part of detention facility officials," a court must ask whether there is a rational alternative purpose).

224 There is some precedent for using a statute's location within a code to determine its meaning. See *Yates v United States*, 135 S Ct 1074, 1083–84 (2015) (Ginsburg) (plurality) (relying on a statute's location in the United States Code in interpreting the term "tangible object"). But see id at 1094–95 (Kagan dissenting) (arguing that a statute's location within the code is not a valid canon of interpretation).

at will? The answer is no, for two reasons. First, even if legislatures cannot constitutionally ban passes, there is still ample room for judicial review, which is discussed at length in Part III.B. For now, suffice it to say that there will be cases in which a professional recommends a pass but the judge is still able to deny it. Second, medical professionals have a number of powerful incentives to thoroughly consider security interests when making decisions. Courts routinely hold medical professionals liable for negligence as a result of treatment-related decisions, including cases in which patients escape and cause harm.[225] Further, professionals are generally both aware of and responsive to this risk of liability. In the aftermath of *Tarasoff v Regents of the University of California*,[226] which exposed therapists to liability for the failure to warn others about the dangers posed by a patient,[227] one study found that doctors in California were generally aware of the decision, feared liability, and adjusted their behavior in response.[228] Holding professionals liable in such circumstances may or may not be appropriate,[229] but professionals are certainly incentivized to consider security interests when granting passes.

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225 See, for example, *Estate of Conners v O'Connor*, 846 F2d 1205, 1208–09 (9th Cir 1988) (finding that hospital administrators could be held liable for damages resulting from gross negligence in the granting of passes); *White v United States*, 780 F2d 97, 103 (DC Cir 1986) (finding that a hospital has a duty to prevent the escape of dangerous patients and that the victim of a stabbing during such an escape could recover damages); *Tarasoff v Regents of the University of California*, 551 P2d 334, 353 (Cal 1976) (finding therapists potentially liable when, upon learning that a client posed a serious threat of danger to another, the therapists did not inform the potential victim). See also Restatement (Second) of Torts § 319 (1965) ("One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm."). But see *People v Roush*, 462 NE2d 468, 472 (Ill 1984) (reversing the criminal conviction of a hospital administrator for the escape of a dangerous patient).

226 551 P2d 334 (Cal 1976).

227 See id at 353.

228 See D.L. Rosenhan, et al, *Warning Third Parties: The Ripple Effects of* Tarasoff, 24 Pac L J 1165, 1202, 1209, 1217 (1993) (finding that 84 percent of psychologists and psychiatrists had heard of the opinion, that 39 percent had warned potential victims of danger since the decision, and that 46 percent had decided not to counsel dangerous patients, often because of the risk of *Tarasoff* liability); Thomas L. Hafemeister, Leah G. McLaughlin, and Jessica Smith, *Parity at a Price: The Emerging Professional Liability of Mental Health Providers*, 50 San Diego L Rev 29, 79–80 (2013) (noting that "encountering a *Tarasoff*-like scenario has tended to strike fear in the hearts of mental health providers," and that "[i]t has even been asserted that the *Tarasoff* duty has now become a central aspect of patient care") (quotation marks and brackets omitted).

229 See Rosenhan, et al, 24 Pac L J at 1185–94 (cited in note 228) (discussing a number of criticisms of the *Tarasoff* decision, including the difficulty of predicting dangerousness, the reality that professionals "are more likely to label healthy patients as dangerous than

B. Broad Judicial Discretion

The previous Section discussed policies that categorically take decisionmaking power away from professionals. This Section considers cases in which the doctors exercise their professional judgment and decide to grant passes, but the courts have broad discretion to deny them. Consider a third variation of the Tybalt hypothetical. This time, the underlying offense was violent. The judge decides to deny the pass, not based on any expert testimony regarding the risks of the pass, but because of the violent nature of the original offense. Again, Tybalt should be able to press a valid *Youngberg* claim.

In states that allow passes, the decision whether to grant passes is often left to the court that committed the patient, regardless of whether the hospital recommends it.[230] For instance, in *Williamson*, the patient's treatment team testified that granting on-grounds passes was so important that the patient's condition would not improve without them.[231] Despite this, the trial court rejected the advice of the staff and denied the on-grounds pass, citing the possibility the patient would escape.[232] The appellate court affirmed that decision, finding that "it is solely within the trial court's determination whether respondent is entitled to unsupervised passes."[233]

It is important to remember that the professional judgment standard generally operates as a shield protecting professionals from liability, not a sword giving patients an affirmative right to whatever treatment their doctors recommend.[234] Therefore, *Youngberg* applies less directly to cases in which the professional recommends the pass. For that reason, this Comment does not argue that the court must, in order to deny a pass, show that the professional's decision to grant it was "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[235] That test applies in the

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to label dangerous patients as healthy," and the barriers such a rule places on effective treatment).

230 See, for example, *People v Bethke*, 6 NE3d 348, 352 (Ill App 2014) ("The clear language of [Illinois's NGRI statute] giv[es] the trial court wide discretion in granting and tailoring passes.").

231 *Williamson*, 564 SE2d at 917.

232 See id.

233 Id at 919.

234 See Part II.C.1.

235 *Youngberg*, 457 US at 323.

context of finding a professional liable, but should not apply in the context of reviewing his decision to grant treatment.[236]

Nonetheless, the Due Process Clause should place appropriate limitations on courts' discretion. The argument flows from two premises. First, *Youngberg* reasoned that courts are not the best situated to assess a patient's medical needs.[237] Second, the Court has held that *someone* must make that assessment.[238] It follows that when a court denies a pass, it must first ensure that someone who is qualified to make that judgment supports its decision.

If a patient's doctors recommend a pass, the court may still deny the pass if it can point to some contrary professional opinion—for instance, expert testimony on behalf of the state—because such a decision would still be rooted in some exercise of professional judgment. If no such contrary opinion exists, the court should presume under *Youngberg* that the treatment team's decision is a valid exercise of professional judgment.[239] If the court were to reject the pass, protected interests would be infringed without the decision being based on professional judgment.[240] While the circumstances in *Youngberg* were different, this is consistent with the principle that a "decision, if made by a professional, is presumptively valid."[241]

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236 The *Jones* Court clearly contemplated a continuing role for courts in the NGRI context. See *Jones*, 463 US at 363 n 11 (noting that there is one important difference in the release standards for civil committees and NGRI patients, in that NGRI patients generally must get court approval).

237 See *Youngberg*, 457 US at 322–23 ("[I]nterference by the federal judiciary with the internal operations of these institutions should be minimized. [ ] [T]here certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions.").

238 See id at 321 ("[T]he Constitution [ ] requires that the courts make certain that professional judgment in fact was exercised."). See also *Allison v Snyder*, 332 F3d 1076, 1080 (7th Cir 2003) ("*Youngberg* holds that, under the due process clause, detainees are entitled to non-punitive programs designed using the exercise of professional judgment."); *Lewis*, 523 US at 863 (Scalia concurring in the judgment) ("[D]eliberate indifference to the medical needs of pretrial detainees, or of involuntarily committed mental patients, may violate substantive due process.") (quotation marks and citations omitted).

239 See *Youngberg*, 457 US at 323 (calling a professional's decision "presumptively valid"). See also *In re Lilly*, 804 NW2d 489, 502 (Wis App 2011) ("Because of the presumptive validity of the medical opinions that support the necessity for continued forced feeding, the [ ] court must accept them unless there is evidence that they are a substantial departure from accepted medical judgment.").

240 This proposal requires only that the state provide enough evidence to ensure that the ultimate decision, if in the state's favor, rests on an acceptable exercise of professional judgment. Of course, the court can also deny the pass if the state meets the more difficult "substantial departure" test.

241 *Youngberg*, 457 US at 323 (citation omitted).

The question remains whether the court itself can exercise professional judgment in the absence of evidence provided by the state, and the answer is no. *Youngberg* strove to take medical decisions out of the hands of judges. The Court believed that "interference by the federal judiciary with the internal operations of these institutions should be minimized."[242] It then warned, "Courts should not second-guess the expert administrators on matters on which they are better informed."[243] This is in harmony with other areas of law in which courts must often defer to more knowledgeable actors. For instance, administrative agencies are more specialized within their respective spheres, so courts must, within reason, defer to their statutory interpretations.[244] Congress is better at making complex factual determinations, among other things, so courts will, in some contexts, defer to its legislation when the legislation has rational basis.[245] When the Court determines that the judiciary is at a comparative disadvantage, as it did in *Youngberg*, it often requires that judges cede some level of discretion to more specialized actors.

The arguments in this Section are ultimately a variation of the arguments made in Part II and Part III.A. *Youngberg* announces the circumstances under which a state actor can be held liable for denying treatment that would be "a substantial departure from accepted professional judgment."[246] In *Youngberg* itself, and in Part II, the state actor was the hospital. In the preceding Section, the state actor was the legislature. Here, the courts are making the decision to deny passes, and similar standards ought

[242] Id at 322.

[243] Id at 323 (quotation marks omitted), quoting *Bell*, 441 US at 544. See also *West v Macht*, 614 NW2d 34, 40 (Wis App 2000) ("In light of the medical and scientific uncertainties involved in the mental health setting, courts show deference to mental health professionals' judgment because they have the necessary education and training to make therapeutic decisions.").

[244] See *Chevron U.S.A. Inc v Natural Resources Defense Council, Inc*, 467 US 837, 844 (1984) ("We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer."); *Skidmore v Swift & Co*, 323 US 134, 139–40 (1944) (choosing to defer to an agency's interpretation because of its "specialized experience," even though the Court was not bound to defer).

[245] See *Katzenbach v McClung*, 379 US 294, 303–04 (1964) ("[W]here we find that the legislators, in light of the facts and testimony before them, have a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce, our investigation is at an end."); *Pegram v Herdrich*, 530 US 211, 221 (2000) ("[S]uch complicated factfinding and such a debatable social judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value.").

[246] *Youngberg*, 457 US at 323.

to apply.[247] To a patient who is wrongfully denied a pass by the state, it does not matter whether the source of that denial is a judge, a state senator, or a hospital administrator. All that matters is that the state, which has an affirmative duty to care for him, is the source of the wrong.

Consider what this standard would look like when applied to several cases. First, take *Williamson*, the North Carolina case in which the patient's treatment team testified that the patient would not be able to advance in his treatment without passes.[248] The trial court reasoned that, despite this recommendation, granting the pass was unwise because of the "potential danger to the public . . . should the [patient] be allowed unsupervised passes and escape from [the hospital]."[249] Under the proposed standard, the court could make that decision so long as it was based on a qualified professional judgment about the hospital's security needs in that situation, rather than the trial court's general uneasiness about escapes. That is plausible, as the hospital lacked fences and other patients had escaped in the past,[250] but the court would have to depend on a qualified professional's assessment.

The treatment team in *People v Bethke*[251] also recommended passes.[252] Despite the team's testimony, the trial court denied the passes, largely on the grounds that there was an additional risk factor given the violent nature of the underlying offense.[253] The Illinois appellate court found that the trial court must "justify its ruling by referencing facts related to defendant's current mental health status as opposed to reflexive reference to the admittedly horrific underlying crime," and that the trial court "cannot rely on [the underlying offense] alone; it must also consider the individual's treatment history and current mental status in determining whether to grant or deny passes that serve as a step toward possibly renewing the patient's liberty."[254]

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[247] See *Palmore v Sidoti*, 466 US 429, 432 n 1 (1984), citing generally *Shelley*, 334 US 1 ("The actions of state courts and judicial officers in their official capacity have long been held to be state action governed by the Fourteenth Amendment.").

[248] See *Williamson*, 564 SE2d at 917.

[249] Id (ellipsis in original).

[250] Id.

[251] 6 NE3d 348 (Ill App 2014).

[252] See id at 349.

[253] See id at 349, 351 (relating the facts of the underlying offense, which included murder, decapitation, and the display of a severed head in a deli case as a result of command hallucinations and years of untreated schizophrenia).

[254] Id at 353.

The appellate court's view is closer to the standard this Comment proposes. It restricts the reasons a trial court is allowed to rely on to deny a pass, and it forces the trial court to consider the patient's current status and treatment history. However, in requiring the trial court to "referenc[e] facts related to [the] defendant's current mental health status,"[255] Illinois courts still have "wide discretion in granting and tailoring passes."[256] The proper standard would instead require that the trial court defer to some professional's assessment of those facts.

Bethke is a good illustration of why this standard is a good policy in addition to being a reasonable extension of *Youngberg*. The original trial court decision denied the passes recommended by the hospital because of the gruesome nature of the crime. Under *Bell*, Bethke's confinement must be nonpunitive because he was acquitted.[257] Denying him privileges and freedoms on the basis of the original crime blurs the line between acceptable and unacceptable purposes of confinement. Of course, the state can deny a pass if it relies on a professional judgment that the individual will pose a danger to others, but it cannot deny a pass to punish the individual for the underlying offense. The benefit of this Comment's proposal is that it forces courts to rely on professional judgment and thus ensures that they will be able to deny passes only in cases in which an expert has testified that there is a legitimate, nonpunitive purpose for doing so. And it achieves this result without imposing an unreasonable or unworkable burden on the state. So long as the state can provide expert testimony, the judge still retains broad discretion to deny the pass. Furthermore, the state will have that small burden only when the hospital staff recommends the pass in the first place, and, as discussed in Part III.A, there are adequate incentives for the hospital to account for the state's interests.[258]

CONCLUSION

Youngberg establishes that patients have valid constitutional claims when the state makes decisions affecting their protected liberty interests without exercising professional judgment. Given that passes implicate those interests, this Comment argues that there are some limitations on the state's ability to deny them.

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[255] *Bethke*, 6 NE3d at 353.

[256] Id at 352.

[257] See notes 24–25 and accompanying text.

[258] See notes 225–30 and accompanying text.

States can regulate passes, but not so heavily that no patients, including those with constitutionally protected therapeutic needs, will ever receive consideration. Judges also have a role, but it is not so broad as to nullify the professional judgment standard. The solution advocated here strikes a fair balance between the constitutional rights of the individual and the state's need to craft meaningful policy. At little cost to society, it greatly benefits a vulnerable, misunderstood population.