the criminal trial. Furthermore, it has been argued that the abrogation of privilege in this case would run counter to child-protection objectives because it could discourage individuals from speaking openly to their psychiatrists, thus preventing victims from being warned of potential danger (Amicus Curiae Brief for New York State Psychiatric Association, December 9, 2013). Finally, in *Rivera*, the court found that criminal proceedings require higher evidentiary standards than child-protection proceedings because criminal proceedings may result in the deprivation of liberty.

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Involuntary Outpatient Treatment

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Involuntary Outpatient Treatment Order Requires a Finding That the Individual Will Deteriorate and Become Dangerous to Self or Others in the Near Future

In *In re T.S.S.*, 121 A.3d 1184 (Vt.), the Vermont Supreme Court reversed the Superior Court, Family Division's decision continuing the order of nonhospitalization (ONH) compelling T.S.S. to undergo outpatient mental health treatment.

Facts of the Case

T.S.S. was a 34-year-old man whose psychotic symptoms first appeared in 1999 when he was 18 years old. Among them was a belief that a transmitter had been implanted in his arm. In response to this delusion, he harmed himself and required admission to the Vermont State Hospital. He was released in 2000 with an ONH that compelled him to participate with involuntary outpatient mental health treatment.

In 2002, the state's reapplication for an ONH was denied. In 2003, T.S.S. exhibited several delusions including that his food was poisoned; he appeared emaciated and had fits of rage. After an emergency evaluation, he was hospitalized at Rutland Regional Medical Center (RRMC). He was released in November 2003 on an ONH that was renewed in September 2004. In 2008, RRMC did not file for a renewal of the ONH for him. From late 2008 to 2011, he did not receive mental health treatment. He was arrested in August 2011 on the misdemeanor charge of unlawful mischief causing damage greater than $250 for breaking windows. In March 2012, he was found incompetent to stand trial. In August 2012, he was placed on an ONH and his charge was dismissed. In June 2013, he did not contest the commissioner's filing for renewal of the ONH.

In February 2014, the commissioner filed for another renewal of T.S.S.'s ONH. T.S.S. objected. At the hearing, his psychiatrist told the court that T.S.S.:

> . . . has demonstrated a clear pattern that for a short period of time, despite denying that he has a mental illness, he, on orders of the non-hospitalization, will take medications and improve significantly. But when he is off the order of non-hospitalization he quickly goes off medication and deteriorates [*T.S.S.*, p 1185].

The psychiatrist also testified that, "I cannot predict the timing because there was a four-year . . . [or] three-year period that he was off [court] orders" (*T.S.S.*, p 1186). The psychiatrist went on to report that T.S.S. did not like being on an ONH or the side effects of some of his medications.

In May 2014, the court granted the ONH. It found that without his current treatment, T.S.S. would "eventually . . . become a person in need of treatment. It is the nature of his particular mental illness that such predictions are very difficult. However, he will reach that point" (*T.S.S.*, p 1187). T.S.S. appealed, arguing that the court misinterpreted the Vermont statute Vt. Stat. Ann. tit. § 7101(16) (2013) regarding ONH by not requiring a showing that the person is likely to become a danger to self or others in the near future without treatment. He further argued that the court's ruling was not consistent with the evidence.

Ruling and Reasoning

The Vermont Supreme Court unanimously vacated the lower court's ONH. The court found that the Department of Mental Health may not be granted an ONH for a psychiatric patient unless it proves that the patient, without treatment, is likely to become dangerous in the near future.

The court found that it is not enough to show that without treatment the person's condition may deteriorate. The state must also show that the deterioration is likely to lead to the person's becoming a danger to self or others. The court acknowledged the need to balance "the constitutional rights of individuals with the state's valid interest in protecting individuals and the public" (*T.S.S.*, p 1193). The court noted that citizens who do not pose an imminent danger to themselves or others have a right to autonomy, including the right to make decisions about their psychiatric treatment. The court also recognized the state's right to intervene before the individual actually becomes dangerous. The state must also be vigilant about "a revolving door syndrome that includes recurring commitments, medication, rejection of medication, and crisis intervention" (*T.S.S.*, p 1193). The court cautioned that finding that "a person could or will 'eventually' become a person in need of treatment [a danger to oneself or others] is, standing alone, a thin reed upon which to predicate a continued intrusion upon fundamental liberty" (*T.S.S.*, p 1193).

In this case, T.S.S.'s pattern over 15 years did not support a continued ONH. The last evidence that he was a danger to himself dated back to 2003. T.S.S. did not receive treatment between 2008 and 2012. Given his history, the court concluded that T.S.S. was not likely in the near future, as a result of mental illness, to deteriorate to the point of becoming a person in need of treatment (i.e., a danger to himself or others).

Discussion

Outpatient civil commitment is intended for adults with mental illness who are unlikely to be able to live safely in the community without supervision and treatment. It focuses on those individuals deemed unlikely to participate voluntarily in recommended behavioral health treatment. Goals of outpatient civil commitment programs are to improve access and adherence to intensive mental health programs to prevent relapse, repeated hospitalizations, justice involvement, violence, property damage, and suicide.

A surge of discharges from state psychiatric facilities in the 1970s followed the rise of the community mental health lobby, along with more effective medications, financial pressures, and the doctrine of the least restrictive alternative to inpatient civil commitment (Miller RD: The least restrictive environment: hidden agendas and meanings. Community Ment Health J 18:46–55, 1982). Despite expectations, many individuals did not voluntarily access outpatient mental health services once released. Consequently, while the population of state inpatient wards declined, hospital readmission rates increased and often became the sole, brief episodes of mental health care that such individuals would receive.

Legal authorities and clinical providers searched for ways to promote adherence to treatment for those released, to avoid decompensation and hospital recidivism. Over time, the courts authorized the legal commitment process and, in most states, determined the location of care. Dangerousness replaced the need for treatment as a key standard for commitment, and compelling an individual to undergo outpatient treatment proved difficult because those posing imminent risk of danger typically required psychiatric hospitalization.

In time, unofficial methods of outpatient commitment, such as community passes, were used to sustain institutional control while testing a patient's ability to tolerate and adjust to living outside the hospital. Judges implemented conditional-release models, similar to those in criminal law, allowing discharge of those patients who had been unable to demonstrate safe community tenure without ongoing medication and structure. In addition, a plea-bargaining model arose within the legal system supporting involuntary outpatient commitment as a compromise between ongoing hospitalization and the individual's wishes for unconditional discharge to the community. Initial involuntary commitment, applicable without the need of the patient's having first been hospitalized, was in the commitment statutes of several states. It was not until the late 1980s that it became more commonplace, with the goal of avoiding eventual and preventable inpatient admissions.

Patients who benefit from involuntary outpatient treatment have serious mental disorders. Of concern is the appropriateness and effectiveness of involuntary civil commitment to outpatient treatment. Studies vary, but many have indicated that involuntary community treatment is no more effective than the same services offered on a voluntary basis. Two studies compared committed and voluntary outpatients and determined that there were no statistically significant differences between groups, but that both exhibited significantly reduced hospitalizations. The result within an 11-month period was attributed to more intensive services available in the study (Policy

Research Associates, Inc: Final report, research study of the New York City involuntary outpatient commitment pilot program. New York, 1998). A longer term analysis of the same study demonstrated that committed patients had reduced hospitalizations and stayed significantly fewer days than inpatients (Telson H, Glickstein R, Trujillo M: Report of the Bellevue Hospital Center outpatient commitment pilot program. New York: Department of Psychiatry, 1999). Moreover, when involuntary outpatient treatment statutes are leveraged, successful outcomes hinge on the quality and accessibility of community services, along with oversight and the willingness of the court to enforce such legal mandates (Kisley S, Campbell L: Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Schizophr Bull 41: 542–3, 2015).

Critics of involuntary outpatient treatment warn of the risk for abuse of broader commitment criteria and the challenges of program implementation. Additional criticism focuses on insufficient community and judicial resources, resistance from treatment providers and community residents, limited government funding and the challenge of effective enforcement of involuntary outpatient treatment (Schwartz SL, Costanzo CE: Compelling treatment in the community: distorted doctrines and violated values. Loy. L.A. L Rev 20:1329–429, 1987). The competence and accessibility of outpatient mental health services can vary widely. The effectiveness, benefits, and potential consequences of outpatient commitment should be carefully considered in each case.

Compelling T.S.S. to participate with the ONH required a showing that his condition would deteriorate and, as a result, he would be dangerous to himself or others in the near future. The state did not meet its burden.

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Serious Mental Illness and the Death Penalty

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Defendant with Mental Illness Successfully Appealed his Death Sentence for Murder Conviction on Grounds That It Was a Disproportionate Penalty

In *Delgado v. State*, 162 So. 3d 971 (Fla. 2015), the Supreme Court of Florida considered whether the trial judge used the correct standard relating to jury override and whether the death penalty in this case was disproportionate. The court found that the trial judge did apply the correct standard relating to jury override, and that the death penalty was a disproportionate punishment. It vacated the sentence and remanded the case to the trial court for imposition of a life sentence.

Facts of the Case

On August 19, 2009, Humberto Delgado, Jr., went to the storage facility where he had slept the previous night and transferred some of his belongings into a backpack, including a laptop computer and four firearms. Despite his chronic knee pain, Mr. Delgado decided to walk, using a cane, the roughly 17 miles to a veterans' hospital in Tampa to seek assistance and shelter.

Approximately eight hours later, police Corporal Michael Roberts observed Mr. Delgado pushing a shopping cart along the road in an area known for crimes committed by homeless individuals, particularly shopping cart theft. By then, Mr. Delgado had walked approximately 15 miles in hot and rainy weather. At 9:58 p.m., Corporal Roberts informed the police dispatcher that he was about to conduct a routine field investigation and then stopped Mr. Delgado for questioning. After Mr. Delgado presented his driver's license and veteran's card for identification, Corporal Roberts began to search his shopping cart and backpack. Mr. Delgado became concerned that his firearms would be discovered and tried to flee, whereupon Corporal Roberts tasered him. A fistfight ensued, ending when Mr. Delgado shot and killed Corporal Roberts. During the struggle, a transmission was received from Corporal Roberts's handheld radio, and another officer, Sergeant Mumford, was dispatched to the scene. By that time, Mr. Delgado had retrieved a firearm from his back-