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# Release From Confinement of Persons Acquitted By Reason of Insanity in Ohio

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## VII. CONCLUSION

The Ohio Supreme Court has maintained a steady and progressive pace in the area of products liability. A reading of the court's decisions in this area shows that the court is concerned with the policies set forth in both *Seely* and *Santor* justifying strict liability for defective products. The court's existing decisions relied upon by the appellate courts and the federal district court to allow recovery for direct economic harm seem correctly decided, since direct economic harm is really nothing less than property damages. However, the extension of this holding to the area of consequential damages in the commercial setting by the lower courts should be restrained. Although recovery of these damages in the consumer area gives substance to one of the policies behind strict liability, recovery in the commercial area undermines the warranty provisions of the U.C.C.

EDWARD J. HOWLETT II

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# RELEASE FROM CONFINEMENT OF PERSONS ACQUITTED BY REASON OF INSANITY IN OHIO*

## I. INTRODUCTION

AN OHIO JURY verdict of not guilty by reason of insanity presumes that such insanity continues.[1] Upon an affirmative finding, the trial judge shall commit the defendant to Lima state hospital.[2] According to statute, the defendant must remain hospitalized until "restored to reason."[3]

This phrase was interpreted by the Ohio Court of Appeals, Allen County, in *Wolonsky v. Balson*.[4] The defendant was actively psychotic at the time of his commitment. By reason of the administration of psychotropic drugs he attained a state of complete remission from the symptoms of his psychosis and sought release from his commitment in a habeas corpus action. Among the questions at issue concerning insanity defense law[5] were

*While this Comment was at the press, the Ohio General Assembly passed Senate Bill 297 (sponsored by Senator Morris Jackson) which became effective April 30, 1980. Among other things, this law strengthens the control of the trial judge over a person who has been acquitted by reason of insanity. It also relieves the probate court of commitment and release authority in these situations. *See* S.B., 297, 113th Ohio Gen. Ass., 2d Sess. (1980).

[1] OHIO REV. CODE ANN. § 2945.39 (Page 1975).

[2] OHIO REV. CODE ANN. § 2945.38 (Page 1975).

[3] *Id.*

[4] 387 N.E.2d 625 (Ct. App. Ohio 1976).

[5] Throughout the note, "insanity" will denote the degree of mental illness that exculpates a defendant in a criminal trial. "Insanity defense" will denote the invocation of mental illness as a defense to criminal liability. "Release" will denote release from a mental hospital or institution. "Acquitted patient" will denote any person who has successfully invoked the insanity defense and then has been hospitalized.

two involving release of acquitted patients: 1) the definition of "restored to reason" as a practical release standard; and 2) the proper authority for effecting release.

The court in its per curiam opinion held that:

> [W]here a person committed under section 2945.39 has acquired the capacity either to know the wrongfulness of his conduct or to conform his conduct to the requirements of law only by reason of a course of medication and will lose such capacity should such course of medication not be continued such person's potential of becoming actively psychotic is substantially greater than the average human being and he has not been restored to sanity and is not sane in the sense required by either section 2945.39 or by *In re Remus,* 119 Ohio St. 166, 162 N.E. 740 (1928) for release pursuant to a petition for a writ of habeas corpus.[6]

The Court also held that the committing court, ". . . a tribunal composed of the judge of the court of common pleas of Allen county, the superintendent of the Lima state hospital, an alienist to be designated by said judge and superintendent, or a majority of them,"[7] can make the "restored to reason" determination and order release. This note focuses on the relationship between acquittal and release standards.

## II. BACKGROUND

### A. *Insanity as a Defense - The M'Naghten Rule*

In England the legal standard and formula for acquittal by reason of insanity remained uncertain for centuries.[8] At the beginning of the nineteenth century modern theories of exculpation began to emerge.[9] In 1843, the now famous *M'Naghten* rule was proclaimed:

> [T]o establish a defense on the ground of insanity, it must clearly be proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as to not know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong.[10]

The rule focuses on the ultimate behavioral product that is produced by mental illness and its effects on reason; hospitalization or institutionalization may be required for the person who was engaged in conduct not socially or morally condoned.

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[6] 387 N.E.2d at 627.

[7] *Id.*

[8] HOLDSWORTH, HISTORY OF ENGLISH LAW 315-16, 172 (1923).

[9] STEARNS, EUROPEAN SOCIETY IN UPHEAVAL: SOCIAL HISTORY SINCE 1800 1-54 (1967) (general historical background).

[10] M'Naghten Case, 8 Eng. Rep. 718, 722 (H.L. 1843). The rule derives from Lord Chief Justice Tindal's answer to a question.

Ohio's version of the *M'Naghten* rule is virtually identical with the old English test. While doing the act, the accused's mind must have been so afflicted with disease as to render him incapable of distinguishing between right and wrong as to the particular act done and as of the time when the act was done.[11] Accordingly, it had been said by the court (*Farrer v. State*[12]) that:

> The power of self-control - "free agency" - is said to be quite as essential to criminal accountability as the power to distinguish between right and wrong. And I have no doubt that every correct definition of sanity, either expressly or by necessary construction, must suppose freedom of will, to avoid a wrong, no less than the power to distinguish between the wrong and the right.[13]

B. *Hospitalization, Institutionalization and Treatment*

A sovereign authority may hospitalize all mentally ill persons within its jurisdiction.[14] Commitment, which is achieved through a variety of procedures, can generally be grouped into five categories. The first two are within the criminal procedure system: commitment upon acquittal by reason of insanity,[15] the focus of this note; and commitment upon a determination of incompetence to stand trial.[16] The three remaining types of procedures are within the civil commitment system and require no evil act for invocation: voluntary application for hospitalization; court ordered commitment, without medical opinion, compelled by an emergency situation; and involuntary commitment after a hearing at which medical or psychiatric testimony is presented.[17]

Authority to commit is justified on the basis of the state's police and *parens patriae* powers.[18] These powers relate to the state's responsibility to protect society from the mentally ill and the mentally ill from themselves. The state's dual responsibility is reflected in the purposes of hospitalization: the security of society and the treatment of the individual.[19] Thus, commitment may be viewed as a balance between the interests of society and the individual.

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[11] The rule was first enunciated in Ohio in Loeffner v. State, 10 Ohio St. 598 (1857).

[12] 2 Ohio St. 54 (1853).

[13] *Id.* at 70.

[14] Broderick, *Justice in the Books or Justice in Action - An Institutional Approach to Involuntary Hospitalization for Mental Illness,* 20 CATH. U. L. REV. 547 (1971).

[15] OHIO REV. CODE ANN. § 2945.40 (Page 1975).

[16] OHIO REV. CODE ANN. § 2945.38 (Page 1975).

[17] OHIO REV. CODE ANN. § 5122 *et. seq.* (Page 1975).

[18] Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment,* 117 U. PA. L. REV. 75 (1968); Note, *Civil Commitment of the Mentally Ill: Theories and Processes,* 79 HARV. L. REV. 1288, 1289-97 (1966); Note, *Compulsory Medical Treatment: The State's Interest Re-evaluated,* 51 MINN. L. REV. 293 (1966).

[19] OHIO REV. CODE ANN. § 5122.01 (Page Supp. 1978).

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It is inevitable that conflict between the requirements of security and therapy will erupt. Treatment is directed toward rehabilitation; yet the mental hospital serves as a prison separating the mentally ill from society.[20]

The conflict is most acute where acquitted patients are concerned, since they are subject to commitment and release through the criminal process. Psychiatric consensus is that a security orientation is important to treatment programs.[21] However, the place of confinement is usually a mental hospital and most often, a maximum security unit within it.[22] While it is unquestionable that security wards are necessary for certain types of patients, a security orientation may be anti-therapeutic.[23] This orientation continues to exist because society's security interest outweighs the patient's individual treatment interest.

The staff in a criminal ward of a hospital or a psychiatric ward of a prison is faced with the problem of devising a program that will treat and care, and at the same time keep the inmates securely locked up. As already stated, there is no way of reconciling these two functions. The therapeutic ideal calls for allowing patients more and more responsibility for their own actions with correlative diminishing restrictions and controls, which inevitably means accepting greater or lesser security risks.[24] Any type of institutionalization, even in the best of hospitals, militates against therapy.[25] A closer family environment would be the best treatment.[26] Maximum security in practice means close confinement in a cell, and there is little in the nature of a treatment program that can be conducted under such conditions.

Faced with this irreconcilable conflict, the administration has only a choice of emphasis. It can place overwhelming stress on security, and in effect abandon almost all efforts at therapy, or it can take a certain degree of risk, and provide some broader therapeutic program. Wise compromises are required, but however wisely the balance is struck, it remains a compromise. Some sacrifice of one of the competing social interests is inevitable.[27]

The security and therapy conflict intensifies where a right to treatment exists for mental patients. The *parens patriae* authority of the state recog-

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[20] Magleby, *Should the Criminally Insane Be Housed in Prisons?* 47 J. CRIM. L.C. & P.S. 677 (1957).

[21] Greenwald, *Disposition of the Insane Defendant After "Acquittal" - The Long Road from Commitment to Release,* 59 J. CRIM. L.C. & P.S. 583, 586 (1968); Weihofen, *Institutional Treatment of Persons Acquitted by Reason of Insanity,* 38 TEX. L. REV. 849, 853 (1960).

[22] A. GOLDSTEIN, THE INSANITY DEFENSE 143-44 (1967).

[23] B. Glueck, *Changing Concepts in Forensic Psychiatry,* 45 J. CRIM. L.C. & P.S. 123, 132 (1954); Magleby, *Should the Criminally Insane be Housed in Prisons?* 47 J. CRIM. L.C. & P.S. 677, 680 (1957).

[24] Clausen & Yarrow, *Paths to the Mental Hospital,* 11 J. OF SOCIAL ISSUES 25 (1955).

[25] Goffman, *On the Characteristics of Total Institutions, Proceedings of the Symposium on Preventive and Social Psychiatry,* WALTER REED ARMY INSTITUTE OF RESEARCH (1967).

[26] TAPPAN, CONTEMPORARY CORRECTION 4 (1951).

[27] *Id.*

nizes that society can and should provide the means by which a patient can obtain release.[28] Ohio guarantees a statutory right to treatment.[29] The guaranteed treatment, however, is directed at a release standard that includes some judgment about the mentally ill person's potential for dangerousness.[30]

Effective implementation of the right to treatment should focus on the effects of hospitalization on the patient's release potential. Release can be difficult if a hospital's security orientation is anti-therapeutic for the patient. A better accommodation must be reached between society's security interest and the individual's right to treatment.

### C. *Release*

There are two general institutional methods for releasing acquitted patients.[31] A hospital superintendent or some other administrative authority may be authorized to order a patient's release.[32] Ohio, and a majority of states, authorize the committing court to order release.[33] This evidences the need felt by state legislatures for keeping a judicial rein on psychiatric decisions and places emphasis on state police power.

A court determination of release is basically an allocation of social risk, while a psychiatric release is essentially a judgment within a rehabilitative framework. The judge decides whether or not the patient is potentially dangerous to society while the psychiatrist decides whether the patient's progress warrants release or will be furthered by his leaving the hospital. A judge, of course, might consider the therapeutic value of a release, and a psychiatrist probably does consider possible social repercussions.[34]

## III. OHIO RELEASE ANALYZED: JUDICIAL POLICY MAKING?

### A. *Release Authority*

Under the Ohio statute dealing with disposition of persons acquitted by reason of insanity,[35] "such fact shall be found by the jury in its verdict,

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[28] *See Ross, Commitment of the Mentally Ill: Problems of Law & Policy*, 57 MICH. L. REV. 945 (1959); Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288 (1966); Note, *Compulsory Medical Treatment: The State's Interest Re-evaluated*, 51 MINN. L. REV. 293 (1966).

[29] OHIO REV. CODE ANN. § 5122.27 (Page 1975).

[30] OHIO REV. CODE ANN. § 2945.39 (Page 1975).

[31] Habeas Corpus, available for all who are illegally deprived of their liberty, is another method by which a patient may obtain his freedom. Ohio guarantees the right to seek habeas corpus for mental patients by statute. OHIO REV. CODE ANN. § 2945.39 (Page 1975).

[32] *Id.*

[33] *Id.; See* Note, *Procedure for the Commitment and Release of the Criminally Insane*, 4 WILLAMETTE L.J. 64 (1966).

[34] Hough v. United States, 271 F.2d 458 (D.C. Cir. 1959); Hayward v. Overholser, 191 F. Supp. 464 (D.C. Cir. 1960); Overholser, v. O'Beirne, 302 F.2d 852 (D.C. Cir. 1962); GUTTMACHER, A REVIEW OF CASES SEEN BY A COURT PSYCHIATRIST, IN THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL 17 (Rappeport ed. (1967).

[35] OHIO REV. CODE ANN. § 2945.39 (Page 1975).

and it is presumed that such insanity continues."[36] The statute provides that the situs of responsibility to release acquitted, committed defendants shall reside in the judge, the hospital superintendent, a designated alienist or a majority of them.[37] This codification of legislative intent indicates that the Ohio legislature intended release power to be shared by judicial and institutional authorities.

Institutional release for patients who have been acquitted in criminal proceedings requires notice, a hearing and a court order in Ohio.[38] Release without a court order is available for most civilly committed patients.[39]

The distinction between civil and criminally acquitted patients is not founded on psychiatric theory or practice. When psychiatrists examine acquitted patients in terms of the danger they pose to society, the hospital and themselves, they are really trying to predict probable future behavior.[40] The illegal act and the individual's personal history become important factors for psychiatric consideration. If, as in the case of *Lynch v. Overholser,*[41] the individual's illegal conduct involved forging checks, psychiatric opinion would likely require less stringent hospital security measures than would be required against a person who committed homicide.

The statutory distinction between civilly committed and criminally acquitted patients implies a difference involving social and legal considerations. Presently, release standards stress dangerousness. However, a test stressing illegality rather than dangerousness would treat two criminally acquitted patients in the same manner; and both would be treated differently than patients civilly committed.

Release in this context becomes a social rather than a medical judgment. A psychiatrist might consider the possibility of continued check forging insufficient "danger" to warrant continued hospitalization; a court would view that same behavior within the context of illegality. The situs of release authority, therefore, reflects an allocation of social risk, and the *Wolonsky* court, in placing that authority with the courts, determined that the courts are best able to allocate that risk. However, an alternative is available, since it seems that the mere existence of an *actus reus* need not require a different disposition for acquitted patients than for patients civilly committed.[42] At the time of release, the patient's initial conduct requiring

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[36] *Id.* [37] *Id.* [38] *Id.*

[39] OHIO REV. CODE ANN. § 5122.03 (Page 1975).

[40] JOHNSON, RELEASING THE DANGEROUS OFFENDER, IN THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL (Rappeport ed. 1967).

[41] 288 F.2d 388 (D.C. Cir. 1961), *rev'd.* 369 U.S. 705 (1962).

[42] This analysis distinguishes between three different types of mental patients: 1) civil patients, 2) acquitted patients whose conduct has not been violently dangerous, and 3) acquitted patients whose conduct has been violently dangerous. Initial hospitalization may require different degrees of security depending which category the patient falls into. However, this original classification should not be controlling at the time a release determination is made.

hospitalization should be only one of many factors affecting a prediction of his dangerousness potential. Hence, any proposal for a new release system should reevaluate the distinction made between civil and criminally acquitted patients for purposes of release.

B. *"Restored to Reason"*

The *Wolonsky* court refused to distinguish between the *M'Naghten* standard for acquittal and the "restored to reason" standard for release. The court found that Balson's psychotic break, without inquiry into the episode's etiology, sufficed under the *M'Naghten* test to establish insanity and to acquit a defendant.[43] Such a break with reality may suffice to acquit a defendant. However, under the "restored to reason" standard, it is inadequate to determine when an acquitted patient qualifies for release. To decide whether a patient is "restored to reason," it is not possible to view the psychotic explosion in isolation from the underlying illness.[44]

Thus, inquiry into the underlying illness was, at the time of *Wolonsky*, necessary for release in Ohio, while it was not necessary for acquittal. This appears to leave the *M'Naghten* and "restored to reason" standards inconsistent. According to the *Wolonsky* court, it was the legislature's view that legal sanity resulted from a defect of reason.[45] Therefore, the court found that the legislature intended no release for acquitted patients until the threat of the defect is eliminated. The *M'Naghten* test, however, might not require the elimination of the underlying illness. The release standard could require remission,[46] the abatement of a patient's symptoms, since a patient in remission might well understand the nature and quality of his acts and the difference between right and wrong. The *Wolonsky* court, however, specifically refused to direct release for a patient whose remission depended on a continued course of medication, since his underlying illness "remains existing."[47] This determination can be harmonized with the *M'Naghten* test by recognizing that the underlying illness is a precondition for the *M'Naghten* defect of reason. Under this analysis to eliminate the defect the underlying illness would also have to be eliminated.

Even without expressly considering *M'Naghten*, the *Wolonsky* court reached the same result since it framed the issue of release as a function of social harm. The court determined that acquittal should not impose upon society the risk of persons whose behavior might again become ir-

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[43] Wolonsky v. Balson, 387 N.E.2d at 625.

[44] *See* JOHNSON, *supra* note 40.

[45] 387 N.E.2d at 625.

[46] HINSIE & CAMPBELL, PSYCHIATRIC DICTIONARY 641 (3rd ed. 1960);

> [A]batement may be partial or complete. Physicians use the expression remission to denote an amelioration, which even if complete for the time being, does not necessarily imply cure; in fact, the term carries the idea that the amelioration of the symptoms is temporary.

[47] 387 N.E.2d at 625.

rationally dangerous. The court, in effect, required a social guarantee; it held that a defendant's "original state of sanity is not restored until the subject's potential for becoming actively psychotic is not substantially greater than that of the average human being."[48]

The court's analysis forces a psychiatric determination of the etiology of the patient's psychosis.[49] The psychiatrist must identify the condition that caused the psychotic behavior. The goal of most psychiatric therapies, however, is to alter deviant behavior, not to remove the underlying illness or condition.[50]

Psychoanalysis is the therapy aimed most specifically at the identification and subsequent neutralization of psychoses.[51] Psychoanalysis is a lengthy and expensive process,[52] however, which is not usually available in public hospitals.[53] Consequently, the probability of an individual satisfying the "restored to reason" release standard seems low.

Effective neutralization of the underlying illness appears to be an alternative to the "restored to reason" standard. The threat of social harm from the defect of reason, however, must still be eliminated. Since remission

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[48] *Id.*

[49] Etiology is the investigation or assignment of causes to a disease. WEBSTER'S NEW INTERNATIONAL DICTIONARY 878 (2d ed. 1955). Psychosis is any serious mental derangement. *Id.* at 2002.

[50] FREEDMAN & KAPLAN, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1196-97 (1967).

[51] *Id.* at 1189. Psychiatrists distinguish among three general types of therapies; psychological, organic and milius. *Id.* at 1189-90. Psychological therapies include psychoanalysis, behavior therapy and group psychotherapy. *Id.* at 1196-1234. The behavior therapies are a recent development. They are based on the theory that any response to any stimulus may be modified. *Id.* at 1217-28. Obviously, to modify responses, the stimuli's effects on the basic personality must be isolated. However, the therapy envisions isolating "incompatible" stimuli and responses. This resembles a channeling process. By isolating the stimulus, psychiatrists can manipulate response-behavior. *Id.* It is doubtful that this therapy will remove the underlying condition of which the court wrote. The therapy may neutralize it. However, two considerations make that doubtful. First, behavior therapy is relatively new; second, conditioning may not be strong enough to provide lasting results. Behavior therapies are currently in use in several public institutions, prisons and hospitals. Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients,* 45 S. CAL. L. REV. 616, 617-20 (1972). Group psychotherapy is the popular "encounter group." FREEDMAN & KAPLAN, *supra* note 50, at 1234.

Organic therapies include the administration of drugs, electric shock therapy and psychosurgery. *Id.* at 1252-96. These therapies are especially successful where an organic disorder, such as a brain tumor, is the cause of the patient's mental illness. Lobotomy clearly removes an underlying condition. However, it is more a surgical procedure than a psychiatric therapy. *Id. See generally* Rose, *Criminal Responsibility and Competency as Influenced by Organic Disease,* 35 MO. L. REV. 326, 330-35 (1970). Although not completely understood, electric shock therapy often produces excellent results in the treatment of schizophrenia. The therapy takes only a few weeks. FREEDMAN & KAPLAN, *supra* note 50, at 1279-82. Either psychosurgery or electric shock might "restore to reason" an acquitted patient. However, psychosurgery is a rather drastic step (especially lobotomy), and electric shock does not always produce lasting effects. *Id.* at 1252-96.

[52] *Id.* at 1197.

[53] STRAUSS, SHATZMAN, BUCHER, EHRLICH & SABSHIN, PSYCHIATRIC IDEOLOGIES AND INSTITUTIONS 137-38 (1964).

was rejected by the *Wolonsky* court as not meeting the "restored to reason" test, neutralization must involve additional psychiatric safeguards.

Spontaneous remission, the cause and duration of which is unknown, cannot provide the basis for a medical guarantee of continued nondangerous behavior.[54] Remission induced by some form of medical therapy, on the other hand, could continue with sufficient medical assurance as long as the therapeutic program was maintained.[55] If conditional release, which existed in Ohio at the time of *Wolonsky*,[56] were made available to Balson, then a post-hospitalization therapy program could have qualified an acquitted patient for release by neutralizing his potential for social harm. The release standard would focus on the patient's dangerousness to others and would recognize "the fairly recent impact on the field of mental illness of the use of psychotropic drugs."[57]

## IV. TOWARD A CONTEMPORARY RELEASE MODEL

Any release system should provide security for society and eventual liberty for those involved.[58] Adoption of a system favoring one or the other goal betrays an implicit bias in favor of societal protection or individual liberty, since the goals are not mutually exclusive. It is submitted that both aims are of equal importance. Since *Wolonsky*, the Ohio legislature has enacted new statutes.[59] The new state code fails to eliminate many of the problems in release advanced herein.

A primary question is where release authority should be placed. The new statutes retain primary authority in the judiciary.[60] However, as long as society's security interest in release is satisfied, there seems no valid reason for courts to pass on every acquitted patient's release. The new statute[61] gives the head of the hospital or managing officer the authority to initiate release proceedings. The state then has five days to challenge the release by requesting a full hearing.[62] Patients will automatically be discharged if

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[54] Beiser, *The Lame Princess: A Study of the Remission of Psychiatric Symptoms Without Treatment*, 129 AM. J. PSYCHIATRY 257 (1972); Beiser, *A Psychiatric Follow-up Study of "Normal" Adults*, 127 AM. J. PSYCHIATRY 1464 (1971).

[55] Conditional release is essential to the psychiatric therapeutic model. *See* FREEMAN & SIMMONS, THE MENTAL PATIENT COMES HOME 201 (1963); SILVERSTEIN, PSYCHIATRIC AFTERCARE (1968); CHANGING PATTERNS IN PSYCHIATRIC CARE (Rothman ed. 1969).

[56] OHIO REV. CODE ANN. § 2945.39 (Page 1975)

> [T]his section provides that when a person committed to Lima State Hospital is released pursuant to a habeas corpus proceeding, his release may be with certain conditions attached. Under former law, only unconditional release was possible. *Id.*, Committee Comment at 283.

[57] 387 N.E.2d at 627.

[58] This avoids a value judgment upon the relative merits of hospitalization goals. Although analysis of the insanity defense is possible by a criminal law goal model, this note does not suggest that rehabilitation and incapacitation are clear goals. Retribution is illogical, for there has been no crime. Deterrence may be part of rehabilitation.

[59] OHIO REV. CODE ANN. §§ 2945.39 and 2945.40 (Page Supp. 1978).

[60] *Id.*

[61] OHIO REV. CODE ANN. § 2945.40 (Page Supp. 1978). [62] *Id.*

no request is made by the court. To ensure a smoothly run administrative release process within the hospital, the statute mandates periodic review of patients' cases.[63]

Beyond finding the proper institutional authority to release, an acceptable release standard must be established. The new statute uses a standard of dangerousness to self and others.[64] As compared with the *Wolonsky* standard, the new statute is more consistent with the capabilities of a release authority, since it is one with which psychiatrists can make more effective evaluations. It is more easily translated into the psychiatric model which bases patient release on patient behavior. It is compatible with the hospital release authority and the goal of providing an individual with the opportunity for release. Although a standard of dangerousness to self and others balances an individual's interest in rehabilitation with society's interest in security, a better balancing would result if the standard were restricted to dangerousness to others.[65] To include dangerousness to self in a test seems incompatible with the suggested premise of individual liberty through rehabilitation. It seems, moreover, to be an unnecessary imposition of the state's *parens patriae* power over the individual.

Another question raised and answered by the court in *Wolonsky* was whether a patient qualifies for release under the "restored to reason" test if his improved mental state is dependent upon the continued use of medication. The court emphatically stated that the individual has not been "restored to reason" within the meaning contemplated by section 2945.39.[66] The court did:

> [C]ommend to the legislature its consideration of the fairly recent impact on the field of mental illness of the use of psychotropic drugs. The effective use of such drugs did not exist at the time of the adoption of section 2945.39 in basic concept. Such impact should be provided for, but is not a subject of action permitted to this court.[67]

The legislation passed in 1978, however, did not embody the court's recommendation. Thus, the impact of psychotropic drugs on mental illness remains unrecognized by Ohio's legal profession and unincorporated in the state's release standard.

The best accommodation of the interests of society and the individual that should be considered for the future, would be a release standard of

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[63] *Id. See* S.B. 297, 113th Ohio Gen. Ass., 2d Sess. (1980) for revisions in this procedure.

[64] OHIO REV. CODE ANN. § 5122.01(B) (Page Supp. 1978).

[65] *See,* Goldstein & Katz, *Dangerousness and Mental Illness, Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity,* 70 YALE L.J. 225, 230-36 (1960); Millard v. Harris, 406 F.2d 964 (D.C. Cir. 1968); Cross v. Harris, 418 F.2d 1095 (D.C. Dir. 1969).

[66] OHIO REV. CODE ANN. § 2945.39 (Page 1975).

[67] 387 N.E.2d at 627.

dangerousness to others which is administered by hospital authorities subject to court review. This model would allow psychiatrists to determine the release potential of individual patients with a minimum of initial legal interference. Finally, the interests of both the legal and psychiatric professions would be respected by the establishment of a standard in which one profession's concern would be accommodated by the other.

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