Dangerousness and Commitment of the Mentally Disordered in the United States

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Abstract

This article describes recent developments in mental health laws in the United States, especially as they relate to uses of the concept of "dangerousness" in the civil and criminal commitment of the mentally ill. In addition to providing a brief overview of the U.S. legal system and noting the importance of the Rule of Law, we review the historical development and current status of the relevant laws, provide some basic epidemiological statistics, and refer to some of the considerable body of extant empirical research in the field.

Preventing behavior perceived as "dangerous" or "harmful" is a fundamental concern of all societies and one that all governments pursue in earnest. While the imposition of the criminal sanction is the principal method used by most societies to limit and control the occurrence of harmful acts, a variety of educational, health, mental health, and welfare laws are also brought to bear (e.g., Cummings 1968). In this article, we discuss the experience of one country—the United States of America—in using one means—mental health law—to prevent and control dangerous behavior.

We first provide a background for non-American readers in the traditional justifications in American law for coercively imposing measures of social control of any sort, and present a brief overview of recent trends in mental health law. We then distinguish *civil* commitment (the involuntary mental hospitalization of those not charged with criminal conduct) from *criminal* commitment (the involuntary mental hospitalization of those who are charged with violating criminal statutes), and in each of these two areas address three topics: (1) the historical development of the law; (2) the law as it currently exists; and (3) the most recent epidemiological statistics. Due to limitations of space, the commitment of children, the developmentally disabled, alcoholics, and persons addicted to drugs will not be considered. And, while we shall make frequent references to the considerable body of empirical research in the United States on dangerous behavior and on civil and criminal commitment, available space will not permit further discussion of this research.

Justifications for Coercive State Intervention

One of two broad rationales must justify any coercive intervention of the Government in the lives of American citizens. The first and most obvious is the *police power* rationale. The Government possesses an inherent power to make and enforce laws and regulations for the protection of public health and safety. Criminal laws, the civil law authorizing the involuntary hospitalization of the mentally disordered who are "dangerous to others," as well as many health and safety laws, are justified by reference to the State's police power.

The second rationale for governmental intervention is the State's paternalistic or *parens patriae* power. As "guardian of its citizens," the Government is empowered to enact laws providing for the protection and care of those unable to care for themselves and to make their own

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decisions (e.g., children and the mentally disabled), and for the benefit of citizens generally (e.g., laws mandating the use of seatbelts in cars or mandating payment into Government retirement plans). The involuntary hospitalization of the mentally disordered who are "dangerous to themselves" or "gravely disabled" is justified by reference to the State's *parens patriae* power.

Whichever rationale is invoked, the Constitution of the United States (often referred to as the "supreme law of the land") places significant constraints upon the power of the Government to intervene in the lives of citizens. In the criminal justice system, for example, some degree of efficiency and effectiveness is deliberately sacrificed to safeguard the rights of the individual to be free from excessive or arbitrary State control. Embedded in the constitutions of the United States and the 50 States, and reflected as well in other laws and institutional arrangements, are some fundamental notions of liberal democratic ideology that accord very high value to individual autonomy, personal liberties, and human rights. These rights and liberties are incorporated into the political traditions of the country and, understandably, are to be found in the basic laws that set forth the purposes, goals, and structure of American society. For example, the liberal democratic ideas of legality and the Rule of Law emphasize the preference for liberty and are reflected in the establishment, through law, of various checks and restraints on the exercise of governmental power.

Thus, under the American constitutional system, individuals are guaranteed certain rights that may not be infringed by either the State Government or the Federal Government. Each State has a written constitution that includes a "bill of rights." The U.S. Constitution also includes a Bill of Rights, which consists of several amendments to the original document. Among the protections included in the Federal Constitution and the 50 State constitutions are the guarantees concerning the free exercise of religion, speech, and the press, and protection against searches and seizures of property unless a court order has been obtained based upon probable cause that a crime has been committed.

After the U.S. Civil War in the 19th century, the Federal Constitution was amended to provide the protection of the U.S. Government against violations of individual rights by State Governments. Because mental health laws are enacted primarily by State Governments, the most important protection of the Federal Constitution is the 14th amendment (adopted in 1867), which, among other guarantees, provides in section 1 that:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor 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.

The phrase "due process of law" expresses the fundamental ideas of American justice. *Due process* refers to the necessity of applying principles of fundamental fairness in dealing with persons who are facing some action by the State that may infringe their rights and liberties. The due process clauses, which are to be found in both the 5th and 14th amendments to the U.S. Constitution, afford protection against arbitrary and unfair procedures in judicial or administrative proceedings that affect the personal and/or property rights of the individual. In addition, these clauses provide protection in preventing the State and Federal Government from adopting arbitrary and unreasonable legislation or other measures that would violate individual rights.

Supreme Court Justice Felix Frankfurter, dissenting in *Solesbee* v. *Blakcom* (1950), described the meaning of the "Due Process Clause" of the Federal Constitution:

> It is now the settled doctrine of this Court that the Due Process Clause embodies a system of rights based on moral principles so deeply embedded in the tradition and feelings of our people as to be deemed fundamental to a civilized society as conceived by our whole history. Due process is that which comports with the deepest notions of what is fair and just. [p. 15]

Any imposition of coercive governmental intervention, therefore, through mental health law or otherwise, and regardless of whether it is justified by the police power or the paternalistic power of the State, must be done in a manner that comports with all of the legal processes specified in the Constitution and in other laws. As noted earlier, however, the U.S. Constitution is the ultimate authority in the country and all other laws and rules (e.g., administrative regulations) must be consistent with it—that is, be "constitutional."

The Rule of Law. The fundamental notion expressed by the phrase "Rule of Law" is that the coercive uses of governmental authority and power need to be constrained with

guiding rules and doctrines. The basic principle emphasizes the supremacy of the law over the discretionary power of public officials. The highest authority, in the American governmental system, is the law—**not** any person or group of persons. In short, respect for the law, as a democratic principle, is recognized as binding on both the governed and those who govern (e.g., Wechsler 1963; Widgery 1976; Abraham 1980).

Hayek (1944) has provided one of the clearest formulations of the ideals embedded in Rule of Law:

> Stripped of all technicalities this means that government in all its actions is bound by rules fixed and announced beforehand—rules which make it possible to foresee with fair certainty how the authority will use its coercive powers in given circumstances, and to plan one's individual affairs on the basis of this knowledge. [p. 54]

Although there is a voluminous body of scholarly legal writings on the topic, it is sufficient for our purposes here to indicate that the values and principles incorporated in the ideal of the Rule of Law include the following:

1. Not only the laity, but also powerful people (including, of course, governmental leaders and functionaries) must obey, operate within, and be guided by the law.
2. All laws should be prospective, open, and clear (i.e., lacking ambiguity and vagueness).
3. Laws should *not* be arbitrary or subject to varying or even erratic and unpredictable application.
4. Laws should be relatively stable so that people can more readily find out what the law is at any given time.
5. Principles of due process (e.g., fundamental fairness) should be observed.

The foregoing background and context will take on additional meaning when, later in this article, we discuss some of the reforms in the field of mental health law in the United States during the 1960's and 1970's. Plaintiffs repeatedly resorted to State and to Federal Courts seeking protection for rights that were guaranteed under State or Federal Constitutions. (For an informative and concise overview of the American legal system, see Chapter 2 of Melton et al. [1987].)

Major Trends in Mental Health Law: An Overview

The most striking development in American mental health law in the past two decades has clearly been the increasing resort to courts by individuals and groups seeking redress for specific grievances as well as by those seeking large-scale reform (e.g., Shah 1981*b*). Viewed in historical social context, this development followed the success of the civil rights movement in the 1960's in achieving rights long denied to black Americans. This movement for civil rights soon broadened to include the rights of children, women, criminal defendants, and the mentally disordered. Much academic and popular writing focused on the glaring discrepancies between the asserted benevolent purposes of many laws (viz., the "law on the books") and the bleak reality that was commonly to be found (the "law in practice"). Particularly in areas justified by the Government's *parens patriae* power, courts began to rule that notwithstanding governmental assertions of benevolent and therapeutic purposes, "due process" safeguards could not be ignored.

In the 1966 case of *Kent* v. *United States*, for example, involving the transfer of a juvenile charged with crimes from the juvenile court to the adult court (where he could have received much more severe punishment), the United States Supreme Court ruled that, among other things, the juvenile was entitled to a hearing, assistance of a lawyer, and access to the relevant records and reports. The Court pointed out that:

> The State is *parens patriae* rather than prosecuting attorney and judge. But the admonition to function in a "parental" relationship is not an invitation to procedural arbitrariness. [pp. 554-555]

In another case, *In re Gault* (1967), the Court ruled that juveniles had the constitutional right to receive notice of the charges against them, to confront and cross-examine witnesses, and to invoke the privilege against self-incrimination. The Court emphasized:

> Juvenile Court history has again demonstrated that unbridled discretion, however benevolently motivated, is frequently a poor substitute for principle and procedure. . . . Departures from established principles of due process have frequently resulted not in enlightened procedure, but in arbitrariness. [pp. 18-19]

The basic problems and prescribed legal remedies addressed in the above and many related cases had rather clear relevance for laws pertaining to the mentally disabled. Hence it was in this context of increased concern for the rights of all citizens that the reform of mental health laws in the United States began to take place in the late 1960's and continued into the next deade. As one

Federal court stated in a case dealing with the institutionalization of a mentally retarded boy:

> It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feebleminded or mental incompetent—which commands observance of the constitutional safeguards of due process. [*Heryford* v *Parker* 1968, p. 396]

During the 1970's, courts ruled that the mentally disordered, at least in some circumstances, had a right to treatment (*Wyatt* v. *Stickney* 1971), a right to that treatment in the least restrictive setting possible (*Dixon* v. *Weinberger* 1975), many due process protections (e.g., clearer criteria for determining "dangerous to self or others," and greater procedural safeguards) in civil commitment (*Lessard* v. *Schmidt* 1972), and safeguards against indefinite confinement after being found incompetent to stand trial (*Jackson* v. *Indiana* 1972). In addition, the majority of States that had special provisions for the indefinite commitment and treatment of persons covered by "sexual psychopath" and related statutes either abolished these laws or made major revisions (e.g., strengthening procedural safeguards and removing the provisions for indefinite confinement in favor of durational limits). (See, e.g., Wald and Friedman [1978]; Brakel et al. [1985]; Melton et al. [1987].)

Much of this judicial activity in mental health law has abated during the 1980's, partially because the civil rights goals of the reform movement have largely been achieved over the past two decades, and partially because a more conservative judiciary has been reluctant to use courts as instruments for further reform. The concern of many mental health professionals, lawyers, and advocacy groups in the United States is now not so much with limiting Government power as with obtaining more and better mental health and related services for those in need of them.

Dangerousness and Civil Commitment

Historical Development of Civil Commitment Law. During the colonial period, there were no statutes concerned with the civil commitment of the mentally disordered in America. Rather, English common law was relied upon. These early commitment policies and practices were extremely vague, often relying upon the allegations by a relative or friend that the individual was "mad" (Brakel et al. 1985, p. 14). A leading 1845 case, *In the Matter of Josiah Oakes*, reflected the prevailing spirit:

> The right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others. . . .The restraint can continue as long as the necessity continues. [p. 125]

In the middle of the 19th century, several notorious cases of improper commitments led to many States passing statutes that specified for the first time some minimal legal procedures necessary for commitment. At the same time, popular concern with the plight of the mentally ill led to the construction of large mental hospitals in most States.

There were few changes in the American law of civil commitment from the mid-19th to the mid-20th centuries. The criterion for involuntary hospitalization was usually a "need for treatment," without further specification, as determined by one or two physicians, and the duration of such confinement was indefinite. Patients had few rights to contest the decision to commit, and fewer rights in the hospital once committed.

Beginning in the late 1960's, as part of the larger movement for civil rights for many groups in American society described earlier, the law of civil commitment changed drastically in three ways (Mills 1986). In brief, the *criteria* for commitment changed from the vague "need for treatment" to a more behavioral concern with "dangerousness." The *duration* of involuntary hospitalization changed from indefinite to time-limited. And many *patient rights* during the commitment process and during hospitalization were accorded by courts and legislatures. In addition, the rather loose and vague definitions of key legal terms (e.g., "mental illness" and "dangerousness") were revised and tightened through both legislative action and judicial interpretation (see, e.g., Shah 1977).

In essence, what was once rather typically a paternalistic "medical" approach to involuntary hospitalization of the mentally ill was changed during the period of mental health law reforms to what has been referred to as more of a legal and "due process" approach. However, as one might expect, such changes in public and mental health policies were accompanied by much debate and disputation (Shah 1981*b*). For

example, what some psychiatrists perceived as a "holy legal war" against State hospital psychiatry (McGarry 1976) or as a "legal onslaught" (Halleck 1979), others viewed as a desirable movement toward shared decisionmaking (Hoffman 1977) and many lawyers and civil rights advocates regarded as overdue and "imperative reform" (e.g., Brooks 1979).

Some in American society—for example, the American Psychiatric Association and the National Alliance for the Mentally Ill (an organization representing the families of the seriously mentally ill)—believe that the pendulum may have swung too far and that the granting by some courts of a mental patient's "right to refuse treatment" has complicated and made difficult the treatment of involuntarily hospitalized patients. Also, that the restrictive civil commitment laws (viz., requiring evidence of "dangerousness to self or others") have resulted in the denial of mental health treatment to some persons who are in need of it but do not seek it voluntarily—for example, nondangerous psychotics and some "homeless mentally ill." (On the basis of studies of the "homeless" in several metropolitan areas, about 30 percent of such persons are estimated to be seriously mentally ill—see, e.g., Morrissey and Levine [1987]; Koegel et al. [1988]; Tessler and Dennis 1989.) No one, however, advocates a return to unrestricted medical discretion, indefinite confinement, or lack of judicial review.

Current Civil Commitment Law. The first thing to be noted about the American law of civil commitment is that there is no *Federal* civil commitment law. Rather, involuntary civil commitment to mental hospitals is the province of *State* law. Therefore, there exist in the United States 51 separate commitment statutes (i.e., the 50 States and the District of Columbia) that differ in various ways among themselves (see, e.g., Brakel et al. 1985). Three common elements are found in most of these statutes, however. Thus, speaking generally, to meet the requirements for involuntary civil commitment in the United States, the individual must be (1) mentally disordered, and (2) dangerous to self or others, or (3) unable to provide for basic needs (i.e., be "gravely disabled").

In addition, the American Psychiatric Association (1983) has proposed a fourth criterion of "substantial mental or physical deterioration."

Mental Disorder. Definitions of mental disorder vary widely across the States. Some are quite precise—for example, the 1971 revision of the Massachusetts law provided a fairly detailed definition:

> For purposes of involuntary commitment "mental illness" shall mean a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but shall not include alcoholism which is defined in M.G.L. ch. 123 s.35. [104 Code of Mass. Regulations, 3.01(A), 1971]

Similarly, the definition in the Utah law is also quite precise: "a psychiatric disorder as defined by the current [American Psychiatric Association 1987] Diagnostic and Statistical Manual of Mental Disorders which substantially impairs a person's mental, emotional, behavioral, or related functioning" (Utah Code Ann. Sec. 64-7-28 [1981]). A few, however, are entirely circular—for example, a person "of such a mental condition that he is in need of medical supervision, treatment, care or restraint" (Colorado Revised Statutes, Sec. 27-10-102 [1982]). (As noted earlier, one specific element of the mental health law reforms in the United States has been the formulation of clearer and more precise *legal* definitions of mental disorder for purposes of civil commitment.)

The American Psychiatric Association (1983) specifies that only a person with a *severe* mental disorder should be committed. "Severe mental disorder" is defined in the Model Law as "an illness, disease, organic brain disorder, or other condition that (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment or (2) substantially impairs behavior as manifested by recent disturbed behavior." The official commentary on the Model Law states that "'severe mental disorder' corresponds roughly to a psychotic disorder" (Stromberg and Stone 1983, p. 313).

Dangerous to Self or Others. Virtually all States over the past 20 years have come to include "dangerousness" as one of the principal criteria for involuntary civil commitment. While several States include danger to property in their statutes, most restrict the "danger" to physical harm to persons. Arkansas, for example, provides that the individual be "homicidal or suicidal" (Arkansas Statutes Ann. Sec. 59-1409, 1981). The American Psychiatric Association (1983) states that "likely to cause harm to others" "means that as evidenced by recent behavior causing, attempting, or threatening such harm, a person is

likely in the near future to cause physical injury or physical abuse to another person or substantial damage to another person's property" (p. 673). The Model Law also states that "likely to cause harm to himself means that, as evidenced by recent behavior, the person is likely in the near future to inflict substantial physical injury upon himself" (p. 673).

Unable to Provide for Basic Needs. Often termed "grave disability" in statutes, the criterion of being unable to provide for basic needs refers to a form of "passive dangerousness" by which the individual will harm himself or herself through neglect rather than through active attempts at suicide or self-mutilation. The American Psychiatric Association (1983), for example, states that this "means that, as evidenced by recent behavior, the person. . .is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health, or safety" (p. 673).

Mental Deterioration. In addition to the above three criteria that apply to civil commitment in most States, the American Psychiatric Association (1983), following Stone (1975) and Roth (1979), recently has proposed a fourth criterion, "likely to suffer substantial mental or physical deterioration," which "means that, as evidenced by recent behavior, the person. . .will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own" (p. 673). The American Psychiatric Association is in the process of trying to persuade State legislatures to include this criterion in their commitment statutes.

It should be noted that there have also been other proposals for improving civil commitment provisions. Perhaps most notable is the comprehensive report of the National Task Force on Guidelines for Involuntary Civil Commitment (1986), of the National Center for State Courts. There are at least two features that make these Guidelines especially attractive. First, they were developed after considerable discussion and work by an interdisciplinary task force that included several lawyers, judges, law enforcement officials, mental health professionals from various disciplines, and advocates for the mentally ill. Thus, a broader and more balanced perspective is reflected. Second, keeping in mind the varying civil commitment laws in the many U.S. jurisdictions, the Guidelines do not present models for legislative reform that require major statutory revision. Rather, they offer a variety of practical measures and suggestions for making improvements within the existing statutory frameworks in the various States.

Each State has several statutory procedures for committing mentally disordered persons. When necessary to prevent immediate harm, *emergency hospitalization* procedures can be used by a physician, psychiatrist, and in many jurisdictions by other designated mental health professionals (e.g., licensed clinical psychologist and social workers) without prior judicial approval. A person who meets the statutorily prescribed criteria can be hospitalized briefly—usually from 3 to 5 working days—before a judicial hearing (Brakel et al. 1985, p. 53; see also Segal et al. 1986).

Under *extended commitment* procedures, typically for renewable periods of 90 days or 6 months, a judge must order the commitment, and the individual is afforded a large number of legal rights, including: (1) notice of the proceedings; (2) a full hearing (and, in many States, a jury trial, if requested) at which the patient has the right to be present and to address the court, and the government must prove the grounds for commitment "by clear and convincing evidence"; and (3) a right to legal counsel, at State expense, if the individual cannot afford one.

The individual generally has these same rights at the time of periodic reviews (typically every 6 months) to determine the need for continued confinement or recommitment (Brakel et al. 1985, pp. 56-72).

Current Epidemiological Statistics on Civil Commitment. The most recent data from the National Institute of Mental Health (NIMH) (Rosenstein et al. 1986) are derived from admission surveys of State and county public mental hospitals, private mental hospitals, and general hospitals during 1980. These data reveal that during 1980 there were 1,144,785 civil inpatient admissions. Of these, 838,317 (73 percent) were voluntary admissions, and 306,468 (27 percent) were involuntary civil commitments. The median length of stay for the voluntary patients ranged from 12 days (in general hospitals) to 20 days (in private hospitals). The median length of stay for involuntary civil patients ranged from 10 days (in general hospitals) to 25 days (in State and county mental hospitals). Among the involuntary group, the longest median lengths of stay were for those diagnosed as having an organic mental disorder

(71 days in State and county mental hospitals) or schizophrenia (43 days in State and county mental hospitals).

There are no national data on the specific criteria by which involuntary patients are committed. Monahan et al. (1982), studying civil commitments in California, found that 70 percent of the patients were perceived by the committing psychiatrists as dangerous to themselves, 29 percent as dangerous to others, and 43 percent as "gravely disabled." One-third of the patients satisfied two or more of the criteria simultaneously. A more recent study of emergency commitment in California by Segal et al. (1988) found that 60 percent of the patients were committed as dangerous to themselves, 49 percent as dangerous to others, and 32 percent as gravely disabled. Again, many patients satisfied more than one criterion.

Dangerousness and Criminal Commitment

"Mentally disordered offenders" is a generic term that subsumes five legally distinct groups in which all persons have been charged with a crime—hence the reference to "criminal" commitments. The five groups are (1) persons charged with crime who are found incompetent to stand trial because of mental disorder, (2) persons acquitted of crime by reason of insanity (i.e., nonresponsibility), (3) mentally disordered sex offenders, (4) persons adjudicated as "guilty but mentally ill," and (5) prisoners transferred to a mental hospital while under criminal sentence. (See, e.g., Monahan and Steadman 1983; Shah, in press.)

Since statutes authorizing the hospitalization of incompetent defendants and mentally disordered prisoners requiring psychiatric hospitalization do not generally invoke or focus upon the concept of "dangerousness" (incompetent defendants are returned to court for trial after their competence is restored, and disordered prisoners are returned to prison to complete their sentence after being treated in a mental hospital), we shall not discuss them here. With regard to the category of "guilty but mentally ill" (GBMI), there are 13 U.S. jurisdictions with statutes allowing such special pleas and sentencing provisions, although there are some variations among the various laws. It should be noted that the GBMI provisions are *not* a replacement for the special defense of insanity; rather, they provide an additional plea and verdict. (See, e.g., Brakel et al. 1985; Shah 1986.)

Since special statutes for the hospitalization of mentally disordered sex offenders have either been repealed or revised in the various U.S. jurisdictions, we shall make very brief reference to them before focusing here on persons acquitted of crime by reason of insanity.

Mentally Disordered Sex Offenders. We use the phrase "mentally disordered sex offenders" to include related special statutes that have typically permitted indeterminate confinement and treatment for persons adjudicated as, for example, "sexual psychopaths," "sexually dangerous persons," and "defective delinquents." These laws were aimed at certain types of sex offenders (especially crimes involving children) and at persons with a persistent and recidivistic pattern of criminal behavior. The first such law was enacted in 1937 in Michigan, and during the following two decades more than half the U.S. jurisdictions adopted such provisions. These laws were viewed as being "civil" and remedial (i.e., nonpunitive) in nature, provided mental health treatment, allowed indeterminate periods of confinement, and had fewer procedural protections. (See, e.g., Brakel et al. 1985, pp. 739-743.) Despite the assertion of benevolent purposes, it was clear that protection of the public through long and indeterminate incapacitation was an important function. Quite predictably, such laws were repeatedly challenged during the aforementioned period of mental health reforms.

Several challenges, for example, focused on the vague and loose definitions and interpretations of the notion of *dangerousness* that could allow an individual convicted, for example, of indecent exposure (a misdemeanor punishable by a penal sentence of less than 1 year) to remain confined as a "sexual psychopath" for several years.

The U.S. Court of Appeals for the District of Columbia critically reviewed the relevant statute and provided a useful analytic framework for assessing *dangerousness*. In the case of a person who had pleaded guilty to indecent exposure, the court noted that the statute required that "dangerous conduct not be merely repulsive or repugnant but must have serious effects on the viewer" (*Millard* v. *Cameron* 1966, p. 471). A few years later and after more than 6 years of confinement, Millard again sought his release. In a noteworthy second decision, the court emphasized that:

> Predictions of dangerousness, whether under the Sexual Psychopath Act or in some other context, require determinations of several sorts: the type of conduct

> in which the individual may engage; the likelihood or probability that he will in fact indulge in that conduct; and the effect such conduct if engaged in will have on others. Depending on the sort of conduct and effect feared, these variables may also require further refinement. [*Millard* v. *Harris* 1968, p. 973].

Several months later in another case involving the sexual psychopath law in the same jurisdiction, the same court referred to its earlier opinion in *Millard* and pointed out that "a finding of 'dangerousness' must be based on a high probability of substantial injury" (*Cross* v. *Harris* 1969, p. 1097). Without such an analytic framework, the court of appeals pointed out, the term "dangerous" could easily become a very loose label for describing persons that one would not wish to encounter on the streets. Moreover, with regard to the determination of "dangerousness," the court emphasized that it was

> . . . particularly important that courts not allow this second question [of likelihood of harm] to devolve, by default, upon the expert witnesses. Psychiatrists should not be asked to testify, without more evidence, simply whether future behavior or threatened harm is "likely" to occur. For the psychiatrist "may—in his own mind—be defining 'likely' to mean anything from virtual certainty to slightly above chance. And his definition will not be a reflection of any expertise, but. . .of his own personal preference for safety or liberty. [*Cross* v. *Harris* 1969, pp. 1100-1101]

Such critical scrutiny of special laws aimed at mentally disordered sex offenders continued, and in 1967 the U.S. Supreme Court followed its earlier reasoning in regard to juvenile delinquency cases (viz., the *Kent* and *Gault* cases) and held that, while sexual psychopath proceedings may be "civil" in nature, greater procedural protections were Constitutionally required (*Specht* v. *Patterson* 1985).

During the 1960's and 1970's, 13 States repealed such laws and another 12 made various revisions—for example, providing greater due process procedural protections and establishing durational limits to the period of confinement (Brakel et al. 1985).

Historical Development of Criminal Commitment Law. From colonial times until the middle of this century, the sole standard for the insanity defense in America derived from the 1843 English case of Daniel M'Naghten. The "M'Naghten rule" holds as follows:

> to establish a defense on the ground of insanity, it must be clearly 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 not to 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.

In response to criticism that the M'Naghten rule, with its emphasis on "knowing," was too cognitive and did not reflect the emotional and volitional components of human behavior, the American Law Institute in 1962 proposed the Model Penal Code test, which reads:

> A person is not responsible for criminal conduct if at the time of such conduct as the result of mental disease or defect he lacks substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.

Current Criminal Commitment Law. Until 1981, about half the American States relied on the M'Naghten rule and half on the American Law Institute test, often with minor variations in wording. Following the public outcry after the acquittal by reason of insanity of John Hinckley, Jr., for the attempted assassination of President Ronald Reagan in 1981, many States and the Federal Government have revised their insanity statutes. While M'Naghten and the American Law Institute are still the dominant insanity standards, three States (Idaho, Montana, and Utah) have abolished the special defense of insanity, while still allowing the acquittal of a defendant who did not have the specific mental state required for the offense charged, such as the requisite "intent," "knowledge," or "negligence." Many other States have attempted to narrow the standards for an insanity defense so that fewer defendants would be acquitted. (See, e.g., Shah 1986.)

In 1983, the American Bar Association and the American Psychiatric Association (through a task force chaired by Dr. Loren Roth) endorsed a proposal by Professor Richard Bonnie (1983) that the volitional aspect of the Model Penal Code test be eliminated. It was felt that assessments by mental health professionals of a criminal defendant's volitional control were often very difficult to make, resulted in many differences in opinions and the courtroom "battle of experts," and also tended to confound the mental health issue with ultimate legal and moral judgments.

The proposals were adopted by Congress and signed by the President in 1984. The new federal insanity test requires:

> [t]hat, at the time of the commission of the acts constituting the offense, the defendant, as the result of a severe mental disease or defect, was unable to appreciate the nature and quality of the wrongfulness of his acts. [Public Law Number 98-473, 98 Stat. 1837]

A person who raises the defense of insanity, like all other criminal defendants, has a right to legal counsel, paid for by the State if the defendant is indigent. In addition, the United States Supreme Court in the case of *Ake* v. *Oklahoma* (1985) held as follows:

> . . .when a defendant has made a preliminary showing that his sanity at the time of the offense is likely to be a significant factor at trial, the Constitution requires that a State provide access to a psychiatrist's assistance on this issue, if the defendant cannot otherwise afford one. [p. 1092]

State statutes for the disposition of persons acquitted by reason of insanity vary greatly. In some States, the laws governing "civil" commitment are also applied to persons acquitted by reason of insanity. In most States, however, special procedures have been adopted for these patients. Under a typical statute, for example, the person is automatically committed to a mental hospital for an evaluation (often for 90 days) to determine current mental disorder and dangerousness, after which there is a hearing to determine whether continued commitment is necessary. Many States have revised their "criminal commitment" laws in recent years. One model for these statutes is the American Bar Association's *Criminal Justice Mental Health Standards* (1984), under which a person is subject to criminal commitment only if he or she was found nonresponsible for a violent offense and also found to be dangerous as a result of mental disorder. "Dangerousness" is defined as existing when the individual "poses a substantial threat of serious bodily harm to others." Under the American Bar Association's *Standards*, the individual, if committed, would be entitled to a new hearing (with counsel and an expert witness provided) 1 year later, and every 2 years thereafter.

While several States limit the duration of hospitalization for insanity acquittees to the maximum time that the criminal sentence would have been had the defendant been found guilty, the United States Supreme Court, in the case of *Jones* v. *United States* (1983), held that under the Federal Constitution a person acquitted by reason of insanity could be hospitalized "until such time as he has regained his sanity or is no longer a danger to himself or society." This decision, however, only states the minimum standards required by the Constitution. States are free to set durational limits on the hospitalization of insanity acquittees and, as we have noted, several have chosen to do just that.

Current Epidemiological Statistics on Criminal Commitment. The NIMH survey described previously (Rosenstein et al. 1986) reported 31,773 admissions to U.S. mental hospitals as involuntary criminal commitments in 1980. This was 3 percent of all mental hospital admissions for the year, the great majority of which (85 percent) were admitted to State and county mental hospitals. Of this 31,773, an estimated 8 percent (approximately 2,500) were admitted in connection with an insanity defense, with 58 percent admitted as incompetent to stand trial, 32 percent admitted as mentally disordered prisoners, and 3 percent as mentally disordered sex offenders (Steadman et al. 1988; see also Pasewark and McGinley 1985). Eighty-one percent of the insanity cases had a diagnosis of schizophrenia.

It is important to note that these data include admissions for *evaluations* as well as adjudicated cases. Many persons evaluated for an insanity defense are not found to be insane by the examining psychiatrist or psychologist (or, if so found by the examiners, are not found insane by the judge or jury, who must make the final decision). Data for 1978 of the number of *adjudicated* insanity cases admitted to mental hospitals were reported by Steadman et al. (1982). These data reveal that only 1,625 persons were admitted to mental hospitals in the United States in that year as having been found not guilty by reason of insanity. (This figure does not necessarily represent all insanity acquittals during 1978; it is possible that some persons—especially those charged with relatively minor crimes—were not hospitalized following adjudication.) The average daily census of hospitalized insanity cases was 3,140. The mean length of hospitalization for persons acquitted by reason of insanity was 23 months.

Empirical Research on Dangerousness

Despite the voluminous empirical research literature that has accumulated on this topic, space constraints permit only a brief summary.

American research on dangerousness in the context of both civil and criminal commitment has focused heavily on the issue of prediction or "risk assessment" (see, e.g., Steadman and Cocozza 1974; Thornberry

and Jacoby 1979; Shah 1981*a*). (For a review of the extensive research literature on the operation of commitment, see Appelbaum [1984] for civil commitment, and Monahan and Steadman [1983] for criminal commitment; for a very comprehensive recent review of the extant research on the clinical prediction of dangerousness, see Webster and Menzies [1987]; for a review of the treatment of violent civil and criminal patients, see Roth [1985].)

A number of empirical studies conducted in the 1970's, most of them using criminally committed patients as subjects, reported that of persons predicted by psychiatrists and psychologists to be violent to others but released despite the prediction, at best one in three were eventually found to commit a violent act, while approximately 10 percent of the persons predicted to be safe were found to be violent. The best predictors of violence appeared to be demographic variables, such as age and gender, and the poorest predictors appeared to be clinical variables such as diagnosis (Monahan 1981, 1984). This finding on the high level of "false positives" in psychiatric and psychological predictions led many to call for an end to the "dangerousness standard" in both civil and criminal commitments.

In the past several years, there has been a renewed interest in the topic of risk assessment in the United States (see, e.g., Mulvey and Lidz 1985; Bieber et al. 1988). There are two reasons for this change. First, U.S. courts have made it clear that, despite the research data, a reliance upon dangerousness in both civil and criminal commitment does not violate the U.S. Constitution. Indeed, courts have been much more comfortable with clinical predictions of violence than have the psychiatrists and psychologists making the predictions. Legal challenges to the dangerousness standard are now rarely raised.

The second reason for the renewed interest in dangerousness is an appreciation of the methodological limits of the existing research. Several recent studies have shown considerably greater accuracy in predicting violence among the mentally disordered (particularly among those with extensive histories of past criminality and violence). Many other studies are reporting relationships between violence and clinical variables such as diagnosis, presence of delusions, psychopathy, and anger control, although no consistent pattern of relationships has yet emerged. There is a guarded optimism in the field that it may be possible to improve the validity of clinical predictions of violence, and much promising research is currently under way (see, e.g., Klassen and O'Connor 1988; Monahan 1988; Brizer and Crowner 1989).

Empirical Research on the Commitment Process and Outcome

During the past two decades, there has been an increasing interest in empirical research to study the civil commitment process by observing court hearings (e.g., Hiday 1977*a*, 1977*b*, 1987; Warren 1977), by systematically investigating the consequences or impact of various changes in civil and criminal commitment policies (e.g., Steadman and Cocozza 1974; Bonovitz and Guy 1979; Luckey and Berman 1979; Steadman 1979; Stier and Stoebe 1979; Bonovitz and Bonovitz 1981; McGarry et al. 1981; Durham and Pierce 1986; Hiday and Scheid-Cook 1987; Peters et al. 1987), and related topics.

Conclusions

The history of dangerousness in both civil and criminal commitment in the United States has been characterized by three changes over the past 20 years. The nature of the *mental disorder* necessary to trigger the possibility of commitment has changed from an open-ended concept of "mental illness" to a severe, psychotic or psychotic-like condition. The definition of *dangerous behavior* has changed from a vague notion of undesirable activity to a specific concern with tangible violence. And thorough *judicial review* of all but the most brief hospitalization is now required. There has come to be a widespread recognition in the United States that the role of the mental health professions in a democratic society is to provide technical advice about degree of disorder and risk to judges and other decisionmakers in the legal system, but the ultimate decisions about who should be hospitalized and who should be released involve social and moral tradeoffs between the patient's liberty and the public's safety. These are fundamentally public policy and legal determinations and are outside the expertise of mental health professionals.

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