National Institute of Mental Health

DANGEROUS BEHAVIOR:

A Problem in Law and Mental Health

Crime and Delinquency Issues

ARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

CRIME AND DELINQUENCY ISSUES:
A Monograph Series

DANGEROUS BEHAVIOR:
A Problem in Law and Mental Health

edited by

Calvin J. Frederick, Ph.D.
Division of Special Mental Health Programs
National Institute of Mental Health

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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National Institute of Mental Health
Center for Studies of Crime and Delinquency
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Contributions to this monograph have been made by recognized authorities on the subject. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the National Institute of Mental Health; Alcohol, Drug Abuse, and Mental Health Administration; Public Health Service; or the U.S. Department of Health, Education, and Welfare.

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PREFACE

Over the years, there has been a great deal of confusion regarding "dangerous" behavior, both in legal arenas and in mental health systems. One of the purposes of this monograph is to clear up the existing confusion and chaos.

The persistence of the problem of dangerousness, as well as the intense interest in it from the public and the professionals, emphasized the need for an extensive look by knowledgeable professionals in the field. As a result, in May of 1974, the Center for Studies of Crime and Delinquency, National Institute of Mental Health, held a symposium on dangerousness and mentally disturbed persons. Members of this symposium were the core contributors to this monograph. They were: Dr. Jonas Robitscher, from the Emory University Law School; Dr. Henry Steadman, from the New York State Department of Mental Hygiene; Dr. Terence Thornberry, University of Pennsylvania; and the Honorable Nicholas Petris, State Senator from California. The monograph editor served as moderator. Discussants were: Dr. Saleem Shah, Chief, Center for Studies of Crime and Delinquency, National Institute of Mental Health, and Mr. Richard Millstein, Chief, Legislative Services Unit, Alcohol, Drug Abuse, and Mental Health Administration.

It became readily apparent that the information originally presented was of such a nature that it should be enlarged upon and published in monograph form for dissemination to interested mental health professionals and to policymakers and program administrators throughout the country. Other contributions were added to broaden the spectrum covered in the monograph. In order to cover the issue as fully as possible, we made certain that knowledgeable individuals from a variety of professions and academic disciplines were represented in the diversity of monograph articles. The authors, therefore, have come from the fields of law, psychology, medicine, psychiatry, and sociology, and include a State legislator who is especially knowledgeable about mental health and legal issues.

Since 1974, when the symposium was held, there have been several important developments, including the decision in the case of *O'Connor* vs. *Donaldson* by the United States Supreme Court.

Therefore, each author was given the opportunity to update his remarks. Some authors availed themselves of this opportunity, while others felt their contributions were already complete. In any case, this monograph represents the current thinking of some of the most outstanding professional and academic persons in the Nation today.

The editor has attempted to present an overview of violent behavior, with a general orientation toward some of the prominent aspects which require consideration. Dr. Saleem Shah has endeavored to bridge some of the gaps, in the updating process, which have appeared since the original symposium was held.

It is hoped that this monograph will be of interest to professionals, policymakers, and program administrators, and will stimulate them to pursue needed solutions to the perplexing problems pertaining to the issue of dangerousness as it relates to the handling of persons considered as mentally ill. The editor would like to thank all of the contributors to the monograph for their helpful participation and refreshing insights.

CONTRIBUTORS

Alexander D. Brooks, LL.B., Professor of Law, School of Law, Rutgers University, Newark, New Jersey.

Calvin J. Frederick, Ph.D., Division of Special Mental Health Programs, National Institute of Mental Health.

Joseph E. Jacoby, Ph.D., Assistant Professor, Department of Human Sciences, University of Houston, Houston, Texas.

Nicholas C. Petris, LL.B., State Senator, Sacramento, California.

Jonas Robitscher, J.D., M.D., Henry R. Luce Professor of Law and Behavioral Sciences, Emory University School of Law, Atlanta, Georgia.

Ralph Kirkland Schwitzgebel, Ed.D., J.D., Assistant Professor, Department of Psychology, California Lutheran College, Thousand Oaks, California.

Saleem Shah, Ph.D., Chief, Center for Studies of Crime and Delinquency, National Institute of Mental Health.

Herbert M. Silverberg, LL.B., School of Law, University of New Mexico, Albuquerque, New Mexico.

Henry J. Steadman, Ph.D., Director, Special Projects Research Unit, New York State Department of Mental Hygiene, Albany, New York.

Terence P. Thornberry, Ph.D., Research Associate, Assistant Director, Center for Studies in Criminology and Criminal Law, University of Pennsylvania, Philadelphia, Pennsylvania.

Albert H. Urmer, Ph.D., President, ENKI Research Institute, Chatsworth, California.

I. General Orientation to the Problems of Violent Behavior

CHAPTER 1

An Overview of Dangerousness: Its Complexities and Consequences

Calvin J. Frederick

Introduction

Although the concept of dangerousness may initially appear specific enough to provide a focal point for much agreement in the areas of law and mental health, in point of fact, it has led to a number of complex issues evoking differing practices and points of view. The components which are most often either confused or falsely equated are these: (1) mental illness and dangerousness; (2) predictability and unpredictability of dangerous behavior; (3) definitions and criteria of the concept of dangerousness; (4) standard of proof required for deprivation of liberty; (5) parens patriae and police power functions; (6) competency to stand trial and criminal responsibility; (7) civil and criminal commitment; (8) voluntary admission and involuntary commitment; and (9) right to receive and to refuse treatment. Mental illness has historically been associated with dangerous, violent behavior. Unfortunately, this concept has carried over into our present day legal system, as Robitscher observes at some length in a later chapter.

It is difficult, even under the best of circumstances, to predict behavior of any kind, especially behaviors (like violence) that are relatively infrequent. For example, one might suppose that, by knowing the behavioral patterns of one monozygotic twin, the other might be expected to behave in the same manner under similar circumstances. Such is not the case, nor do persons with equivalent types of inherited mental deficiency or the same organic brain disorders behave in a predictably like fashion. Behavior is learned. It does not exist in the germ plasm but varies with past experience and type, degree and intensity of the situation at hand. Further to prediction, Stone (1975) postulates that, even if a hypothetic instrument could be produced which would be 95 percent effective in predicting dangerousness, out of every 100,000 people who were tested, several thousand could be termed potentially dangerous and would become so-called false positives, i.e., predicted as likely to be dangerous but not displaying such behavior. Even though the tend-

ency to overpredict dangerousness has been discussed at length within the professional community recently, it is still widely practiced as a "safe" procedure. The chief reasons for this seem to be: (a) It protects the examiner from making a mistake which might be tragic to society; (b) it avoids criticism of psychiatry or other mental health professions in the media; and (c) it can be rationalized, since it provides a means for obtaining treatment for "potentially dangerous" persons.

Cultural Attitudes and Dangerousness

People have been labeled dangerous for centuries, but in recent decades the term has gained more saliency. This state of affairs seems to have come about because of an increase in the crime rate and the eminence of recent victims of violence in the United States, and because of some historic legal developments that have questioned the fairness and constitutionality of some longstanding laws and practices. Contrary to popular belief, the incidence of violent acts, including homicide, has no significant relationship to mental illness. Although the thrust of this monograph is toward dangerousness as related to mental health, an effective overview should note the breadth of the problem by at least touching briefly upon several other components within the spectrum of violent behavior.

When compared with many of the other developed countries in the Western World on incidence rates of violence, the United States does not fare very well. In particular, this country discloses unenviable rates in the categories of homicide and crimes against the person. Although correlation does not prove causality, it seems worth noting that most of the modern developed countries have strict gun control laws and a much lower incidence of homicide than the United States. Illustratively, in the Netherlands permits are required for all firearms, while in France all guns must be registered and their owners licensed. In Sweden, an applicant for any gun ownership license must prove a need for the gun and complete knowledge of the weapon. The private ownership of pistols is forbidden in Japan to everyone except police or military personnel and a few competitive marksmen. Most persons in Great Britain, including officials of the British Rifle Association, find it difficult to comprehend our concept of "the right to bear arms." They believe it is an absurd idea and stress that personal protection should be a matter for the police alone (Block 1976).

A comparison with another English-speaking nation may serve to illustrate the persistent magnitude of the problem of criminal homicide in the United States. Striking differences are disclosed when we contrast the incidence levels of homicide in the United Kingdom

with the United States. When comparing a recent 5-year average from 1971-1976, from British Home Office data, it may be seen that the homicide rate in the United States is about 11 times greater than that found in Great Britain. Characteristically, there has been less than one victim per 100,000 in the British population, while there have been roughly 10 victims for each 100,000 persons annually in the United States, according to the British Home Office (1976*a*). Although caution should be shown when making cross-national comparisons, due to the possible lack of equal variables and populations, the information is provocative and supplies food for thought. Taking figures from 1973, British Home Office data (1976*b*) showed crimes of violence against the person, when compared against the total crime index, to be 46 percent less in England and Wales, and 38 percent less in Scotland, than in the United States. Between 1953 and 1963, the United States showed very little change in homicidal deaths; but in the decade following 1963, the rate nearly doubled. The rate in 1963 was 4.9 per 100,000 population annually. About a decade later, in 1974, it reached a peak of 10.2 per 100,000, with a slight decrease to 10.0 in 1975, according to Health Resources Administration Figures (1976). These rates have varied little for either sex within all racial categories.

While it is difficult to fully explain the cultural differences noted, attitudes appear to exert some influence. Based on surveys conducted in 1969 and 1974, Blumenthal (1976) reported that violence was viewed widely in the U.S. male population as necessary to maintain social control. Eighty percent of the male respondents felt police should use clubs to control crowds; and about two-thirds felt police should use guns, but only to wound or frighten, not to kill. Nearly half of the low-income persons scored high on an index which indicated a belief that violent protest is necessary to bring about fast change. Males who subscribed to the concept of retribution as a form of justice believed that murderers deserve capital punishment. Among blacks, such beliefs were associated with positive attitudes toward violence as a vehicle for social change. Based on this information, Blumenthal reached the conclusion that attitudes in favor of violence are not confined to markedly deviant persons, but, instead, reflect positive attitudes toward violence that are deeply embedded in significant segments of our culture.

Population Groups at Risk in the Major Crimes of Violence

In order to provide a backdrop against which to view the many vignettes of dangerous behavior, selected information is briefly

summarized here, but the interested reader may wish to obtain further details from Kelley (1976) and Klebba (1975). Kelley's data (the Uniform Crime Reports of the FBI) refer to criminal homicides (murders), while Klebba's data refer to all homicides. Historically, for most problems, it would seem that, as long as the socially disadvantaged are the persons primarily affected, little is done to modify the social problems. When persons of renown become involved, greater interest is aroused. The reader will readily recall some of the prominent figures affected by violent acts in recent times, such as President John F. Kennedy, Senator Robert Kennedy, Reverend Martin Luther King, Jr., Governor George Wallace, Senator John Stennis, and former President Gerald Ford. Notwithstanding the prominence of these individuals and the periodic, heightened public concerns and reactions, the Nation has experienced great difficulty in passing effective gun control laws, despite the fact that the percentage of homicide deaths from firearms and explosives rose from 54.7 in 1960 to 67.2 in 1973 (Klebba 1975).

About 30 percent of all homicides result from quarrels among family members, other relatives, or lovers. The number of friends or acquaintances killed in other arguments is not known. A gun is the weapon used in about two-thirds of all murders committed annually; a knife or cutting instrument is employed in only 18 percent of the cases, and clubs or poisons are used in 12 percent of the cases. Thus, firearms constitute the chief means for homicidal violence in this country (Kelley 1976). Of course, few perceptive persons would hold that the passage of effective gun control laws would completely eliminate dangerous, violent behaviors, or reduce the homicide rate markedly. Nevertheless, depending upon the breadth of the law and the manner in which it is actually enforced, there seems to be little doubt that numerous lives could indeed be saved.

Available demographic data indicate that, although both victims and perpetrators of dangerous, violent acts cut across socioeconomic and cultural lines, some persons are at much greater risk than others. A study of repeated offenders by the FBI reveals the following data: Among all persons arrested for major violent crimes, who were released in 1972, the following percentages represent rearrests on particular criminal charges 4 years later—homicide, 64 percent; robbery, 77 percent; rape, 73 percent; and aggravated assault, 70 percent (Kelley 1976). It seems evident that some individuals continue to prove greater risks to the community than others. In the author's experience, few persons of this type have been admitted to mental hospitals or clinics, since they are not usually regarded as mentally ill. They simply continue to engage in criminal behavior. More definitive psychological studies of

this high-risk, repeated offender population might add appreciably to our knowledge about them.

Since 1972, arrests for crimes of violence have shown an increase of 32 percent. Blacks are disproportionately represented both as murder victims and in the percentage of arrests for murder, with figures of 47 percent and 53 percent, respectively. Despite such high percentages, blacks represent only about 12 percent of the total population. This disparity is revealed in arrests for robbery as well, since about 6 out of every 10 persons arrested are black, while about 4 in 10 are white. For all races, males are murder victims three-fourths of the time, and almost 10 percent of all violent crimes involve females. While all crimes of violence increased in the early 1970s, they showed a slight downturn in 1976.

Regarding age trends, violent acts by younger persons, particularly males, appear to be increasing despite a recent decrease in homicide rates. A decrease in arrests for murder among those under 18 years took place after 1972, but, numerically, the 18- to 22-year age group still showed the greatest involvement, with about one-fourth of the arrests coming from that age group. Since 1972, there has been an increase of 40 percent in arrests for aggravated assault by persons under 18 years. Seventy-six percent of the arrests for robbery occurred among those under age 25 (Kelley 1976).

Obviously, women are at greater risk in crimes of rape. A violent crime in the legal and physical sense, it is predominantly an experience of sexual humiliation, with potentially devasting emotional and psychological consequences. As a significant health, mental health, and social problem, it frequently disrupts the lives of its victims and their families and friends. In the author's experience, rapists are rarely mentally ill, which is consonant with the view that most dangerous, violent acts are not usually committed by persons suffering from mental illness.

Some Central Issues in Involuntary Civil Commitments

Within the last decade, there have been a variety of court decisions dealing with the topic of dangerousness, patients' rights, and related issues. Some of the most salient cases are: *Dixon* v. *Attorney General*,[1] *Bell* v. *Wayne County General Hospital*,[2] *Lessard* v. *Schmidt*,[3] *Lynch* v. *Baxley*,[4] *State ex rel Hawks* v. *Lazaro*,[5] and *O'Connor* v. *Donaldson*.[6] Although each State requires mental illness, or some similar condition, as a part of the

necessary criteria in commitment procedures, standards of commitment vary considerably from one State to another. With the advent of the Supreme Court's ruling in *O'Connor*,[6] a move toward some greater degree of national congruence may develop over the next few years.

Dangerousness has been held to be a major prerequisite to involuntary commitment, but the concept itself is subject to numerous and conflicting interpretations by mental health professionals, attorneys, and judges, alike. Most State civil commitment statutes fail to define the term precisely and clearly, as the various authors in this monograph emphasize. Questions such as the following must be addressed if the issue is to be understood:

a. How is the current commitment standard using the concept of dangerousness generally implemented?
b. How accurate and reliable are mental health professionals in predicting dangerousness?
c. Should the concept of dangerousness be employed at all?
d. If employed, what can be done to refine the notion of dangerousness and implement standards of commitment more equitably, and, possibly, even increase the likelihood of accurate prediction to some degree?

In a summary of civil commitment laws for the mentally ill, a *Harvard Law Review* article (1974) indicated that commitment is possible if a person is mentally ill and: (a) is dangerous to himself or others (29 States); (b) is in need of care or treatment or is a fit subject for hospitalization (29 States); (c) is unable to care for his physical needs (15 States); and (d) requires commitment for his own welfare or others (7 States). Unfortunately, terms like "dangerousness" and "in need of care or treatment" are not defined. Scott (1976) develops this issue by pointing out that, as a consequence, statutes give mental examiners, administrative agencies, courts, and juries wide latitude in determining whether specific individuals should or should not be committed.

In virtually all jurisdictions, persons may be involuntarily committed for the following reasons: (a) being mentally ill and constituting a danger to self, others, or property; or (b) in need of care and/or treatment, and with no suitable less restrictive alternative available.

Commitment for Mental Illness

Mental illness is generally assumed to be the undisputed first criterion necessary for involuntary admission to a mental health facility. This admission is often without regard to the degree or

severity of illness. In some instances, the only definition provided for mental illness is that it is a condition which substantially impairs mental health. Circular reasoning is sometimes apparent when mental illness is defined as a condition which requires hospitalization. In essence, when hospitalization is deemed necessary, that signifies the presence of serious mental illness.

As Robitscher observes in a later chapter, common law has upheld the right to deprive mentally ill persons of their liberty from early Colonial times. Any individual could arrest an insane person or one characterized as too dangerous to be allowed in the community at large. Such a person could then be confined for the duration of his disturbance, which was tantamount to indeterminate sentencing in many instances, as illustrated in *O'Connor*.[6]

Danger to Self

The *Lynch*[4] court commented that while *danger to self* and *danger to others* are often considered together, they represent quite different State interests. *Parens patriae* power applies to danger to self because the State assumes the authority to become the ultimate guardian of the individual. *Police* power is implicit in the commitment of persons dangerous to others; it is invoked to protect society from harm, apart from the welfare of the individual who is incapable of caring for his or her own best interests. Danger to self is a parens patriae invoked procedure generally given to protect an individual from presumed self-harm. As noted in *Lynch*,[4] even though a person does not threaten actual violence to himself, the individual may be properly committable under the dangerousness standard if it can be demonstrated that: (a) the person is mentally ill; (b) the mental illness manifests itself in neglect or refusal to administer self-care; (c) such neglect or refusal poses a real and present threat of substantial harm to well-being; and (d) the person is incompetent to determine whether or not treatment for his, or her, mental illness would be desirable.

With regard to commitment for *danger to self*, the courts ordinarily have held that the commitment cannot be done merely to meet a need for custody, care, or treatment. In *State ex rel Hawks*[5] the court ruled against a commitment standard resting simply on "need of custody, care, or treatment" and a lack of capacity to render a responsible decision pertaining to hospitalization. Yet, the court upheld commitment when the individual would be "likely to injure himself." The *Hawks*[5] court further held that, if an individual possesses a self-destructive urge toward violence to self, or is so mentally ill that by "sheer inactivity" the person will allow

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death to occur by starvation or lack of care, the State is entitled to require hospitalization. Similar holdings appear in *Dixon*,[1] *Bell*,[2] and *Lessard*.[3]

Danger to Others

The notion of posing a real and present danger of doing substantial harm to others, or to oneself, underlies most of the current court requirements in the United States today. While the threat of physical danger is an obvious component, the *Lynch*[4] court alluded to the possibility of "emotional injury as well." Most of the current court rulings have tended to impose the requirement of a recent overt act for commitment, but in one new case, *Mathew* v. *Nelson*,[7] a Federal district court held that dangerousness could occur even in the absence of recent overt behavior.

A brief summary of the principle court holdings for commitment due to being a danger to others follows:

> *Bell*: "The basis for confinement must lie in threatened or actual behavior stemming from the mental disorder, acts of a nature which the State may legitimately control; viz., that causing harm to self or others." (384 F. Supp. at 1096).
>
> *Dixon*: "Manifests indications that the subject poses a threat of serious physical harm to other persons or to himself." (325 F. Supp. at 374).
>
> *Humphrey*: "A social and legal judgment that the mentally ill individual's potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty." (405 U.S. 504, 509).
>
> *Lessard*: "Mental illness and imminent dangerousness to self or others beyond a reasonable doubt based at a minimum upon a recent act, attempt, or threat to do substantial harm." (379 F. Supp. at 1380).
>
> *Lynch*: "Minimum findings (that) the person to be committed is mentally ill . . . and a real and present threat of substantial harm to himself or to others." (386 F. Supp. at 390).
>
> *O'Connor*: "Mental illness alone cannot justify . . . locking a person up against his will and keeping him indefinitely . . . . There is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." (422 U.S. 563).

A more extensive coverage of these legal issues is provided later in the chapter by Brooks, while specific problems of prediction are addressed in the chapter by Shah.

Constituting a Danger to Property

Acting-out behavior in the *destruction of property* has been the subject of some dispute regarding the criteria for involuntary commitment of the mentally ill. In a recent case, viz. *Suzuki* v. *Yuen*,[8] the court ruled that a danger to property did not, in itself, warrant involuntary civil commitment. The court stated that, while dangerousness to self or to others was necessary for commitment, there was an implicit exclusion of dangerousness to property as a basis for hospitalization. The court expressed the view that requirements of "substantive due process" were met "only when an individual is found to be a danger to himself or to others"; therefore "dangerousness to property is not a constitutional basis for commitment in an emergency or nonemergency situation." It was further noted that the State's interest was not so compelling as to justify the commitment of Suzuki on any other basis, particularly when the State's interest could be adequately protected through the use of criminal statutes prohibiting damage to property. Even if not committed to a mental health facility, a person may be incarcerated to prevent further property damage when the evidence justifies it.

The question of degree of dangerousness has an impact on the need for care and treatment. Such behavior is usually mentioned in the context of some definitive acting-out form of behavior which is physically assaultive to others, but the notion of emotional injury may also obtain, as noted previously in *Lynch*.[4] Physical assault can vary, of course, from the severe spanking of a child to intentional homicide. In *Humphrey* v. *Cady*,[9] the U.S. Supreme Court dealt with this topic by stating that the degree of danger constitutionally required before one may be involuntarily deprived of liberty must be great enough to "justify such a massive curtailment of liberty." For further details the reader is referred to this case and the chapter by Brooks later in this monograph.

The Insanity Defense

Shah (1975, 1977) notes that there are a number of public policy issues with regard to defining dangerousness, particularly in the context of insanity. In common law, restraining insane persons without the usual legal process can only be justified when the use of this restraint is limited to situations that involve imminent danger to persons or property, as shown by Brakel and Rock (1971). Involuntary civil commitment involves an exercise of State power which deprives an individual of his liberty and which may

compel him to undergo psychiatric treatment, thereby raising the legal and public policy questions addressed in this monograph. Shah has made a particular point of stating that this problem is complicated by mixing public policy and legal issues with concerns about mental health questions. The practice of confusing insanity with dangerousness has confounded the picture immensely. Persons who are seriously disturbed may or may not be insane for particular legal purposes; and they may or may not be any less dangerous than persons not so diagnosed psychiatrically. Many criminal offenders, exfelons, and persons convicted of drunk driving are likely to be equally, if not even more, dangerous than persons who are mentally ill. (See the discussion by Shah in this monograph.)

Stone (1975) affirms that there are those who believe the insanity defense should be modified or eliminated. He emphasizes that the insanity defense touches upon the ultimate social values and beliefs of our citizens, and purports to draw a line between those who are to be held morally responsible and those who are not; those who are blameworthy and those who are not; those who have free will and those who do not; those who should be punished and those who should not; and those who can be deterred and those who cannot. Wexler (1976) discusses this issue at greater length by observing that, for purposes of release, the crucial distinction should be drawn between *dangerous* and *nondangerous* patients, rather than between persons not guilty by reason of insanity and all others, which is the procedure usually followed.

It is evident, therefore, that a variety of philosophical, moral, legal, and public policy questions come together around the issue of the insanity defense. Since persons acquitted by reason of insanity may well face involuntary hospitalization for an indefinite period, it is obvious that fears about future "dangerousness" remain of major concern to the legal decisionmakers following such adjudication.

Pretrial Competency and Criminal Responsibility

Competency to stand trial and criminal responsibility are often confused, in part, because alleged incompetency of criminal defendants is raised on the basis of potential mental illness. This obfuscation about the criteria for competency in the commitment process has been jumbled by the lack of relevant communication on the issue between the disciplines of psychiatry and the law. In a monograph dealing with this topic by the Harvard Laboratory of Community Psychiatry (1974), the authors comment that pretrial competency is based on the English common law heritage which

held that a person must possess the capacity to defend himself adequately against his accusers. There are three criteria for this capacity: (a) an understanding of the nature of the legal process; (b) a recognition of the consequences which could develop from the accusation; and (c) the ability to assist legal counsel in one's own defense. Such criteria provide due process safeguards in the law.

A number of socially deviant acts, including dangerous ones, can be labeled either as sick, or criminal, or both. The label employed frequently will depend upon the social class of the offender, the value system of those in control, and the choice of community resources made by persons responding to the deviant acts, as noted by Stone (1975). However, the question of pretrial competency continues to be incorrectly equated with the insanity defense. This confusion obtains for both dangerous and nondangerous individuals who are processed for commitment. Many mental health professionals seem insufficiently aware of the distinction between competency and criminal responsibility. Psychoses are confused with legal insanity, even though the latter specifically refers to not being classified as criminally responsible. Further confusion exists with respect to competency to stand trial and competency to serve a sentence. An individual may be competent to stand trial by meeting the three criteria listed above, but still be mentally incompetent to serve a sentence, in which case, involuntary admission to a hospital rather than a prison will follow. Moreover, the question of competency to stand trial may also be confused with competency to accept and understand the implications of the right to accept voluntary admission and undergo specific forms of treatment. Possessing some awareness of one's condition and recognizing the need for professional care are quite different from being able to cooperate with counsel in one's defense and to undergo the rigors of a court trial. For further elaboration upon this issue, the interested reader is referred to the works of Stone (1975); Wexler (1976); and McGarry et al. (1974).

Standard of Proof

The standard of proof required for legal decisions regarding civil commitment of the mentally ill has caused some disagreement within the judicial system. There are essentially three levels to consider in this matter: (a) preponderance of evidence; (b) clear, unequivocal, and convincing evidence; and (c) evidence beyond a reasonable doubt.

Preponderance of evidence is seldom acceptable when the issue is the involuntary deprivation of liberty in civil commitment

procedures. There is a lack of unanimity, however, in the requirement for a higher standard of proof, namely, the need for "clear, unequivocal, and convincing evidence" or "evidence beyond a reasonable doubt." In some instances, the two are used almost interchangeably, but two district courts, in the recent past, have taken different postures on the standard of proof necessary for involuntary civil commitment. The *Lynch*[4] court stated, "Due process demands that a person be subjected to involuntary commitment only if the necessity for his commitment is proved by evidence having the highest degree of certitude reasonably obtainable in view of the nature of the matter at issue, and trier of fact must be persuaded by clear, unequivocal, and convincing evidence that the subject of the hearing is in need of confinement under the minimum standards of commitment, and no greater margin of error can be tolerated as to either the underlying facts or the ultimate conclusion." (386 F. Supp. at 382).

The *Lessard*[3] court, however, stated that the necessary findings for an acceptable standard of proof are "mental illness and imminent dangerousness to self or others beyond a reasonable doubt, based, at minimum, on a recent act, attempt, or threat to do substantial harm, and a showing is made by evidence beyond a reasonable doubt that all less drastic alternatives to commitment have been investigated and are unsuitable or unavailable" (379 F. Supp. at 1377). The *Lynch* court viewed the highest degree of certitude as being "clear, unequivocal, and convincing evidence," while the *Lessard* court put itself on record as advocating evidence "beyond a reasonable doubt" as a minimum requirement for commitment.

For purposes of a general understanding, a requirement might be instituted to set arbitrary levels of confidence which would be acceptable in the minds of examiners and the courts in such instances. For example, "preponderance of evidence" might require 51 or 55 percent certainty; "clear, unequivocal, and convincing evidence," 75 percent certainty; and "beyond a reasonable doubt," at least 90 percent certainty. In other words, the notion of reasonable certainty could be analogous to statistical probability in the minds of the examiners and the court. In essence, 90 percent certainty would mean that out of every 100 cases, the likelihood (probability) is that 90 of them would be judged correctly to meet the criterion established for commitment. Casting the assessment and admission procedures in this light could be helpful to persons who have the responsibility for making legal commitment decisions. Certainly, a very high standard of proof must be a primary consideration when persons are likely to be labeled as "dangerous to others." This is particularly important in view of the subjective factors involved in psychiatric and other mental health assessments and predictions.

For more extensive discussion of this topic, the reader is referred to Wexler (1976).

The Right to Receive and Refuse Treatment

For a comprehensive discussion of the right to receive and refuse treatment, the interested reader is referred to monographs by Stone (1975) and Wexler (1976). Many mental health professionals and attorneys had hoped that the Supreme Court would address these issues in the *O'Connor* decision, but the Court restricted itself to focusing upon the single issue of an individual's constitutional right to liberty. The Court merely ruled that it is inappropriate to confine nondangerous persons "without more" (evidently meaning without any treatment) if they are capable of living in the community. The Court did not consider two matters which would have been of particular interest to the readers of this monograph, namely, whether nondangerous persons could be confined if treatment were forthcoming, and whether individuals confined due to dangerousness have a right to treatment. Parens patriae patients presumably enjoy a right to treatment; but it is not clear whether such a right must also be accorded to patients confined under the police power. Patients who are considered a danger to themselves are often committed under parens patriae power and become entitled to treatment accordingly. Civil patients considered dangerous to others and patients found not guilty by reason of insanity are confined under police power authority. Police power patients have frequently been given the right to treatment by the courts, after a hearing for committing a specific offense for which therapy was presumably appropriate.

The right to treatment issue for civilly committed patients involves additional legal considerations, such as providing treatment which is "available in the least restrictive" setting. Some institutional facilities are not well equipped to deal with high-risk security patients who might constitute a hazard to others. The potential hazard from some dangerous patients may be great enough to justify long-term confinement, resulting essentially in custodial care and treatment under humane conditions.

Some authors have recommended that, in order to demonstrate that the benefits to society from committing a person would outweigh any harm to the confined individual, the State might present evidence about the nature and amount of the treatment available which could reduce the predicted duration of the confinement. Police power commitment, in light of such information, could be justified by the promise of treatment, and an individual committed

under such conditions would have a due process right to receive it if he so desired. However, care should be taken to avoid promises which may be tantamount to coercion, indicating that a particular form of treatment will definitely be curative and will reduce the length of stay, when, in fact, it may not. This obtains especially if the treatment is of an intrusive or aversive type.

The right of an involuntarily committed patient to refuse treatment is also an important issue. When judged to be legally competent, a patient presumably has the right to voluntarily receive, or to refuse, the proposed treatment. Lacking the competent patient's consent, a State does not have the authority to impose therapeutic procedures upon the individual. However, if judged to be legally incompetent, the patient's refusal may be handled by the court appointing a guardian, or other legally qualified individual, to provide proxy consent, if it is judged to be in the best interests of the incompetent individual. Persons involuntarily committed under the police power are confined in view of their potential dangerousness to society, but they may well be legally competent. These patients may voluntarily avail themselves of treatment, but they also have the right to refuse treatment if they so choose.

The easy access to civil commitment procedures for persons who may be classified as mentally ill and/or dangerous to themselves or others has begun to reverse itself in recent years. Even though a direct ruling was not made by the U.S. Supreme Court on this issue, the dicta in *O'Connor*[6] by Mr. Justice Stewart and Chief Justice Burger have stimulated legal and mental health professionals to examine anew the entire process of commitment of dangerous persons (Frederick 1976). Some earlier studies very relevant to this topic have centered around such cases as *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania*[1] and *Baxstrom* v. *Herold*,[10] which are elaborated in chapters by Thornberry and Steadman, respectively, later in this monograph. Steadman (1973) has followed the Baxstrom patients at length.

The courts[2,3,4,11] have spelled out definitive formal commitment proceedings surrounding due process, giving particular attention to the concept of dangerousness and involuntary commitment. Courts have become cognizant of the necessity for procedural safeguards in the civil commitment process. These are summarized for the quick reference of the reader as follows:

(a) Notice—notice for commitment must be given sufficiently in advance of the court hearings to allow an opportunity for suitable preparation.

(b) Presence of the person considered for commitment—unless the right has been knowingly waived, the person proposed for commitment must be present at the court's proceedings.

(c) Right to prompt preliminary hearing—when held on an emergency basis, detention is justified only until a probable cause hearing can be conducted, while emergency detention after a probable cause finding is justified only for the time required to arrange for a full hearing.

(d) Right to counsel—the subject has the right to be represented by counsel at all judicial proceedings and other official hearings affecting the decision.

(e) Requisite findings to support commitment—justifiable reasons, rather than personal opinion, are necessary to remove an individual from society.

(f) Commitment with the least restrictive alternative necessary and available—the burden of proof rests upon locating the alternatives that are available and deemed suitable to the individual's needs.

(g) Standard of proof—due to stigmatization and loss of liberty, a high degree of certainty and standard of proof are necessary to remove a person from society.

(h) Conduct of the commitment hearings—the subject of involuntary commitment proceedings, whether civil or criminal, must be given the opportunity to offer evidence in his own behalf.

(i) Right to remain silent—this includes the right to silence during mental examinations and the right to refuse to answer incriminating questions.

(j) Trial by jury—while there is no constitutional right to a trial by jury, most courts assume that in most, if not all, cases a jury hearing is desirable.

(k) Record of proceedings—the full record, including findings appropriate for review, must be compiled and maintained.

(l) Waiver of rights—waiver of constitutional safeguards required in involuntary commitment is acceptable with the understanding that the waiver is made with the informed consent of the subject and with the approval of the court.

These safeguards help insure that civil commitment hearings will be administered with justice and will focus upon the specific issues that need to be addressed. In addition to refinements resulting from case law, legislation will also be needed to achieve more accountable and desirable procedures in the commitment process. It is hoped that the contributions in this monograph will stimulate legislators and interested professional groups to reexamine their own State laws and policy regulations in order to serve the needs of all concerned more effectively.

Footnotes

1. *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966, 1971.
2. *Bell* v. *Wayne County General Hospital*, 384 F. Supp. 1085, E. D. Mich., 1974.
3. *Lessard* v. *Schmidt*, 349 F. Supp. 1078, E. D. Wis., 1972.
4. *Lynch* v. *Baxley*, 386 F. Supp. 378, 1974.
5. *State ex rel Hawks* v. *Lazaro*, 202 S.E. 2d 109, W. Va., 1974.
6. *O'Connor* v. *Donaldson*, 422 U.S. 563, 1975.
7. *Mathew* v. *Nelson*, Civil Action 72-C-2104 (N.D. Ill 1975), appeal pending No. 75-1995 (7th Circuit).
8. *Suzuki, et al.* v. *Yuen, G., et al.* Civil 73-3854, Hawaii, 1977.
9. *Humphrey* v. *Cady*, 405 U.S. 504, 509, 1972.
10. *Baxstrom* v. *Herold*, 383 U.S. 107, 1966.
11. *Kendall* v. *True*, 391 F. Supp. 413, W.D., Ky., 1975.

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CHAPTER 2

Dangerousness of the Mentally Ill— A Methodological Reconsideration

Joseph E. Jacoby

Introduction

The Issue: Are the Mentally Ill Dangerous?

The mentally ill are a group of deviants who suffer a particular burden more extensively than many other deviant groups; *they are feared.*[1] To most people the apparently unpredictable or bizzare behavior of the mentally ill suggests the possibility of imminent violence.

Popular concern over the dangerousness of the mentally ill is reflected in Western legal history.[2] In common law, the restraint of an insane person without judicial approval has been limited to situations involving imminent danger to people or property. This common-law principle became statute law in the United States shortly after the Colonial period, with the modification that restraint was to be necessary for medical treatment. The legal history of mental illness is elaborated elsewhere in this monograph by Robitscher. As of 1971, of the 43 States which provided for judicial hospitalization, 9 made dangerousness the sole criterion, and 18 other States also included need for care or treatment as an acceptable reason for hospitalization.

Today, concern for the civil rights of powerless groups is being manifested in revisions of statutes and in court decisions. As forced treatment for a person's own good is being discarded as a violation of his civil rights, dangerousness (variously defined, or indeed, even undefined) has become the residual acceptable justification for involuntary hospitalization.

All of the public concern and legal provisions beg the question as to whether the mentally ill are in fact dangerous or, more precisely,

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whether they are any more dangerous than the general population. While psychiatry provides clues to the theoretical relationships between mental abnormality and violence, social science has provided the empirical data on which consensus on this issue is based.

The methodology of existing research on the dangerousness of the mentally ill is reviewed critically in this treatise to determine whether this consensus is soundly based.

Literature Review

Over the last half century, the most widely adopted method for assessing the dangerousness of the mentally ill has been to study the extent of dangerous behavior among large cohorts of patients discharged from State mental hospitals and then to compare the dangerousness of the former patients with the dangerousness of the general population. In practice, dangerousness has been operationalized as officially recorded arrests for violent offenses, though not all studies have differentiated among types of offenses.

Seven major studies, conducted between 1922 and 1967, form the basis for most informed generalizations about the dangerousness of the mentally ill.[3] In the first of these studies, Maurice C. Ashley (1922), Superintendent of Middletown Homeopathic Hospital in New York State, reported on 1,000 cases paroled from his hospital over the preceding 10 years. Approximately one-third of the patients had been readmitted, but only 12 had been arrested (for vagrancy, assault and battery, forgery, swindling, and profiteering).

In February 1938, Pollock (1938) followed up on all 9,563 patients (5,092 men and 4,471 women) paroled from New York State civil mental hospitals during the fiscal year ending June 30, 1937. He found rates of arrest for all offenses committed by former patients of both sexes to be lower than arrest rates for the general population: 12.5/1,000 versus 184.4/1,000 for males and 1.03/1,000 versus 15.1/1,000 for females, or total rates of 6.9/1,000 for all patients versus 99.7/1,000 for the general population.

Cohen and Freeman (1945) reported on all 1,676 patients who were either discharged or paroled during the 4-year period, November 1, 1940 to October 28, 1944, from the Norwich Connecticut State Hospital. Transfers from the State prison and out-of-State residents were excluded. After an estimated average of 2 years outside the hospital, 5.2 percent of the subjects had been arrested, presenting an arrest rate of 4.2/1,000 for the patients versus 27/1,000 for the general population. Comparison with biannual arrest rates of the general population for individual offenses revealed lower rates for every offense among the patients. Breakdowns for arrests of male and female patients were not given.

Brill and Malzberg (1962) followed up the largest group of patients, studying all 10,247 male patients over the age of 16, discharged from New York State mental hospitals in fiscal 1947. The fingerprints of 5,354 of these men were registered in the State central fingerprint file. Postdischarge arrest records for this sample were obtained by a search of the files at the end of 1952. The selection of patients for fingerprinting had not been random, but it had stressed including cases "where there was any probability of antisocial activity in the past." Therefore, arrest rates for the unregistered patients were estimated from the presence in the unregistered group of background characteristics which were strongly associated with arrest in the registered group.

For the followup period, averaging 5.6 years after release, Brill and Malzberg found arrest rates among former patients of 44.65/10,000, compared with 491.09/10,000 for the general population of males in New York State age 16 and over. Annual arrest rates for various offenses were lower for patients for almost every offense.

Rappeport and Lassen (1965) did the first major study in which findings appeared to contradict those of previous researchers. They found that for two cohorts of male patients, released in Maryland in 1947 (N=708) and 1957 (N=2,152), arrest rates for some serious violent offenses were higher than for the general population. Former patients were arrested more often, almost every year after discharge, then were the general population, with diminishing variation in the differences between patient and population arrest rates in each of the 5 years after discharge.

In a parallel study of two female cohorts (for 1947, N=693 and for 1957, N=2,129), Rappeport and Lassen (1966) found significantly higher rates of aggravated assault among the 1957 cohort than for the general female population in 4 of the 5 years following release.

Finally, Giovannoni and Gurel (1967) studied 1,142 male patients discharged from Veterans Administration hospitals in California, following their arrest histories from 1957 through 1960. Considering only those patients who remained outside the hospital at least 30 days and alive 4 years after admission, they found homicide, aggravated assault, and robbery rates which exceeded those of the general population by factors of 21, 3, and 1.6, respectively.

Consensus on the Issue

The opinion commonly held by mental health professionals and social scientists is economically summarized in the following statement by the Professional Advisory Council of the National

Association for Mental Health, submitted to the National Commission of the Causes and Prevention of Violence (Mulvihill and Tumin, 1969. p. 444):

> (1) The popular idea that the mentally ill are overrepresented in the population of violent criminals is not supported by research evidence.
>
> (2) Generally, persons identified as mentally ill represent no greater risk of committing violent crimes than the population as a whole.

To this the Commission staff added:

> Most studies indicate that the discharged mentally ill, as a whole, are significantly *less* prone than the general population to involvement in violent behavior. *All* studies, to date, indicate that the mentally ill are no more likely than the general population to be involved in crimes such as assault, rape, or homicide. (Italics in original.)

The violence commission staff did not indicate whether it had considered the studies cited here, which present apparently contradictory findings.

In the face of some contrary evidence, mental health professionals share the belief that mentally ill persons, as a group, are not especially dangerous. It remains to be seen whether the available research evidence warrants their confidence.

Selection of Research Populations

A basic problem of all studies cited here was not created by the researchers, but rather results from the dispersion (throughout and outside treatment programs) of the group known as "the mentally ill." All seven studies used former patients of mental hospitals; six used State hospitals, and one a Veterans' Administration hospital. Therefore, generalizations drawn from these studies would apply only to discharges from this type of institution, not to all mentally ill persons, unless it could be shown that these discharged patients were representative of all the mentally ill.

The concept "mental illness" has never been operationalized adequately in epidemiological studies to permit comparisons between mental hospital patients and all persons to whom the label might apply. However, there is evidence that State mental hospital residents are not representative of all persons who *receive treatment* for mental disorders.

In their landmark study on social class and mental illness, Hollingshead and Redlich (1958) found that two-thirds of their research

population, under treatment, were patients in State hospitals. However, persons suffering from the two major diagnostic categories of mental disorders received treatment in very different ways; 10 percent of neurotics versus 84 percent of psychotics were in State hospitals (p. 258). Furthermore, Hollingshead and Redlich found among psychotics an inverse relationship between social class and length of hospitalization, with patients from the lowest social class staying nearly 50 percent longer than persons from the highest class, 14 versus 7 years (p. 229). Because lengths of hospitalization of psychotics were so substantial, the lower class members of discharge cohorts would be substantially older than upper class members.

A further confounding variable is presented by the fact that hospitals select patients for discharge partly on the basis of predictions of low probability of postrelease violence. Historically, these predictions have been very conservative, leading to long periods of hospitalization for many patients (Steadman 1972). If such predictions do result in better-than-chance selection of potentially dangerous patients, from among all patients, those patients who would, in fact, be dangerous would be spending longer periods, on the average, in the hospital. Their longer stays would mean older average ages at time of release; and older ages are known to be associated with lower rates of violence. Therefore, discharge cohorts would be underrepresented in proportions of patients likely to be dangerous.

One of the major problems in assessment of the dangerousness of the mentally ill is the rapidly changing form of institutional response to mental illness. The Community Mental Health Centers Act of 1963 created a massive construction program, resulting in the establishment of over 300 community mental health centers. Meanwhile, other psychiatric clinics have been established or have expanded their services. Thus, increasing numbers of mentally ill persons have been diverted from State mental hospitals and into inpatient and outpatient programs of other facilities.

The general trend toward decentralization of mental health care is reflected in the changing distributions of patient care episodes among various types of facilities. State and county mental hospitals, which accounted for half of the patient care episodes in 1955, accounted for only one-fourth in 1968 (NIMH 1970).

This decentralization causes studies of discharged State hospital patients to include increasingly smaller proportions of all persons receiving treatment. Therefore, it becomes ever more tenuous to maintain that these studies include representative samples of all mental patients, let alone all mentally ill persons.

For all the above reasons, it is not justifiable to assume that postrelease dangerousness of State hospital patients is equivalent to

dangerousness of all persons receiving treatment for mental disorders. It is an even larger leap of faith to assume that the dangerousness of hospital discharges is equal to the dangerousness of the unknown number and character of all mentally ill persons.

It is to the credit of the authors of studies cited here that none took that leap. All restricted their conclusions to statements about the dangerousness of discharged mental patients, not the mentally ill in general.

The issue of nonrepresentativeness is raised here because other authors *have* drawn more general conclusions from the studies reviewed here, primarily because these studies constitute the best available evidence. Some writers have acknowledged the problem (see, for example, Gulevich and Bourne 1970, p. 310). However, logical and linguistic rigor sometimes give way to pressure to draw general conclusions, particularly when there is a felt need for generalizations on which policy can be based. Note, in the quotation at the end of the preceding section, the ease with which the violence commission slipped from a statement about studies of "the discharged mentally ill" to a conclusion about "the mentally ill."

Common Methodological Problems

If the seven studies are considered in light of what they are—attempts to determine the dangerousness of discharged mental patients, they are still flawed in several crucial ways. Here each of the flaws is discussed along with the sensitivity of the researchers to the underlying issues.

Use of Arrest Records

The first problem, involving the use of police arrest records as the sole basis for assessing dangerousness after discharge, generates several difficulties. One problem with using police records is the incompleteness of central record files. Practices vary among cities and States, but not all police agencies report all offenses to a central State agency. Only Rappeport and Lassen avoided the pitfalls of depending on central files by checking the arrest records of all police jurisdictions in the State.

Though Rappeport and Lassen were more thorough than other researchers in checking police records, they, as well as others, overlooked patient offenses committed in another State. Cohen and Freeman sought to diminish the effect of subject mobility by excluding out-of-State residents. None of the studies included methods

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for uncovering offenses by the more mobile subjects who could, by virtue of their relative youth, be more prone to violence than residentially stable subjects.[4] Excluding out-of-State arrests causes underestimation of mental patient dangerousness rates.

The general inadequacy of police records as indicators of the extent of crime is well documented. The major problem in using official arrest data is that not only are officially recorded offenses only a small proportion of all offenses committed, but they are likely to be unrepresentative of all offenses. Furthermore, we cannot assume that arrests of mental patients are either representative of all offenses by mental patients or that these arrests are unrepresentative of mental patient offenses in the same ways and to the same degree that general population arrests are unrepresentative of all offenses. This aspect of the use of police records, therefore, may create bias whose direction cannot be inferred from available evidence.

Different contingencies may come into play when the police encounter an ambiguous situation involving someone who is apparently mentally ill or who is known as a former mental patient. The suspect's apparent or alleged condition may weigh heavily in the investigating officer's decision to make an informal adjustment, make an arrest, or attempt to have the suspect hospitalized.

Various factors, such as State law, local police practice, proximity of a mental hospital, severity of alleged offenses, and desires of victims and family, would no doubt affect this decision. Readmission to a mental hospital is a viable and frequently employed alternative to arrest, but it was generally ignored in the studies cited.[5]

As noted, Ashley (1922) showed an awareness of the incomplete picture drawn by the exclusive use of arrest rates. He reported the percentage of subjects readmitted to the hospital, their economic condition, and adjustment problems, indicating a broader awareness that post-hospital adjustment includes factors in addition to arrest. Unfortunately, he did not pursue the issue further, omitting the reasons for readmission.

All the other studies missed the point completely; an unknown number of former patients are returned to hospitals by the police, relatives, or others without an arrest being recorded, even though the precipitating event may have been a violent incident. In addition to the possibility of new civil commitment, informal readmission to the hospital is greatly facilitated in the 46 States which provide for conditional release, where no further judicial process is required to return a patient on that status to the hospital (Brakel and Rock 1971, p. 134-135). The exclusion of rehospitalization data results in underestimation of subject dangerousness.

Controlling for Demographic Variables

Giovannoni and Gurel (1967), in puzzling over the apparently contradictory findings of Rappeport and Lassen to previous studies, stated:

> . . . the numbers and kinds of patients released from New York State hospitals in years past, were undoubtedly different from the numbers and kinds of patients currently being released from other hospital systems . . . . (p. 152)

Unfortunately they did not clarify what they meant by "kind," or attempt to make corrections in their own study for this changing phenomenon, but then none of the preceding studies took into account the different kinds of patients.

All except Ashley (1922) and Cohen and Freeman (1945) reported arrest rates separately for male and female subjects, recognizing that males have an overall arrest rate in the general population of about five times that of females. They saw that it is necessary to compare subject arrest rates with base rates computed on general population members of the same kind (in this case, sex). Yet, none pursued this commonsense notion further than the sexual distinction.

Other demographic factors besides sex are known to be associated with arrest rates. None of the studies controlled for any of them. This is particularly surprising in the case of Brill and Malzberg (1962), who reported, in detail, the association of a variety of background factors with arrest for their subjects and concluded:

> Arrest rates among the patients (sic) group are directly related to the same factors as are the crime rates of the general population. These factors include recidivism, metropolitan residence, unmarried status, age, sex, alcoholic and drug addiction, and residence in delinquency areas. (p. 6)

Pollock (1938), Brill and Malzberg (1962), and Rappeport and Lassen (1965) took into account the very low incidence of mental hospitalization of people under age 16 (less than 1 percent of the mental hospital population, compared to over 20 percent of the general population). They computed base arrest rates for the general population over age 15. However, Cohen and Freeman, and Giovannoni and Gurel, did not report adjustments for the attenuated age distribution of mental patients in computing base rates. Even correcting for low incidence of hospitalization of the young may not be sufficient to create comparable base rates. None of the studies took into consideration the well-documented association between age and criminal offensivity. If it were the case that the

age distribution of a particular patient discharge cohort differed from the age distribution of the general population, one would expect different offense rates based on this difference alone.

Comparison with Base Rates

Once a full accounting of all arrests and violent episodes of released patients is made, the task would appear to be nearly over. All that remains is to compare the arrest rate with a base rate for the general population to determine whether patients are arrested more or less often, are more or less dangerous, than the general population. Again, on this apparently simple point, most studies fail, in various degrees, because they ignore certain factors in computing arrest rates for patients and comparison base rates for the general population.

To note that hospitalized mental patients have very low arrest rates is to state the obvious; hospitalized patients are not "at risk." They have little opportunity to commit offenses which would be reported to, or recorded by, the police. Only Pollock, and Giovannoni and Gurel, took into account, in computing patient arrest rates, the well-known fact that mental hospitals have revolving doors; a large proportion of discharged patients return to the hospital.[6] They recognized that it makes sense to compute annual arrest rates based on 365 patient-days at risk, outside the hospital. This involves knowing how much time, cumulatively, the subject population spent in hospital or jail during the followup period, subtracting this total from the gross number of patient-days since discharge, and recomputing arrest rates on the deflated time base. Of course, the same correction should be made for the general population, but the affect would be much less, since released patients are a much greater risk for hospitalization than are the general public.[7]

Pollock based his calculations on the average daily population of patients on parole from the hospital, but he appeared to ignore time spent in jail. Giovannoni and Gurel did the same calculation, reporting "the average number of patients in community on any one day" was 764 out of a possible 1,461. Thus, they demonstrated the tremendous importance of considering the factor of diminished period at risk; the correction caused a 48 percent inflation of annual arrest rates for discharged patients.

Giovannoni and Gurel made the best attempt to take into account factors other than rehospitalization which decrease time at risk apparently, only they deducted, from the time base, subject-days spent in penal institutions. They also reported a method of

controlling for the affect of mortality, which differs considerably between mental patient and general populations.[8] They included in their analysis only subjects who remained alive at the end of the followup period.

However, this maneuver excluded those subjects who might have been too frail to commit offenses requiring much physical prowess, while, at the same time, excluding subjects who may have died through participation in violent crimes. It is difficult to say in which direction the resulting bias would be.

A Suggested Research Design

The existence of such a variety of methodological deficiencies suggests we attempt to plan a study which avoids errors of the past. The following sketchy outline touches on the major methodological features which might be included in an ideographic study of the dangerousness of the mentally ill.

Given the current impossibility of directly assessing any characteristic of all the mentally ill, we are forced to focus plans on patients under treatment. After a geographical area is selected, the first consideration would be to describe a research population which represents the distribution of patients who had received inpatient or outpatient treatment from all sources: State, county, and private mental hospitals; psychiatric units of Veterans' Administration and general hospitals; psychiatric clinics and mental health centers; and private psychiatric practice.[9] There are several ways in which the research sample could be selected, each with advantages and disadvantages, and each leading to different results. One reasonable choice would be all patients who had received treatment within a brief, given time period (day, week, or month), whether or not this was the first treatment episode.

To permit calculation of annual rates of dangerous behavior, based on time at risk, entire postdischarge histories of the inpatient sample of the research population would be followed, including dates and circumstances of any deaths which occur, reasons for arrest, lengths of imprisonment, and reasons for and lengths of rehospitalization. Outpatients would be considered at risk during periods when their treatment does not involve 24-hour residential treatment. Since it appears that peak arrest rates occur within 2 years after discharge, it would probably not be necessary to extend the followup period much beyond 2 years. To insure that arrest and rehospitalization data were conserved, records of mental health and criminal justice agencies in adjoining States would be checked to

supplement national arrest data from FBI files. A factor in selection of geographical location for this study would be the reliability of arrest reporting by all police agencies in the region to a central agency.

It is worth noting, here, the practical difficulties which would be involved in a study like the one proposed. Particularly difficult would be obtaining official and confidential information from a variety of sources. Therefore, this suggested design must be considered a guide and not a refined plan. Supplemental research would be conducted, contemporaneously, to determine the ways in which local police practices determine the disposition of allegedly mentally ill suspects. Of particular interest would be the influence of the knowledge that a suspect was formerly, or is currently, a mental patient. Because the results of such a substudy would be in the form of police *inaction* (i.e., the circumstances in which police failed to arrest in cases involving mental patients), we would probably have to consider these results only suggestive of the affect of local police discretionary behavior. The difficulty of assessing such a phenomenon by survey or participant observation techniques would be formidable.

After all the data were collected, dangerous behavior rates of the mental patients would be calculated by dividing total numbers of rehospitalizations and arrests, for actions resulting in injuries to persons, by subject-days at risk. For comparison with the mental patient rate, a general population dangerousness rate would be computed by first determining from local police records the various arrest rates for violent offenses of subcategories (i.e., sex, age, race, residence, socioeconomic status, and marital status) of the general population. Then, a comparable base-dangerousness rate would be calculated by weighting subcategory rates by the proportion of mental patients in each subcategory and, then, by summing the weighted rates. This sum would be the officially recorded dangerous-behavior rate for a sample of the general population with the same demographic characteristics as the mental patient sample.

The findings of such a study would not be limited to a comparison of two rates, however. They would permit the pinpointing of subclasses of mental patients who might be highly prone to dangerous behavior after discharge, suggesting the most efficient channeling of therapeutic and aftercare attention. This somewhat crude outline of a research design does not contain solutions to all the methodological deficiencies of previous studies. However, if such a study were attempted, and most of the errors of past studies could be corrected, the results would be a better indicator than furnished by previous studies of whether mental patients are

more or less dangerous than the general population. Furthermore, the gap between substantiated empirical generalizations about mental patients and inferences about all the mentally ill would be narrowed.

Summary and Conclusions

Review of the seven major studies of the dangerousness of mentally ill populations after discharge indicated that earlier studies showed fewer offenses among former patients than in the general population, while more recent studies seem to show the opposite. There is consensus among mental health professionals, however, that the mentally ill, as a group, are not especially dangerous. The studies were criticized on a range of methodological deficiencies. Several of these flaws cause an underestimation of the dangerousness of the mentally ill: use of incomplete arrest records, omission of out-of-State arrests, omission of violent incidents resulting in rehospitalization rather than arrest, and failure to take into account decreased time at risk in computing annual arrest rates.

The direction of the effect of other deficiencies is unknown: nonrepresentativeness of arrests of the mentally ill and of the general population, and differences in demographic characteristics between mentally ill and general populations.

Many of the methodological problems discussed here could be solved or substantially alleviated. Others, such as the comparability of patients under treatment with all mentally ill persons, may remain forever imponderable. However, the social consequences of assumptions about the dangerousness of the mentally ill are both clear and serious. In the past, our society has incarcerated many thousands of people for decades because they were believed to be dangerous as a consequence of mental disorder. Rubin (1972) estimates that 50,000 mentally ill persons are preventatively detained each year because they are believed to be dangerous.

Considerable heat is generated whenever the dangerousness of the mentally ill is discussed. Advocates of deinstitutionalization cite the studies which indicate low rates of violence among released patients and bemoan the enormous human and financial waste resulting from the unnecessary prolonged incarceration of many allegedly dangerous mentally ill persons. Those opposed to rapid deinstitutionalization, sometimes with vested interests, easily find sensational examples of the horrible consequences of prematurely releasing violent mental patients: A recent study (Zitrin et al. 1976) of 867 mental patients in New York, which indicated higher rates of crime among released patients, prompted

a furious attack by a citizens' group concerned with the rights of mental patients (McDonald 1975). The attack involved not only a criticism of the methodology of the study, but also an indictment of the objectives of the researchers.

The public believes that there is an association between dangerousness and mental illness. The behavioral and social sciences are faced with the obligation to provide answers about the direction and degree of this relationship, to inform public opinion, and to provide hard data for policymakers. In the face of substantial flaws present in existing studies, it seems necessary that we reconsider empirically, with all the methodological sophistication we can muster, the validity of the generalization that the mentally ill are not particularly dangerous.

Footnotes

1. Rabkin (1972) has provided a fine review of the literature on opinions of mental illness held by the general public, mental health professionals, and mental patients.

   Nunnally (1961) found that the mentally ill are regarded with "fear, distrust, and dislike by the general public" (p. 46). Furthermore, "Old people and young people, highly educated people, and people with little formal training all tend to regard the mentally ill as relatively dangerous, dirty, unpredictable, and worthless" (p. 51).
2. The following brief summary of the legal response to mental illness is taken from Brakel and Rock (1971, p. 36).
3. This paper is not represented as an exhaustive review of the literature on the dangerousness of the mentally ill. Excellent reviews already exist. (See for example, Gulevich and Bourne (1970) for studies in the United States, and Wolfgang and Ferracuti (1967) for international studies.) Rather, those major studies were selected which were performed in the United States and are often cited as evidence of the level of dangerousness of the mentally ill.
4. Lystad (1957) studied the geographic mobility after discharge of all first admissions in 1953 and 1954, diagnosed as schizophrenic at the State mental hospital serving New Orleans. Though her findings are only suggestive, due to the small sample size (N=94), she found significantly higher rates of geographic mobility among younger than among older discharged patients.
5. In a study of commitment practices in several major cities, great differences were found in police practices in disposition of allegedly mentally ill persons. While in most jurisdictions police commonly charge mentally ill persons with disorderly conduct and hold them in local jails preliminary to judicial commitment, Los Angeles police formally arrest few such persons. In 1 year, in the early 1960s, the special police hospital detail which acts as a screening and petitioning agency for the entire Los Angeles Police Department, processed 1639 persons taken into custody as mentally ill. Temporary commitment was obtained for 40.5 percent, while only 6.3 percent were booked on criminal charges. This situation has most likely

changed in Los Angeles, with drastic changes in California's mental health laws.

As counterpoint to the low proportion of arrests, the same source cites an unpublished study of hospital admission notes of 100 randomly selected patients. In 71 percent of the cases, the precipitating events leading to admission were one or more chargeable criminal offenses, 24 of which were considered felonies, and 124 misdemeanors. Of the misdemeanors, more than half were assaults, batteries, or disorderly conduct offenses (Rock 1968, p. 98-99).

6. Additionally, readmission frequently occurs within the time span covered by most followup studies. Gorwitz (1966) reported on the hospitalization experience of a cohort of all persons aged 25 to 54, admitted between July, 1961, and December, 1962, to the three major Maryland State mental hospitals. Of the 4,263 subjects, 94 percent were released within 18 months. Of those released, 37 percent were rehospitalized within 18 months of their first admission, averaging 1.6 rehospitalizations for subjects rehospitalized.
7. In the year 1969, 47 percent of all admissions to State and county mental hospitals had been admitted previously to such institutions. Broken down by age, the percentage of previously admitted patients varied from 13 percent for ages under 18, to 56.3 percent for ages 45-64 (NIMH, 1971).
8. In the study by Gorwitz (1966), mental patients grouped into 10-year age intervals had mortality rates 4.3 to 6.5 times higher than the general Maryland population of the same age groups. Of the deaths occurring during the 18-month study, 56 percent occurred in the community. It should be noted that this study excluded patients over age 54, the age group which would be expected to have the highest mortality rate.

   In a continuation of Hollingshead and Redlich's study, Myers and Bean (1968, p. 66) found higher age-specific mortality rates for patients and former patients than for the general Connecticut population in all but the over-85 age group. They explain the difference as a result of the association between psychiatric and physical disorders.
9. There currently exists in the United States, one area, Monroe County, New York, where every treated case of mental illness is recorded in a central register, making this county a likely prospect for the type of study envisioned here.

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II. Legal and Legislative Aspects

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CHAPTER 3

Notes on Defining the "Dangerousness" of the Mentally Ill

Alexander D. Brooks

Introduction

The legal determination that a mentally ill person is "dangerous" can have drastic consequences. A finding of dangerousness can result in an indeterminate and lengthy involuntary confinement in a civil mental hospital.[1] If the civilly committed, mentally ill person is found to be too dangerous for safe confinement in the civil hospital to which he has been committed, he may be transferred to a correctional hospital for the so-called "criminally insane," even though he has committed no crime.[2] In some States, a "dangerous" civil patient, though guilty of no offense, can be transferred to, and placed in, a prison.[3]

For the mentally ill offender, the consequences of a finding of dangerousness are likely to be even harsher.[4] A finding of dangerousness applied to a defendant accused of crime, but ruled incompetent to stand trial, may result in confinement in a correctional or maximum security hospital, rather than in a civil hospital, regardless of the seriousness of the original charge.[5] If the mentally ill offender has been tried but acquitted because of insanity, he can, in a number of States, be further confined only if he is found to be "dangerous," the mode of his confinement being affected by that finding.[6] Release will depend on a determination that the dangerousness is no longer present, a difficult proposition for the patient to establish.[7]

A mentally disturbed prisoner, who is otherwise able to withhold his consent to being drugged, may be subjected to drugs against his will if a consulting psychiatrist finds him to be dangerous.[8] A prisoner who becomes mentally ill can be transferred to, and retained in, a correctional mental hospital if he is found to be dangerous.[9] Even juvenile offenders, in many ways members of a protected group, may, if confined, be subjected to invidious transfers if found to be mentally ill and dangerous.[10] In California, the confinement of a juvenile, who would otherwise be subject to

release, may be extended for 2 year periods, which are indefinitely extendable to what has been characterized as a life term if the juvenile is found to be ". . . physically dangerous to the public because of his mental . . . deficiency, disorder or abnormality."[11]

Many States provide long-term indeterminate confinement in special treatment programs for particular types of "dangerous" offenders, such as dangerous sex offenders, whose confinement is sometimes provided in lieu of, but often in addition to, regular prison terms.[12] Maryland requires an indeterminate confinement for so-called "defective delinquents," defined as "intellectually deficient, or emotionally unbalanced persons, who, because of their persistent antisocial or criminal behavior, demonstrate that they are an 'actual danger' to society."[13]

The A.L.I. Model Penal Code proposes lengthier imprisonment for "mentally abnormal persons" who are found to be dangerous.[14] The Model Sentencing Act provides for longer terms for convicted criminals suffering from severe personality disorder who are found to be "dangerous."[15] A Federal statute provides for additional sentences for "dangerous special offenders."[16] Finally, a recent California Supreme Court decision has made a determination as to "dangerousness" critical by imposing a duty upon psychotherapists, to warn a prospective victim of any potentially dangerous act threatened by a person in treatment for emotional and mental problems.[17] If a patient is considered dangerous, the usual confidentiality of the doctor-patient relationship is breached.

This brief, and by no means complete, list of special and invariably onerous dispositions resulting from a finding of dangerousness suggests the importance of the concept of dangerousness in the evolving body of mental health law. In recent years, the concept of dangerousness has emerged as a major factor in determining the disposition of mentally disabled persons. Indeed, the dangerousness concept is widely regarded as embodying an even more restrictive approach, with respect to the civil commitment of mentally ill persons, than has previously been the case, in view of the fact that earlier commitment standards have been significantly looser and more permissive. The dangerousness requirement has been perceived by many as substantially more protective of the civil liberties and rights of the mentally ill. Whether it is, in fact, more libertarian depends on how it is actually applied. What is quite remarkable is that, despite the importance of a finding of dangerousness, and the extraordinary effect the implementation of that standard has had on the lives of thousands of persons,[18] there has, until recently, been little rigorous examination of what is meant by "dangerousness"; whether dangerousness can be adequately predicted; how much so-called dangerousness our society should tolerate; and what

procedures should be used to determine dangerousness. In some quarters, the dangerousness approach has been presented as a liberalizing force in law, representing a rejection of the position that mentally ill persons should be confined for less. Others contend that the dangerousness standard, by reason of its vagueness, is both under- and over-inclusive, in that an over rigorous application of it, particularly as an exclusive criterion, prevents the hospitalization of many who desperately need confinement; whereas a loose application of it does not discourage inappropriate confinement. It is argued, moreover, that the dangerousness standard can unnecessarily stigmatize persons as "dangerous," who are merely disabled, or who are in need of treatment.

Elsewhere in this monograph, there are discussions of other facets of the dangerousness issue. This discussion is confined to but one dimension of the dangerousness question: the problem of defining what we mean, particularly in the context of civil commitment, when we refer to a mentally ill person as dangerous.

How Is Dangerousness Defined?

One would ordinarily expect that, if significant individual deprevіations flow from a finding of dangerousness, the term would be carefully and precisely defined so that it could be applied in an appropriate manner and with reasonable uniformity. It is the tradition of another branch of law, the criminal law, that, where the deprivation of an individual's liberty is at risk because of an application of the State's police power, rigorous specificity in defining offenses is demanded. However, that has not been our history in dealing with the mentally ill, even though a substantial proportion of involuntary hospitalizations are implementations of the State's police power and are just as surely implementations of the State's social control function as are confinements under the criminal law. This is not to say that involuntary civil hospitalizations are "punishment." Nevertheless, to the extent that mentally ill persons are confined against their will because of their dangerousness to others, it is clear that the deprivation of their liberty is primarily for the benefit of the State and not themselves.

That part of the law which deals with the involuntary civil commitment of the mentally ill is one area in which findings of dangerousness now play a particularly substantial role. Yet, in earlier civil commitment statutes, legislatures have neglected to define the term, beyond providing that a mentally ill person may be involuntarily confined if he is "dangerous," or is likely to "injure" or

"harm" others, or himself. Indeed, some legislatures merge the concept of mental illness and dangerousness by defining mental illness as a condition that makes one dangerous.[19] Other statutes are circular. For example, New York's 1971 Criminal Procedure Law (now repealed) once defined a "dangerously incapacitated person" as ". . . an incapacitated person who is so mentally ill, or mentally defective, that his presence in an institution operated by the Department of Mental Hygiene, is dangerous to the Safety of other patients therein, the staff of the institution, or the community."[20]

It is not at all obvious why there has been such a lack of precision in definition. Some legislatures, in adopting earlier statutes, may not have been clear in their own minds when they adopted the term. A review of legislative history reveals that the word "dangerousness" and its counterparts are often not defined adequately, at the inception of the legislative process. Other legislatures may have thought, when adopting their statutes, that words such as "danger," "harm," "injury," and the like were sufficiently clear and needed no further refinement. Indeed, one court, in rejecting a contention that the term "injury" was unconstitutionally vague, argued that, "Webster has no difficulty giving a definition of these words which are in ordinary and common usage," and reasoned that, while the word "injury" was "not an absolute model of clarity," those charged with administering the law, would have no difficulty in defining and applying it.[21] Still other legislatures may have hoped that further clarification would emanate from the courts. Some legislators may have intended that the term be defined in an ad hoc manner by mental health professionals, judges, and juries. This last approach seems to have been the case in California, where the term "dangerousness," as used in the Lanterman-Petris-Short Act, was deliberately left undefined in the statute, "in order to allow some flexibility in the commitment standards."[22] In any event, legislators in earlier days either failed to recognize the complexity of the concept, or, having recognized it, were unwilling to wrestle with difficult problems of definition.

The courts did not fill this definitional gap, either in their rulemaking or adjudicative capacities. Trial judges, charged with adjudicating cases, and confronted by day-to-day decisional demands, relied heavily on the conclusory testimony of psychiatrists, unhampered by rules of law. In the exercise of broad discretion, they uniformly rubberstamped psychiatric evaluations. The appelate courts, which did not have the rulemaking responsibility for defining that which would be applied below, provided little guidance. In part, this may have been because reviewing courts were not asked for such definitions. Lawyers, whose function it is to test questionable legal practices, did not present questions for appelate

review, and did not challenge the questionable applications of the term by trial judges.[23] Their performances were perfunctory. Until recently, there were few lawyers attentive to most civil commitment cases, with little goad to the courts as a consequence.

To the extent that appelate courts were called upon, occasionally, to consider what the word "dangerousness" meant, they originally defined the term with such sweeping broadness that it was stripped of any significant meaning. To illustrate: In 1960, a three-judge panel of the District of Columbia Circuit Court, in dealing with the release from hospital of an offender acquitted by reason of insanity, defined the term "dangerousness," as used in the District of Columbia involuntary civil commitment statute, as including any criminal act, whatsoever, such as passing a bad check.[24]

It had been argued before the court, that the term "dangerousness" should be limited to describing a likelihood that the patient would commit "an act of violence." However, the Court rejected this argument, saying, "We think the danger to the public need not be possible physical violence, or a crime of violence. It is enough if there is competent evidence that he may commit any criminal act, for any such act will injure others and will expose the person to arrest, trial and conviction. There is always the additional possible danger—not to be discounted even if remote—that a nonviolent criminal act may expose the perpetrator to violent retaliatory acts by the victim of the crime.[25]

A year later, the court, *en banc*, reiterated its position, but in the face of a three-judge dissent which pointed out that the term "dangerousness" had not been intended by Congress to apply to "any kind of unlawful conduct, however minor," but had been intended to apply only to "persons who have engaged in unlawful conduct of a dangerous character." "The language used," said the dissenters, "convey the idea of physical danger to persons, and, perhaps, to property."[26] In 1962, the same court ruled that the term "dangerousness" also encompassed emotional injury.[27]

Because the legislatures and courts did not provide adequate and specific definitions, the burden devolved upon psychiatrists, general practitioners, physicians, and other mental health professionals, to give meaning to terms such as "dangerousness," "harm," and "injury." Since, in psychiatry and other mental health circles, there is no generally accepted legal, psychiatric, or medical meaning of the term, and, inasmuch as it is not a part of psychiatric training to evaluate dangerousness,[28] each expert provided his own personal and subjective definition. These definitions tended to implement the expert's idiosyncratic legal views, his personal set of values about the protection of persons and society, and his hidden agenda about appropriate dispositions for the mentally ill.

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For many psychiatrists, "dangerousness" is an elastic concept that includes within its ambit any harm to others or to self that is psychiatrically cognizable, and for which hospitalization and treatment seem appropriate. Indeed, dangerousness is equated by many psychiatrists with "need for treatment," a concept which the term dangerousness was originally intended to displace. It is understandable why this should be so. The physician is trained in a tradition in which he responds with treatment and applications of the medical model to the most minor problems perceived as medical. The doctor's perception of deprivation to his patient is minimal. Even onerous treatments are subsumed within his perception of appropriateness. Finally, the average physician and mental health professional, working within the medical sphere, has little awareness that he is performing a social control function, often masked as an individual treatment function, in which he is the agent of others, and is not, necessarily, acting on behalf of the person who is euphemistically referred to as his "patient."

For the average psychiatrist, the notion of "dangerousness to others" is regarded as including even remote supposititious harms, however trivial, and whether physical or emotional. The mere outside possibility of the occurrence of some minor harm can elicit a psychiatric, or medical prognosis that the person is dangerous to others or to himself. For example, a leading psychiatrist has acknowledged that, "When practicing psychiatrists are faced with a potentially dangerous patient, we may evaluate him, using vague and subjective criteria which do not distinguish among menace, nuisance, assaultiveness, and violence."[29] Such an approach would include within the concept of dangerousness not only all criminal activity but also risks that: A manic person might deplete his family's financial resources and expose them to economic hardship; a paranoid schizophrenic might frighten another with bizarre behavior; an hysterical person might regularly call people on the phone in the middle of the night; and a sex deviant might expose himself to others, or be a "peeping Tom."

"Dangerousness to self" is a particularly elastic concept for the psychiatrist. Judicial reports, transcripts, and empirical studies are filled with instances in which psychiatrists have characterized as "dangerous" persons who have engaged in the following: wandering; being a vagabond; "eating out of maybe the trash cans, or something like that"; failing to take medicine; or wearing inadequate clothing. Left by the courts to their own devices, psychiatrists are prepared to characterize virtually all deviant behaviors of mentally ill persons as dangerous. Since very few mentally ill persons are presented for commitment unless their behavior is perceived as somewhat deviant, the extent to which deviance is equated

with dangerousness tends to render the dangerousness standard meaningless. The term affords guidance neither to the psychiatrist who testifies, nor to the judge and jury who must evaluate the testimony. This development has troubled psychiatrists as well as lawyers. A director of a court clinic has remarked, "Too often, in my experience, judges and attorneys have failed to challenge psychiatric testimony which is either incompetent, or clearly erroneous. . . . The absence of any clear written criteria for such evaluations have (sic) two consequences. It leaves the examining physician with only the broadest concept of what is expected of him. It leaves the courts and the attorneys without the means of adequately measuring the quality of his evaluation."[30]

Some psychiatrists routinely equate dangerousness with certain mental disorders. For example, they may see all paranoid schizophrenics as dangerous. In one well-known case, a celebrated psychiatrist, when asked whether "an aggressive paranoid" would be "potentially dangerous," answered: "It is conceded universally an aggressive paranoid is dangerous. I would even say that, universally, we think that any paranoid schizophrenic is potentially dangerous, because one can never tell when the meekness and submissiveness may turn around and become aggressive. . . . Ask me whether a paranoid schizophrenic is potentially dangerous, and I would say, 'yes,' "[31] Other psychiatrists are careful to point out that not all persons diagnosed as paranoid schizophrenic are dangerous; only those with certain types of delusions. In one case, a doctor stated that he had known delusional patients who were not dangerous to others, but "not with this kind of delusional material," i.e., delusions regarding law enforcement and law officers.[32]

Experienced observers have expressed the view that many psychiatrists are well aware that legal definitions of dangerousness are intended to be more restrictive, but that they ignore this and manipulate the dangerousness concept in order to accomplish their treatment objectives. In a typical commitment case, the psychiatrist, when asked why he had certified the respondent as a "menace" to himself and others, testified that the respondent "had certain paranoid delusions; feelings of persecution to the extent that he felt his life had been jeopardized on numerous occasions . . . I felt there was a reasonable possibility that he would seek redress for his persecution and . . . I had no assurance that such redress would be of an orderly or lawful type. Therefore, I felt that he might seek redress of a violent nature." However, later the psychiatrist said, "Actually, he need not have been much of a menace to himself and society. That is the current phrase used by anybody we feel needs hospital care, whether he wants it or not."[33]

In a careful study of Arizona commitment practices, Wexler has pointed out, "The literal meaning of dangerousness is admittedly ignored in favor of the best interest of the patient, i.e., whether he will benefit from treatment. Although it is recognized that such a determination is probably illegal, the psychiatrists feel it is more humanitarian to require treatment than to be thwarted statutorily in their attempt to prescribe it."[34] Judge David Bazelon has pointed out, "I have even been told that psychiatrists believe they are justified in fudging their testimony on 'dangerousness,' if they are convinced that an individual is too sick to know that he needs help."[35]

Psychiatric testimony, to the extent that it overextends the reasonable boundaries of dangerousness, reflects an amalgam of ignorance, zeal, and self-protectiveness. The ignorance represents an unawareness that the concept of dangerousness either is, or should be, carefully conceptualized. Indeed, to the extent that psychiatric and legal views run parallel, there are no constraints for the psychiatrist to be aware of. The zeal reflects the willingness of the psychiatrist to offer the appropriate legal talismanic language which will accomplish his psychiatric objective, whether or not the words are strictly applicable. In this enterprise, the psychiatrist finds that many judges are eager to defer to them. Self-protectiveness reflects the understandable desire of the psychiatrist not to run unnecessary risks by testifying to the nondangerousness of a mentally ill person who may later comit suicide, assault others, or engage in other undesirable acts.

In a perceptive analysis of the role of the psychiatrist in establishing the dangerousness of the mentally ill persons, Shah has pointed out that, "Psychiatrists may find themselves placed in a social role in which society expects them to assist in the labeling and social control of persons who are perceived by the community as disturbing, discomforting, and threatening. . . . The 'experts' might be responding to what they *perceive* is socially expected of them rather than in response to the specific legal questions and processes designed to attain the desired societal objectives." Shah points out further that, while many psychiatrists who are asked to apply the dangerousness label "might not actually be very knowledgeable in the sense of having demonstrable and reliable knowledge" about dangerousness, nevertheless, such psychiatrists often find themselves "in a social role (viz., of knowledgeable and skilled 'experts') which *requires* that they not jeopardize this ascribed expertise—and, thus, the associated status, prestige, and power. . . . It is not surprising that psychiatrists and other experts turn to medical decision rules which state: 'When in doubt, suspect illness'; 'When in doubt, suspect dangerousness. . . .' " (Italics in original.)[36]

If judges actually wished a more careful explicitation of the al-

leged dangerousness of the mentally ill person, they could insist on it. However, trial judges have routinely accepted the conclusory opinions of psychiatrists in hearings that are strikingly superficial and brief. A 1966 study of civil commitment hearings in Texas reported that patients were committed at a rate of 40 within 75 minutes, or at a rate of less than 2 minutes per commitment hearing.[37] Contemporary studies indicate that the situation in many States remains substantially unchanged. Wexler has reported that in 1971 the average duration of a commitment hearing in one Arizona county was 4.7 minutes.[38] Zander has reported that in 1974 the average duration of commitment proceedings in Milwaukee, Wisconsin, under the Lessard decision, was 13 minutes.[39] In such a short period of time, there is frequently little opportunity for an adequate inquiry into dangerousness. Testimony tends to be conclusory. A typical psychiatric statement is, "The patient suffers from a major psychiatric illness and would be dangerous to others."[40] The psychiatrists are ordinarily not asked for an explanation of any of the factors that go into the formulation of their opinions, or what they mean when they say a patient is dangerous.

A typical hearing on the need for confinement because of mental illness and dangerousness following an insanity acquittal in the District of Columbia is cut and dried. The following is an example:

Examiner:	Do you find that the defendant is still suffering from paranoid schizophrenia?
Psychiatrist:	Yes.
Examiner:	Is he likely to be dangerous to himself or others in the foreseeable future, because of his illness?
Psychiatrist:	Yes.
Judge:	I hereby commit the defendant to Saint Elizabeths Hospital, until such time as this court is satisfied that he is no longer likely to be a danger to himself or others, in the foreseeable future, by reason of mental illness. Adjourned."[41]

There is a twofold reason for such abbreviated hearings. First, the term "dangerousness" has been stretched to such an extent that is has become practically meaningless. Second, judges have typically abdicated their decisional role to the psychiatrist in their deference to psychiatric judgment. Indeed, many judges are unwilling to reject a psychiatric opinion, especially one from an "official" source, such as a court-appointed psychiatrist, or a psychiatrist from an "official" hospital, such as Saint Elizabeths, in Washington, D.C. Such unquestioning deference brings the court into an uneasy connivance with the psychiatrist in bending the law. Wexler has

reported the following characteristic judicial reaction: "In one county . . . the veteran judge freely expressed his own lack of knowledge . . . to the end that he has exclusively followed the doctors' recommendations for the past 20 years. In another county, little concern was expressed about the statutory commitment standards, for the attitude prevailed that the State hospital was capable of correcting errors which might be made by the commiting court.[42] Zander has reported a Milwaukee judge saying to the patient's attorney, after the attorney had said he didn't understand why full-time inpatient hospitalization was necessary, "My feelings are the same as yours, but I can't disregard the expert testimony."[43]

New Approaches

Judicial

A major focus in the new awareness of rights for mental patients is concern about the vagueness of standards. Many older statutes provided, typically, that mentally ill persons could be involuntarily hospitalized if they were found to be "in need of treatment." Lawyers entering the mental health field found such criteria to be intolerably vague, in that they give practically no guidance, whatsoever, to judges, for the purpose of discriminating among the mentally ill to determine which persons are appropriately committable, and which not.[44] Indeed, it is arguable that if all mentally ill persons are in need of treatment (a position maintained by a large proportion of psychiatrists), then all, not merely some, mentally ill persons are subject to involuntary hospitalization, a position recently repudiated by the U.S. Supreme Court in *O'Connor* v. *Donaldson*,[45] discussed elsewhere in this article.

In the early 1970s, mental health lawyers, new to the field and dissatisfied with such loose standards, attempted to persuade the courts that no mentally ill person could constitutionally be involuntarily confined, even for a brief period of time, unless found by a court to be "dangerous." A case arguing this view, *Fhagen* v. *Miller*, was presented to the New York Court of Appeals in 1971. In January, 1972, the New York Court ruled, not unlike the D.C. Court of Appeals a decade earlier, that, "One 'afflicted with mental disease,' as defined in our statute. . . need not be violent, or dangerous, to justify a short confinement prior to notice, and an opportunity to be heard. The public is entitled to prompt protection against the acts of such a person which, *though not dangerous*, might—if committed by a sane person—constitute a punishable

offense, or which, by reason of his urgent need for immediate care and treatment, might harm others, albeit in a nonviolent manner" [italics added]. The Court of Appeals quoted, with approval, the opinion of the court below which had held that "if the allegedly mentally ill person is engaging in conduct which, if committed by a sane person, would constitute disorderly conduct, criminal nuisance, public lewdness, or sexual abuse of a minor, the State's legitimate interest in protecting society would warrant that person's temporary confinement, as surely as if the individual was engaging in conduct amounting to felonious assault or homicide."[47] The N.Y. Court of Appeals not only rejected dangerousness as a constitutionally required standard, but also seemed to characterize public lewdness and sexual abuse of a minor as "nondangerous," confining the term "dangerous" to more violent acts, such as felonious assault and homicide. This traditional, and limited, view of dangerousness stands in marked contrast to later definitions.

A short time later, in 1972, the U.S. Supreme Court decided *Humphrey* v. *Cady*,[48] which dealt with Wisconsin's sex offender program. In its opinion, the court issued dictum concerning Wisconsin's involuntary civil commitment provision, which, at the time, provided for commitment if the mentally ill person was diseased "to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community."[49] The Supreme Court, in commenting on this definition, noted that the language denoted a "social and legal judgment that (the person's) potential for doing harm to himself, or to others, is great enough to justify such a massive curtailment of liberty" as is involved in involuntary civil commitment.[50]

Shortly thereafter, the case of Alberta Lessard, a Wisconsin school teacher, was brought before a three-judge court in Wisconsin, and the Wisconsin statute was attacked as unconstitutional. *Lessard* v. *Schmidt*,[51] decided in October, 1972, became the first landmark case dealing with the concept of dangerousness. In *Lessard*, the Federal district court relied on the Supreme Court's dictum in *Humphrey*, and took a quantum leap from it. The *Lessard* court noted that earlier courts had not "felt much concern for either a definition of 'dangerousness,' or the effects of deprivations of liberty upon those committed."[52]

In commenting on the Supreme Court's dictum in Humphrey, the *Lessard* court said, "In other words, the (Wisconsin) statute, itself, requires a finding of 'dangerousness' to self or others in order to deprive an individual of his, or her, freedom."[53] The *Lessard* court then went on to acknowledge that the Supreme Court "did not directly address itself to the degree of dangerousness that is constitutionally required before a person may be involuntarily

deprived of liberty."[54] The three-judge court undertook to provide such a definition. In upholding the Wisconsin statute by interpreting it so that it conformed with what the three-judge court interpreted as the Supreme Court's standard, the *Lessard* court defined "dangerousness," as a condition where "there is an extreme likelihood that if the person is not confined, he will do immediate harm to himself or others.[55] Elsewhere in the opinion, the court also used the language "imminent danger."[56] Although the *Lessard* court did not further define the words "extreme likelihood," "immediate harm," or "imminent harm," it seemed clear, from the context, that these terms ruled out long-term "self-harm," the type of self-harm which results from neglect of self, the condition which by 1972 had, for several years, been characterized as "gravely disabled" in California's Lanterman—Petris-Short Act.[57] In a later order, presented after a remand from the U.S. Supreme Court, which called for greater precision, the *Lessard* court modified its standard by removing the terms "extreme" and "immediate," substituting the language "imminent dangerousness to self or others . . . based, at minimum, upon a recent act, attempt, or threat to do substantial harm."[58]

It is worth noting that the *Lessard* requirement that commitment supported by a finding of dangerousness be based on a minimal showing of a "recent act," a "recent attempt," or a "recent threat," is not a further definition of "dangerousness," but, rather, an evidential requirement. In view of the questionable accuracy of psychiatric predictions concerning future behavior, the *Lessard* court decided that one or more of these relatively objective facts would have to be in evidence to support a psychiatric opinion concerning dangerousness. A psychiatric opinion, however persuasive, could not prevail, absent such a showing. A number of other courts and legislatures have since adopted this, or a similar, formulation; but the formulation itself raises further definitional questions: What act suffices? What is recent? What is an attempt? What is a threat? The Arizona statute uses a 12-month period rather than the vaguer concept of recency. Other statutes include different time spans.

How did the Wisconsin judges apply the *Lessard* ruling? One influential Wisconsin judge interpreted the *Lessard* language as permitting the commitment only of mentally ill persons who had engaged in, who had seriously threatened, homicidal or other violent behavior, suicidal behavior, or neglect of self which presented imminent danger to health or life. Under his view, if a mentally ill person threatened to starve himself to death, he would not qualify as "dangerous" until his condition had reached a point where further fasting would be imminently threating either to his health

or his life. Other Wisconsin judges either ignored the *Lessard* dangerousness standard entirely or applied the standard loosely. Over 56 percent of Wisconsin judges, when questioned about their interpretation of the Lessard language, responded that the words "substantial harm" could be interpreted as including not only property damage, but also severe psychological and financial hardship to the mentally ill person's immediate family. The judges characterized as "dangerous" such behavior as "wandering" and "acting out" in an abnormal way."[59]

The *Lessard* case became a high-water mark in "dangerousness" law. Many civil libertarian mental health lawyers hoped that other courts would follow Lessard's lead in providing highly restrictive standards concerning commitments focusing on dangerousness, defined narrowly to encompass only physical violence to self or others. However, while other courts followed *Lessard* in providing for extensive procedural due process of law and other protections for the mentally ill and while they struck down extremely vague standards, they were more cautious in defining dangerousness. Two significant cases followed Lessard: *State ex rel. Hawks* v. *Lazaro*[60] and *Lynch* v. *Baxley*.[61] *Lazaro* defined "dangerousness" in terms of "violence" and "physical injury" to self or other, but modified the *Lessard* approach by providing that the physical injury to the person need not be through overt acts, but could take place by means of the slow deterioration that leads to death through starvation or bodily neglect. *Lynch* v. *Baxley* took the same approach, stating that a showing of "actual violence" is not necessary to establish dangerousness to self. Said the *Lynch* court, "There is sufficient dangerousness if a mentally ill person's neglect or refusal to care for himself poses a real and present threat of substantial harm to his well-being.[62] In other words, a person who in California's terms was "gravely disabled" was dangerous, within the interpretation of these newer cases.

The trend toward the inclusion of disablement within the concept of dangerousness, was capped by the U.S. Supreme Court in *O'Connor* v. *Donaldson*,[63] where the U.S. Supreme Court did not hold that a finding of dangerousness is a required constitutional standard,[64] but did rule that a mentally ill person may not be involuntarily committed if he is "dangerous to no one and can live safely in freedom."[64] The Court's precise holding was that ". . . a State cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by himself, or with the help of willing and responsible family members or friends."[65] In a footnote, the Court added a significant gloss to the "dangerousness" definition: "Of course, even if there is no forseeable risk of self-injury or suicide, a person is literally 'dangerous to himself'

for physical or other reasons, he is helpless to avoid the hazards of freedom, either through his own efforts, or with the aid of willing family members or friends."[66] The Court provided no further explication of what was meant by the "hazards of freedom." It does seem, however, that the Court's tentative definition of "dangerousness" includes what in some jurisdictions, e.g., California and Washington, has been separately defined as being "gravely disabled." The Supreme Court, having originally used "dangerousness" language in *Humphrey* v. *Cady*, may now feel compelled to define dangerousness in such a broad and permissive manner as to encompass conditions which only a few years ago were not generally regarded as dangerous. This is an unfortunate development, since the stronger term "dangerousness" does tend to stigmatize. It is inappropraite to refer to a gravely disabled person as a "dangerous" person, with the potential for misunderstanding that may be involved. Yet, by suggesting dangerousness as a constitutional requirement for involuntary civil commitment, the Supreme Court may have boxed itself into an unrealistic label.

Legislative

On the legislative front, there has been a flood of new State legislation in the field of civil commitment. Most of the new statutes conform to a common pattern. Typically, new legislation provides two categories of dangerousness: to others and to self. Dangerousness to others is commonly defined in terms of acts, threats, or inducing fear of "violence" or "physical harm" to a person. Ordinarily, harm to property is not included, although it is understood that certain acts against property, such as arson, are also acts against persons.

The Massachusetts statute, adopted in 1970, is a progenitor of many of the more contemporary statutes. It provides for commitment, where there is "likelihood of serious harm," which is defined as including "a substantial risk of physical harm to other persons as manifested by evidence of homicidal, or other violent behavior, or evidence that others are placed in reasonable fear of violent and serious physical harm to them . . ."[67] It is clear that only physical harm is included in the Massachusetts statute. So much is definite; but, what is a "substantial" risk of harm? One Massachusetts analyst has commented that, "to one judge, a 20 percent change of harm may be 'substantial,' whereas, another judge may require the harm to be more likely than not. Moreover, how soon must the anticipated harm occur? There may be a relatively low risk of harm within six months, but a high risk of its occurring within several

years' time. Such complexities predominate in every civil commitment hearing . . ."[68]

A few statutes go beyond physical harm to include emotional harm within the concept of dangerousness. A recent Iowa statute permits commitment where a person "is likely to inflict emotional injury on members of his, or her, family, or others who lack reasonable opportunity to avoid contact with the afflicted person . . ."[69] "Serious emotional injury" is further defined as "an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a licensed physician or other qualified mental health professional, and which can be causually connected with the act or omission of a person who is, or is alleged to be, mentally ill."[70] Such emotional harm can go beyond the type of harm which results from being put in fear of threatening behavior. It could include the consequences of bizarre behavior. In the view of one authoritative commentator, under the Iowa statute, "The injury need not be physically overt, but it must be medically overt, and susceptible of medical diagnosis . . ."[70]

Emotional injury is not precisely delineated, but it would include, for example, serious disruption of family relations leading to depression or nervous breakdown of family members, physical violence on the part of others, or other medically diagnosable complications . . ."[71] Many of the newer statutes seem reasonably restrictive, especially in light of evidentiary requirements.

The category of "dangerousness to self" is more broadly defined. "Dangerousness to self," in many contemporary statutes, breaks down into three basic categories of behavior: (1) suicidal; (2) self-maiming; and (3) disabled behavior. The Massachusetts statute is again typical. That enactment provides that the "likelihood of serious harm" to self includes "a substantial risk of physical harm to the person, himself, as manifested by evidence of, or attempts at, suicide or serious bodily harm," or "a very substantial risk of physical impairment or injury to the person, himself, as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community, and that reasonable provision for his protection is not available in the community."[72] A recent Pennsylvanis statute is even more explicit in requiring a finding that "the person has severely multilated himself, or attempted to multilate himself severely, and that there is the reasonable probability of mutilation, unless adequate treatment is afforded . . ."[73]

It is noteworthy that, in defining dangerousness to self, the statutes tend to go beyond immediate physical harm to subsequent physical impairment or injury, by now including within that definition the condition previously defined as "gravely disabled." The

Massachusetts statute speaks of potential "physical impairment or injury" and an inability to protect oneself. Here, too, the Pennsylvania formulation is particularly explicit, requiring a finding that "the person has acted in such manner as to evidence that he would be unable, without care, supervision, and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and there is a reasonable probability that death, serious bodily injury, or serious physical debilitation would ensue within 30 days, unless adequate treatment were afforded under this act."[74]

This broadening of the definition of "dangerousness" to include the concept of "grave disablement" represents a significant departure from the criteria originally enunciated in the *Lessard* case, which civil libertarian lawyers hoped would be adopted as a universal one. Although such provisos are far more restrictive than the "in-need-of-treatment" criterion, they, nevertheless, provide a broad and highly inclusive standard, subject to significant manipulative potential and, thus, a far cry from the original restrictiveness associated with dangerousness. The fact is that most, if not all, of the literature dealing with prediction of dangerousness does not apply to this loose definition. It is only recently that legislatures (and courts) have expanded the term "dangerousness" to include "being disabled." Thus, a standard originally associated exclusively with the police power has also become a parens patriae standard.

Defining "Dangerousness to Others"

While the newer judicial definitions discussed here represent a marked improvement over a previous situation in which dangerousness to others was totally undefined, nevertheless, they still represent a relatively modest attempt at dangerousness definition. Although the *Lessard* court referred to the need for a "balancing test," in which the mentally ill person's "potential for doing harm" should be weighed against the "massive curtailment of liberty," no further clues were offered as to the components that should go into such a balance. The beginnings of such an analysis of dangerousness have been provided by Chief Judge Bazelon, speaking for the District of Columbia Circuit Court, in the context of decisions dealing with the release of a committed sex offender. The D.C. sex offender statute defines dangerousness as a condition where one is "likely to attack or otherwise inflict injury, loss, pain, or other evil on the objects of his desire."[75] In two leading cases, *Millard* v. *Harris*[76] and *Cross* v. *Harris*,[77] Judge Bazelon ruled that a finding of dangerousness under the statute requires the factual determination of

three questions: "(1) the likelihood of recurrence of sexual misconduct; (2) the likely frequency of any such behavior; and (3) the magnitude of harm to other persons that is likely to result."

As to magnitude, the court ruled that the legislature did not intend the words "injury," "loss," "pain," or "evil" to apply merely to offensive or obnoxious behavior, but, rather to "extremely aggravated situations," where persons are a "dangerous menace" to society. In effect, the court used the "substantial injury" notion. With respect to the "likelihood" of the harm, the court acknowledged that a precise definition of "likely" may well be impossible. The court indicated that factors determining likelihood should include seriousness, availability of inpatient and outpatient treatment, and the expected length of confinement required. It is difficult to see how seriousness bears on probability, when it is more relevant to magnitude. Moreover, the expected length of confinement does not appear to be relevant; yet, the availability and likely efficacy of treatment would seem to be highly probative.

Where release is conditional, the conditions of release may bear substantially on the probability issue. If the undesirable conduct is provoked by drinking, or by some other condition susceptible to control, probationary conditions imposed by the court can tend to insure a low probability of recurrence. The third factual finding relates to the frequency of occurrence of the relevant behavior. The court stated that the behavior would be considered less dangerous as the likely extent of frequency diminished. The court did not consider the question of imminence.

In the *Millard* case, which dealt with an exhibitionist, the court concluded that, although the offender might in fact exhibit himself, he was not "dangerous" because he would probably exhibit himself infrequently, if at all, and the impact of his exhibitionism would not be serious. The magnitude of the harm was small. The careful analysis of the D.C. Circuit Court in the *Millard* and *Cross* cases represents a high-water mark in sophistication in defining dangerousness. Few other courts in the country have approached the complexity of its analysis in this area.

Conclusion

What will be the effect of the newer definitional thrusts? Reform on the appelate court or legislative level does not guarantee that practices in the lower courts will immediately follow suit. Trial judges have been known to ignore and subvert, on a day-to-day basis, the unpopular mandates of reviewing courts or legislatures

which they regard as unrealistic. If trial court judges view a more restrictive interpretation of dangerousness unsympathetically, and apply it accordingly, a long tug-of-war is likely to ensue. Psychiatrists, too, are likely to be unsympathetic to a more limited definition of dangerousness; but the weight of the American Psychiatric Association has been brought to bear in attempting to encourage a more sophisticated view of dangerousness on the part of psychiatrists who participate in legal decisionmaking. In its thoughtful "Task Force Report 8,—Clinical Aspects of the Violent Individual," The A.P.A. has presented a careful analysis of dangerousness which should, in time, influence forensic psychiatrists.

Some of the newer legislation has apparently had some significant effect on psychiatric practices in defining dangerousness. A California psychiatrist has reported that, following the adoption of the Lanterman-Petris-Short Act, mental health professionals in California began to "use a rather narrow definition of the criteria" dangerous to self or others.[78] Many mental health professionals regarded the California standards, when adopted, as a rebuke to their previous exercise of discretion under looser criteria. The psychiatrist points out that, "At times, there seems to be an almost passive-aggressive strictness to the way they have interpreted these new criteria . . . ." He goes on to say that "even institutional psychiatrists, who are long used to treating the involuntary patient, apply the LPS criteria strictly."[79]

Until more precise formulations of the dangerousness concept can be worked out, we should at least press for an awareness among lawyers, psychiatrists, and judges of the various component elements that go into the making of the dangerousness label. The magnitude of harm dimension, whether to person or to property, whether to physical being or to the psyche, should be more carefully elaborated and examined. The degree of probability of the harm should be carefully appraised. The frequency with which the harm is likely to occur is critical; and, finally, the courts should more closely examine the imminence question. Such an examination is likely to lead to more objective and more reliable findings. It is also important to require that the judge make findings of fact to support his ruling that the respondent is dangerous. In at least one interesting case, an appelate court reversed and remanded a commitment order because of a confused finding on the dangerousness issue.[80]

The U.S. Supreme Court has not helped much in the process of defining dangerousness. Apart from its broad inclusions, referred to earlier, the Supreme Court, in *Donaldson*, did rule that dangerousness does not include the "nuisance" cases. Said the Court, "May the State fence in the harmless mentally ill to save its citizens

from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty."[81] The court's rhetoric is interesting, but the illustrations are not particularly helpful. Mentally ill persons are ordinarily not presented for commitment because they are physically unattractive, or if their eccentricities do not bother anyone. It is when the eccentricities adversely affect others that commitments are requested. In *Donaldson* the Court presented no guidelines to distinguish between so-called "nuisance" behavior and behavior that could be characterized as "dangerous." In addition to which, it should be noted, that the Supreme Court has not closed the constitutional door to confinement of the mentally ill for purposes of treatment.

If the courts are to avoid constitutional attacks on the looseness of the dangerousness standard based on the void-for-vagueness doctrine, they must take steps to provide, in the concept, a greater degree of objective definition and less room for unbridled discretion which has been the order of the day until recently. It is hoped that the courts and legislatures will respond with more carefully articulated definitions in order to further limit the subjectivity and judicial discretion that has characterized this area of the law until recently.

Footnotes

The evaluation of the various definitions of the term "dangerousness" set forth here is not intended as a final analysis, but is a small portion of a substantially larger work in progress in which I intend an all embracing discussion of the use of the "dangerousness" concept in the way the law deals with the mentally ill. There are, therefore, many dimensions of the dangerousness issue, even those of definition, not treated here, or dealt with only in passing.

1. See generally A. Brooks, Law, Psychiatry and the Mental Health System 677-717 (1974). Many jurisdictions provide for the involuntary civil commitment of mentally ill persons who are dangerous to themselves or others or who are unable to care for their physical needs. The most recent compilation is to be found in Developments in the Law: Civil Commitment of the Mentally Ill, 87 *Harv. L. Rev.* 1190 (1974).
2. See, e.g., Ohio Rev. Code Ann. § 5125.03 (Baldwin 1971) which "permits an administrative transfer of any patient in a State [civil] hospital "who exhibits dangerous or homicidal tendencies, rendering his presence a source of danger to others in Lima State Hospital for the criminally insane." Such transfers have been ruled unconstitutional in New York in an important case, *Kesselbrenner* v. *Anonymous*, 33 N.Y. 2d 161, 305 N.E. 3d, 350 N.Y.S. 2d 889 (1973), but the constitutionality of a similar provision has been upheld in New Jersey in *Singer* v. *State*, 63 N.J. 319, 307 A.2d

94 (1973), where the Court said, "Surely a hospital does not become a jail merely because convicts are admitted when they are ill." 307 A.2d at 96. The difference between the New York and New Jersey cases seems to be that the New York institution was, at the time, within the corrections system and the New Jersey institution nominally in the mental health system. Although both institutions served virtually identical functions.

3. A Colorado statute permits the transfer of civil mental patients to the State penitentiary "for safekeeping" if they "cannot be safely confined in any institution for the care and treatment of the mentally ill or retarded." This statute has been declared unconstitutional, but only because psychiatric treatment in the prison was considered substantially inferior to that provided in the civil mental hospital; otherwise the statute would be constitutional. See *Romero* v. *Schauer*, 386 F. Supp. 851 (D. Colo. 1974). See also *Craig* v. *Hocker*, 405 F. Supp. 656 (D.C.D. Nev. 1975), holding unconstitutional Nev. Rev. Stat. § 433.315, which permitted confinement of the "dangerous" civilly committed mentally ill in the death row cell block of Nevada State Prison.
4. For a valuable general description see D. Wexler, *Criminal Commitments and Dangerous Mental Patients: Legal Issues of Confinement, Treatment, and Release* (1976). Also see an excellent new study, German and Singer, *Punishing the Not Guilty: Hospitalization of Persons Acquitted by Reason of Insanity*, 29 *Rutgers L. Rev.* 1101 (1976).
5. A number of States require a finding of dangerousness to support a commitment of an accused found incompetent to stand trial. See, e.g., Iowa Code § 783.3 (Supp. 1972); Okla. Stat. Tit. 22, § 1167 (1958); S.D. Compiled Laws § 23-38-6 (1967).
6. A number of statutes provide for the commitment of the N.G.R.I. (not guilty by reason of insanity) if he is found to be not only still mentally ill, but also "dangerous." Other statutes provide only for the commitment of a person upon his acquittal. See, e.g., D.C. Code § 24-301 (1967) which provides, "If any person tried upon an indictment or information for an offense, or tried in the juvenile court of the District of Columbia for an offense, is acquitted solely on the ground that he was insane at the time of its commission, the court shall order such person to be confined in a hospital for the mentally ill." But a number of new cases have written in a finding of dangerousness as a requirement for commitment. See e.g., *State* v. *Krol*, 68 N.J. 236,344 A.2d 289 (1975) and other cases analyzed in German and Singer, op. cit., n.4.
7. For an illustration of how difficult it is for even a "model patient" to shed the label of "dangerousness" after 10 years of trouble-free confinement see *Covington* v. *Harris*, 419 F.2d 617 (D.C. Cir. 1969).
8. See Sitnick, *Major Tranquilizers in Prison: Drug Therapy and the Unconsenting Inmate*, 11 Willamette L.J. 378 (1975).
9. See, e.g., *United States ex rel. Schuster* v. *Herold*, 410 F.2d 1071 (2s Cir. 1969).
10. *Morales* v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973), reversed, 535 F. Supp. 864 (5th Cir. 1976).
11. Cal. Welf. and Inst. Code § 1800 et seq. (West 1972), discussed in Note, A Dangerous Commitment, 2 Pepperdine L. Rev. 117 (1974). See In Re Gary W., 5 Cal. 3d 296, 486 P.2d 1201, 96 Cal. Rptr. 1 (1971).
12. A typical sex offender statute is New Hampshire's, which defines a "sexual psychopath" as "any person suffering from such conditions of emotional instability or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of

his act, or a combination of any and such conditions, as to render such person irresponsible with respect to sexual matters and thereby dangerous to himself or to other persons."

13. Md. Ann. Code art. 31B, § 5 (Supp. 1965) provides the indeterminate confinement of a "defective delinquent," defined as "an individual who, by the demonstration of persistent aggravated anti-social or criminal behavior, evidences a propensity toward criminal activity, and who is found to have either such intellectual deficiency or emotional unbalance, or both, as to clearly demonstrate an actual danger to society so as to require such confinement treatment, when appropriate, as may make it reasonably safe for society to terminate the confinement and treatment."
14. Model Penal Code § 7.03(3) (Proposed Official Draft, 1962).
15. National Council on Crime and Delinquency, Advisory Council of Judges, Model Sentencing Act § 5 (with commentary 1963).
16. See 18 U.S.C.A. § 3575 (Supp. 1971) as discussed in *United States* v. *Duardi*, 384 F. Supp. 861 (W.D. Mo. 1973); *United States* v. *Duardi*, 384 F. Supp. 871 (W.D. Mo. 1974); and *United States* v. *Duardi*, 383 F. Supp. 874 (W.D. Mo. 1974).
17. *Tarasoff* v. *Regents of Univ. of California*, 551 P.2d 334,131 Cal. Rptr. 14 (1976), discussed in Brooks, Mental Health Law, 4 Admin. in Mental Health 94 (Fall, 1976). See also Stone, The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society, 90 Harv. L. Rev. 358 (1976).
18. Rubin has estimated that approximately 50,000 persons a year are involuntarily committed on the basis that they are dangerous. Rubin, Predictions of Dangerousness in Mentally Ill Criminals, 27 Arch. of Gen. Psychiat. 397 (1972).
19. A now superseded Washington statute had defined a "mentally ill person" as one "found to be suffering from psychosis or other disease impairing his mental health, and the symptoms of such disease are of a suicidal, homicidal, or incendiary nature, or of such nature which would render such person dangerous to his own life or the lives or property of others." Wash. Rev. Code 71.02.010. A typical formulation is that of Montana, which defines a commitable mentally ill person as one who is "so far disordered in his mind as to endanger health, person, or property." Mont. Rev. Codes Ann. § 38-208 (Interim Supp. 1974).
20. See, e.g., Steadman, Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry, 1 J. Psychiat. & L. 409, 413 (1973).
21. In Re Alexander, 336 F. Supp. 1305, 1307 (D.D.C. 1972). The court cited Webster's Unabridged New International Dictionary (1955) as defining "injure" a person to mean: "to do harm to"; to hurt; damage; impare; to hurt or wound."
22. See Note, Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act, 7 Loyola of L.A. L. Rev. 93, 113 (1974). But see § 5300, providing that a patient may be detained for a 90-day period if he has recently either threatened, attempted, or successfully inflicted physical harm upon another individual.
23. The Supreme Court, in *Jackson* v. *Indiana*, 406 U.S. 715 (1972) commented on this, saying, "The basis [for the power exercised in involuntary civil commitments] that have been articulated include dangerousness to self, dangerousness to others, and the need for care or treatment or training. Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." 406 U.S. 715, 738 (1972).

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But the Supreme Court has since refused to decide several significant mental health law cases.

For example, the Supreme Court vacated *Lessard* v. *Schmidt*, a landmark case, twice. *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated on other grounds and remanded 414 U.S. 473 (1974), judgment modified on other grounds and reinstated, 379 F. Supp. 1376 (1974), vacated on other grounds and remanded, 421 U.S. 957, 43 U.S.L.W. 3600 (May 12, 1975). The Court refused to deal with the right to treatment issue in *O'connor* v. *Donaldson*, 422 U.S. 563, 95 S. Ct. 2486 (1975) which it vacated and remanded. It also vacated and remanded *Reynolds* v. *Neil*, 381 F. Supp. 1374 (N.D. Texas 1974), vacated and remanded *sub nom. Sheldon* v. *Reynolds*, 95 Sct. 2671 (1975), a decision dealing with procedures and standards relating to the confinement and treatment of insanity acquittees. It is perhaps not surprising that Dr. Alan Stone has referred to the Court's comment in Jackson as "disingenuous." A. Stone, *Mental Health and Law: A System in Transition* 50 (1975).

24. *Overholser* v. *Russell*, 283 F.2d 195 (D.C. Cir. 1960). The language of the statute required a finding that the "person will not in the reasonable future be dangerous to himself or others." D.C. Code § 24-301(3) (Supp. VII, 1959).
25. Id.
26. *Overholser* v. *O'Beirne*, 302 F.2d 852 (D.C. Cir. 1961).
27. *Overholser* v. *Lynch*, 288 F.2d 388 (D.C. Cir. 1961).
28. Kozol and his colleagues point out that, "the terms used in standard psychiatric diagnosis are almost totally irrelevant to the determination of dangerousness." Kozol, Boucher, and Garafalo, The Diagnosis and Treatment of Dangerousness, 18 Crime & Delinquency 371, 383 (1972).
29. Panel Report: When Is Dangerous, Dangerous?, 1 J. Psychiat. & L. 427, 431 (1973).
30. Jacobs, Psychiatric Examinations in the Determination of Sexual Dangerousness in Massachusetts, 10 N.E. L. Rev. 85 (1974).
31. *Hough* v. *United States*, 371 F.2d 458, 468-469 (D.C. Cir. 1959).
32. *People* v. *Sansone*, 18 Ill. App. 3d 315, 309 N.E. 2d 733, 736 (1st Dist. 1974), leave to appeal denied, 56 Ill. 2d 584 (1974).
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36. Shah, Some Interactions of Law and Mental Health in the Handling of Social Deviance, 23 Cath. U. L. Rev. 674, 710 (1974). See also Shah, Dangerousness and Civil Commitment of the Mentally Ill: Some Public Policy Considerations, 132 Am. J. Psychiat. 501 (1975). An official publication of the American Psychiatric Association has acknowledged at least a portion of this problem. See, e.g., American Psychiatric Association Task Force Report 8, Clinical Aspects of the Violent Individual (1974) which points out that, "Psychiatrists, in order to be safe, too often predict dangerousness, especially in the case of the mentally ill offenders," At 25.
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68. Walker, Mental Health Law Reform In Massachusetts, 53 B. U. L. Rev. 986, 994 (1973).
69. Ch. 229 [1975] Laws of the 66th G.A. of Iowa, Ist. Sess. § § 1-82 (1975), as cited in Bezanson, Involuntary Treatment of the Mentally Ill in Iowa: The 1975 Legislation, 61 Iowa L. Rev. 261, 289 (1975).
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72. Mass. Gen. Laws Ann. Ch. 123 § 7 (1972).
73. Senate Bill No. 1025, Printer's No. 2097, Section 301 (b)(2) (iii).
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76. 406 F. 2d 964 (D.C. Cir. 1968).
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78. Abramson, The Criminalization of Mentally Disordered Behavior: Possible Side Effect of a New Mental Health Law, 23 Hosp. & Commun. Psychiat. 101 (1972).
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CHAPTER 4

Legal Standards and Their Implications Regarding Civil Commitment Procedures*

Jonas Robitscher

Policy concerning the commitment of unwilling patients is always caught between two equally desirable imperatives.

We will assume, first of all, that it is desirable for people who are sick to be hospitalized. However, in the field of mental health we have extraordinary trouble in defining sickness, unless we are a Szaszian or a Laingian. We either deny the existence of mental illness or see it as an asset instead of a liability (Szasz 1967; Laing 1967). We can conclude that some mentally ill people require hospitalization and that it is the duty of the helping professions to see that such people are received into institutions. The opposing imperative is the right to liberty, a right conferred by the Constitution and central to the American system of individual rights. Inevitably, these important interests will conflict, but in recent years they have conflicted more than ever. The courts are placing a greater responsibility on the mental hospital, both to hospitalize those who need hospitalization and to abstain from hospitalizing, or to free from the hospital those who deserve liberty. The problem is the reconciliation of these different legitimate interests.

While the individual has an interest in being cared for, he also has an interest in not being cared for. There is an interest in determining one's own care, if the mental ability exists to decide what is in his best interest. Involuntary commitment is reserved for those whom society, or the psychiatric profession, feels are unaware that hospitalization will benefit them; who protest, or have no opinion, concerning a hospitalization that to other "more rational" observers seems necessary.

Society has an interest in preserving individual liberties, but it has another interest in protecting itself from harm. To the extent that society emphasizes liberty and the freedom of choice to make one's

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own mistakes, we will have stringent commitment policies, fewer patients committed, and more risks in society. To the extent that society believes in the usefulness of a therapeutic involuntary holding, and to the extent that the safety of the individual and of others seems more important than individual autonomy, we will have more liberal commitment standards, more patients committed, and a minimization of risks in society. Physicians and hospitals have an interest in holding patients for therapeutic purposes, but they also have an interest in not being forced to hold more patients than they can treat; therefore, economical and logistical factors enter into the decisionmaking process.

The idea that overcommitment represents a harm to society, both to the concept of individual liberty which is central to our society and to the economic well-being of the medical care system which is overburdened by too many hospitalized patients, has only been clearly recognized in recent years. During 300 years of American history, we have seen liberal and stringent approaches to commitment alternate with each other. Originally, commitment was a fairly simple and informal process; we can call this the period of "Unregulated Commitment" (although the term "unregulated" will need some qualification). Then, following the Civil War, all United States jurisdictions became convinced of the need for procedural safeguards for commitment, and the court, the adversary process, and jury decision became the usual mechanisms to accomplish commitment. Although this was certainly a period of Judicial Commitment, patients were not given the full range of legal resources and protections that are now available to them; commitment was not too difficult to achieve, although the insistence on a judicial hearing made it time-consuming and expensive. In the 1920s, and later, most jurisdictions moved to a medical commitment on the theory that patients did not need strict legal safeguards. Since doctors were believed to be acting in the best interest of the patient, the expense and bother of the courtroom procedure could be eliminated. While some less progressive jurisdictions were still trying to catch up with "progress," making commitment less legalistic, and were attempting to get their legislatures to adopt medical commitment, other jurisdictions were concluding that the medical commitment was too loose, that it did not sufficiently protect the patient, and that they were moving back to a second period of Judicial Commitment—this time with more emphasis on the spirit as well as the letter of protection for the rights of the patient.

We are still in the process of moving from the "easy" Medical Commitment to the "difficult" Judicial and Legalistic Commitment. In Colonial times, there were few statutory provisions

respecting commitment. Common law upheld the right to deprive insane persons of their liberty. At common law, anyone could arrest a "furiously insane" person, or one deemed "dangerous to be permitted to be at large," and confine him for the duration of his condition. It was also permitted to "confine, bind, and beat" him if this appeared to be in his best interest (Deutsch 1949). One of the earliest Colonial statutes, dating back to 1676, in Massachusetts, orders the selectmen to take care of dangerously distracted persons "that they do not damify others."[1] Doing damage, damifying, and being dangerously distracted are, thus, old rationales for the segregation from society of the mentally ill. Indeed, one historian has traced back a rationale for segregation to the Twelve Tables of Rome, promulgated in 449 B.C., which provided for the protection of the person and goods of the mentally ill by relatives (Szasz 1967; Laing 1967).

Early post-Revolution commitment statutes authorized the detention of the mentally ill. An example is a New York law of 1788, modeled after an English law of 1744, authorizing any two justices of the peace to cause to be apprehended, locked up in a secure place, and, if necessary, chained "persons who by lunacy, or otherwise, are furiously mad, or are so far disordered in their senses that they are too dangerous to be permitted to go abroad . . ." (Deutsch 1949, p. 420). A Massachusetts statute of 1797 included the mentally ill with those who bring disorder to society. It is entitled "An act for suppressing rogues, vagabonds, common beggers, and other idle, disorderly and lewd persons" (Deutsch 1949, p. 420). Research from the Colonial period has uncovered no case of anyone formally demanding his release from forcible detention.[1]

When psychiatrists or alienists of the early 19th century offered to help a patient, they had little to provide except kindness, custodial care, and rest, or detention, restraint, and torture cures such as bleeding or twirling. Hospitalization was seen less as therapeutic than it was as protective. If a patient could be kept incarcerated long enough, God or nature might effect a cure. Throughout this period, which carries us, roughly, to the Civil War, commitment remained on about the same level of informality as when Benjamin Rush authorized the admittance of a patient by scrawling, "James Sproul is a proper patient for the Pennsylvania hospital," on a chance scrap of paper, and appending his signature (Deutsch 1949, p. 422). During this early period, a law case which has been called a leading American case concerning the criteria for the restraint of an insane person, was decided in Massachusetts; the case is the 1845 *Matter of Josiah Oakes*.[2]

Oakes, an elderly and ordinarily prudent man, became engaged to a young woman of unsavory character, a few days after the death of

his wife. He was not a violent person. He was detained on the allegation that he suffered from hallucinations and that he displayed unsoundness of mind in conducting his business affairs. The court, in its decision, forcefully enunciated a danger-to-self-and-others standard. "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 . . . and the necessity which creates the law, creates the limitation of the law. The question must then arise in each particular case whether a patient's own safety, or that of others, requires that he should be restrained for a certain time; and whether restraint is necessary for his restoration, or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation; and the proper limitation." After clearly setting forth a "dangerousness" standard and stressing the need to limit the application of the law, the court found that under this set of circumstances there was enough danger to Oakes so that his family and the McLean Asylum could continue his commitment.

Jacques Quen, psychiatrist and psychiatric historian, has pointed out that the earliest commitment policy was not as unregulated as it might appear. Most institutions were private asylums; there were boards of trustees that took seriously the duty of seeing that patients were not improperly held. Records from Quaker-sponsored Philadelphia, and other asylums, show that the trustees fulfilled their duties as the "Board of Visitors," and ordered the release of patients whom they felt were being unnecessarily held (Quen, 1976, 1975). There were a few successful cases brought against family, and others involved in involuntarily commiting patients where the proper procedures were not observed,[3] or where the commitment was held to have been unwarranted (Ray 1973). The right to a writ of habeas corpus does not mean a great deal without free access to lawyers, a point that courts of the first period of commitment did not insist upon. Thus, it is safe to assume, as Deutsch and the American Bar Foundation's Report, *The Mentally Disabled and the Law*, have concluded, that, until the middle of the last century, the commitment of patients to asylums "was effected with surprising ease and informality (Deutsch 1949;[1] p. 34).

The *Oakes* case has been cited for a number of different propositions: the court's imprimatur of the concept of "dangerousness" as the criterion for commitment; the emphasis of the courts on the importance of liberty; and the departure of courts from the "violent" standard to a concept of committability that emphasized other kinds of danger. Oakes was not a violent man, but, very possibly, his contemporaries would see poor business sense and a haste to rush into an imprudent marriange as real dangers during a

time when financial mismanagement could lead to hunger, social ostracism, and the almshouse. The *Oakes* case has been called an example of the courts' insistence on the rights of patients, but it can just as easily be given as an example of the great reliance courts placed on psychiatric testimony. Those whom the alienists labeled as dangerous were accepted by the courts as being dangerous.

During all the various swings of the pendulum regarding policy on commitment, when the procedural rights of patients were considered unimportant or were strictly enforced, the attitude of the *Oakes* case prevailed. Courts, relying on either common law or on statute, called attention to the deprivation of liberty involved in commitment; but they gave the committing doctor much latitude in interpreting the statute and fitting the patient into its definition. Such vague concepts as "need for care," which appeared in some statutes, put the patient at a disadvantage in resisting commitment, even when strict procedural safeguards were given him. The courts were not likely to question a doctor's statement that a patient was dangerous. As long as narrow criteria for commitment applied by doctors whom the court did not challenge, procedural safeguards, including the person's most important day in court, were less helpful and protective than they first appeared. The judicial commitment laws, initially called "personal liberty bills," were secured for all States as the result of crusading activities by Mrs. E.P.W. Packard, a former patient, and by Dorothea Dix and others. They provided for commitment, not on the basis of opinions expressed by the patient, but on the basis of irregular conduct which indicated that the individual was so lost to reason as to become an unaccountable moral agent. However, the distinction between verbal behavior and more overt action was soon blurred. This increased, perhaps, after the introduction of "Depth Psychology" when clinical inferences, Rorschach, and other testing techniques attributed thoughts and feelings to patients which they may never have entertained on a conscious level. Only recently have some courts and legislatures returned to an insistence that commitment be based on observed actions rather than on verbalizations, or on inferences from verbalizations that purport to reveal unconscious processes.

The third phase, providing less formal protection to the patient and giving the physician much more autonomy, produced the medical commitment; and during this century, this certification by two physicians (or in some cases by only one) has been substituted for the judicial commitment in a majority of jurisdictions. The proponents of this standard have argued that the medical procedure is quicker and cheaper, there is less stigmatizing and trauma, it enables mentally ill people to receive treatment promptly, and it gives proper respect to the diagnostic ability of the physician. Until very

recently, medical commitment was seen as more modern, more humane, and more scientific than a judicial determination, particularly when the judicial commitment placed the burden of decision upon a jury. During recent years, influenced by, (1) the Civil Rights movement and a new emphasis on individual rights, (2) a growing critical literature on the fallibility of psychiatric diagnosis and prediction, (3) a campaign for treatment of the mentally ill in the community, and (4) the rise of a Mental Health Bar, the medical commitment has been challenged, and an increased emphasis on according the individual the due process of the law—his procedural rights—has made judicial commitment more popular once again.

Some conclusions can be drawn from this alternating pattern of committing practices. It indicates the extraordinary difficulty that society has in reconciling the conflicting interests of the individual, society, and the so-called helping professions, to the extent that even though the stated objective of policy may change, the impact on the individual sometimes remains fairly constant. It indicates the difficulty of articulating precise standards for committability. It may even indicate the pragmatic advantages of a vague commitment standard that can be applied flexibly by courts. It very possibly illustrates that "the more things change, the more they remain the same." Brief and superficial court hearings, either under the procedures of the post Civil War period, or in their more procedurally stringent recent manifestation, are often seen as giving patients little more protection than unregulated commitment or medical commitment.

Our present statutory language, whether in jurisdictions that have a medical or judicial commitment, continues to emphasize conditions necessary, but not necessarily sufficient, to justify commitment. We now require the presence of a mental disease or defect, along with additional sufficient justifications, "dangerous to self or others," and "need for care or treatment." Slovenko (1973) has suggested that the premise of mental illness or defect serves no valid operational purpose. Therefore, the Szaszian quarrel with the concept of mental illness can be avoided by allowing commitment for dangerous behavior, or for individuals needing care or treatment, without putting a diagnostic label on the condition. The problem here is that, in the absence of mental illness, behavior which presents danger to self or others is often seen as criminal. The insistence that commitment is reserved for the mentally ill creates a difficult classification problem, that of differentiating the "mad" from the "bad" (Shah 1969). One aspect of the problem is the use of the commitment process to displace the criminal process for purposes of prevention detention.

The concept of "need for care" or "need for care or treatment" or "need for hospitalization" can be criticized for vagueness and for circularity. The criterion that remains as the less assailable standard, although it too is vague, is "dangerousness." As is stated in the Post-Trial Memorandum of Amici, the American Psychological Association, the American Orthopsychiatric Association, and the American Civil Liberties Union, in *Wyatt* v. *Stickney*:

> *Amici* submit that involuntary commitment is constitutionally permissible only where the mentally-ill person presents an actual danger to himself or others. In *Amici's* view, the Constitution requires that a person can be deprived of his liberty by civil commitment only where a clear and compelling State interest is established, and the person to be committed is afforded procedural due process. See: In re Gault, 387, U.S. 1 (1967); In re Winship, 397 U.S. 358 (1970); *Dixon* v. *Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971).
>
> There is no sufficient State interest to justify involuntary confinement of a harmless person, even if he is mentally ill. Whether or not treatment is afforded, involuntary commitment is a total deprivation of liberty. For this reason, *Amici's* proposed standards for commitment specify that patients now in the hospital may be retained, and those individuals subject to commitment in the future may be placed in the hospital only if: (a) they suffer from a mental disorder; and (b) as a result of this disorder, they represent a danger to themselves or others . . .[4]

The brief goes on to cite the disagreement between psychiatrists concerning predictions of dangerousness, and gives two justifications for commitment which must be present for a valid commitment: the overt act requirement of actual danger or imminent physical harm; and proof beyond a reasonable doubt that required standards for commitment have been met. These requirements have been adopted in some jurisdictions, and they have received some favorable comment in the legal literature; they represent a minority of jurisdictions, but possibly a growing trend.

Beginning with the case of *Heryford* v. *Parker* in 1968,[5] a long series of innovative and provocative court decisions has emphasized new rights during commitment process. Though these cases only have application to their own jurisdictions, the emerging pattern is the spread of these rights to additional jurisdictions. *Heryford* v. *Parker* is a Federal case involving the continued holding of a mentally retarded man under the terms of a Wyoming statute, which provides that the proposed patient "may be represented by counsel." The case stands for the proposition that there is not an optional, but an obligatory, right to counsel at each stage of the

proceedings, even when, as in this case, the original commitment had been of a minor and his parents had waived the right to counsel. The importance of this case is that the court says it sees no real difference between civil commitment and criminal incarceration.

As a result of this and similar cases, courts have been increasingly willing to equate the benign, well-intentioned psychiatrist with the malevolent and punitive jailer, at least so far as the effect on the detained individual. We thus have the rationale for a new emphasis on procedural rights. Legislative interest in the mentally disabled has also become more sensitive to civil liberties. For example, North Carolina has required that dangerousness of a patient be shown by overt acts and not by the unsupported clinical impression of the examiner,[6] and the Lanterman-Petris-Short Act in California has required that dangerousness be reassessed at frequent intervals, so that there is a necessity to promptly release patients who no longer meet the criteria of committability.[7] We can note a series of court cases dealing not with civil commitment but with the proper criteria for detention in a hospital for the criminally insane; these cases have had an impact on civil commitment cases because they have employed, or have incorporated, the findings of sociological studies of patients ordered released, proving that psychiatrists had overpredicted dangerousness.

A case, which began like *Baxstrom* v. *Herold*[8] to deal with inmates of a hospital for the criminally insane but which concluded with a determination that the two-doctor commitment procedure did not provide sufficient procedural due process and that judicial commitment must be used exclusively, was the Pennsylvania case of *Dixon* v. *Attorney General.*[9] The court, here, went further than merely ordering patients out of a maximum security institution and into a more "civilian" kind of mental hospital; it cited the *Gault* case,[10] which provided for important procedural safeguards for juvenile delinquents, and *Heryford* v. *Parker* and found the medical commitment procedure fatally defective. The court expressed its approval of decisions which found that committing procedures and rules of commitment, although civil matters, should provide important safeguards of criminal or quasi-criminal cases. Because of the *Dixon* case, Pennsylvania has had to return to the judicial commitment of patients with its expense, delay, lack of dignity, and requirement for the court appearance of psychiatrists—making additional demands, in time and money, on the personnel of psychiatric hospitals and on patients and their families—which may or may not be too high a price to pay for a stricter observance of patients' rights.

As recently as 1960, it was possible for a State supreme court to hold that the loss of liberty to an involuntary patient does not fall

"within the meaning of the constitutional provision that 'no person shall be deprived of life, liberty, or property without due process of law.'"[11] However, starting with the Pennsylvania case of *Dixon* v. *Attorney General* in 1971, some Federal courts and some State courts have "broken with a century-old tradition that 'civil' commitment of the mentally ill, whether for their own good or that of society, demands fewer procedural protections than does incarceration for punishment (Steingarten 1976). These rulings have required strict judicial commitment to be reinstituted in Pennsylvania, Wisconsin, Alabama, Michigan, West Virginia, and Kentucky.[12]

A fuller discussion of the rationale for more stringent commitment standards, and the complete elimination of the medical certification commitment, can be found in *Lessard* v. *Schmidt*, a Federal case concerning the commitment law of Wisconsin. The *Lessard* case has been called the most frequently cited Federal case on civil commitment. It is the most extreme statement of the strictly protected commitment position. It was a class action in which the court found the State medical commitment law invalid because it failed to provide the kind of procedural safeguards guaranteed by the criminal law. Although the decision has twice been vacated by the United States Supreme Court on technical legal grounds, it has been reinstated by the three-judge District Court in Wisconsin. Since *Lessard* has the makings of a landmark case, it is receiving much attention. This is unfortunate because the case has much antipsychiatric bias, and its reasoning seems inexact.

It is not unusual for a court, laboring under severe time constraints, to depend upon inaccurate historical data gathered by a harried law clerk. Similarly, statements of philosophy, intended to buttress or illuminate the court's own reasoning, frequently leave much to be desired, not only in fidelity to the intent of the philosopher, but in the constancy of the logic of the court itself. These "helpful" quotations, stripped of their context in time and purpose, reduced to ambiguous generalities, do little to advance the cause of clarity. The *Lessard* court, for example, singles out this passage from John Stuart Mill's essay "On Liberty":

> The only freedom which deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each other to live as seems good to the rest (Mill 1859).

Not only has this particular passage served as the bludgeon of reason in the hands of both the right and the left over such diverse

issues as narcotics regulation, child labor and minimum wage laws, and Civil Rights legislation (which in itself should warn off any well-intentioned court), but Mill, himself, put a serious stipulation on his thesis, which is usually ignored. He explained in the same essay that, "It is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties."

Certainly, a recognition of philosophy as a tool of legal reasoning is fundamental to law, but it would be more helpful to refer to the closely reasoned and specific, rather than the generously idealistic. John Rawls in his *A Theory of Justice* takes a much more practical approach:

> It is important to recognize that the basic liberties must be assessed as a whole, as one system. That is, the worth of one liberty normally depends upon the specification of other liberties, and this must be taken into account in framing a constitution and in legislation generally. While it is by and large true that a greater liberty is preferable, this holds primarily for the system of liberty as a whole, and not for each particular liberty. Clearly, when the liberties are left unrestricted, they collide with one another (Rawls 1971).

Rawls uses as an example the right of free speech. Certain rules of order are necessary for intelligent and profitable discussion. Without the acceptance of reasonable procedures of inquiry and debate, freedom of speech loses its value. One liberty must be balanced against another.

> The best arrangement of the several liberties depends upon the totality of limitations to which they are subject, upon how they hang together in the whole scheme by which they are defined (Rawls 1971).

The analogy of freedom of action and of freedom of speech is close. If psychotic people are free to express themselves as they desire, their actions may impinge not only on their own liberties, but the liberties of others. Psychiatry has felt that it was performing a humanitarian service by seeing that much deviant behavior would be classified as symptomatic of mental illness rather than as criminal activity (disturbing the peace, creating mayhem, committing murder) so the psychotic could be prevented from impinging on the rights of others, without being stigmatized as a criminal and subjected to criminal penalties. The courts are rapidly coming to the conclusion that there is no substantial difference between the psychiatric approach and the correctional approach to these restraints on individual liberty. Indeed, some courts have observed that the indefinite nature of psychiatric institutionalization is a

more severe punishment that the fixed sentence of a criminal judgment. Most psychotic people will not harm themselves or others, and so can be left to their own devices, but when other psychotic people are left free, their rights to be left alone will inevitably clash with the rights of others to be left alone by them. If psychiatry is not allowed to use the medical model, the only alternatives are either to ignore the behavior and permit the individual to exhibit disordered behavior in public, or, if the behavior violates the criminal code, to deal with it by criminal sanction.

The conflict between the reliance on the medical model, which fairly or unfairly diverts people from the criminal justice system into the mental health system, and the social deviancy model, which forces fewer people into the mental hospital system and protects the rights of social deviants, but lays them open to charges of criminal misconduct, has been set forth very forcefully in two contrasting articles. Abramson described the effect of stringent commitment statutes as "criminalizing mentally disordered behavior." In response, Monahan wrote that using the medical or therapeutic model led to a "psychiatrization of criminal behavior (Abramson 1972; Monahan 1973).

The court, in the *Lessard* case, emphasized the protection of the patient on the ground that, in many respects, deprivations caused by civil commitment are greater than those accompanying a criminal conviction. The court cites the Thomas Eagleton affair for the proposition that the stigma of hospitalization will produce difficulties for the committed individual in attempting to adjust to life outside the institution, following release. Bruce Ennis, a mental health crusader who wrote *Prisoners of Psychiatry*, is quoted for his statement that "former mental patients do not get jobs," and in the job market "it is better to be an ex-felon than an ex-patient." The *Lessard* court levels an even graver charge against psychiatry:

> Perhaps the most serious possible effect of a decision to commit an individual lies in the statistics which indicate that an individual committed to a mental institution has a much greater change of dying than if he were left at large. Data compiled in 1966 indicate that, while the death rate per 1,000 persons in the general population in the United States each year is only 9.5, the rate among resident mental patients is 91.8.

In this author's view, the figures cited by the court represent a gross misuse of statistics. If the death rates in the institutions, and in the general population, were studies on an age-matched basis, it would be seen that much of the discrepancy between the rates comes because committed patients tend to be much older than the general

population; senility and other problems associated with extreme age are frequent reasons for commitment. The other factor which may produce a higher death rate for committed patients, after making adjustment for age, is that hospitalized patients have physical and psychiatric pathology. Complications of drug abuse and alcoholism are common, and many patients have long histories of health and nutritional neglect; these factors would be true of a much smaller percentage of the general population. It is the writer's belief that many health professionals see hospitalization as life preserving, and not life threatening; they feel that these same patients, left to their own devices in the community, would show high death and illness rates. The *Lessard* Court went on to hold the Wisconsin two-doctor commitment statute constitutionally defective because it failed to require effective and timely notice of "charges" justifying detention; it failed to require a notice to the individual of rights, including the right to a jury trial; it permitted detention for more than 48 hours without a hearing on probable cause; it permitted detention of longer than 2 weeks without a full hearing on the necessity for the commitment; it permitted commitment based on a hearing in which the individual was not represented by counsel, at which hearsay evidence was admitted, and at which the individual was not given the benefit of the privilege against self-incrimination; it permitted commitment on the basis of proof of mental illness and dangerousness, that was on the basis of the civil law standard of a preponderance of evidence, and was, thus, less than the criminal law standard of beyond a reasonable doubt; it failed to require those seeking the commitment to consider less restrictive alternatives; and it failed to require that the same warnings that are given to criminal defendants be given before the start of psychiatric evaluations:

> Wisconsin may not, consistent with basic concepts of due process, commit individuals on the basis of their statements to psychiatrists in the absence of a showing that the statements were made with "knowledge" that the individual was not obliged to speak.... The patient should be told by counsel and the psychiatrist that he is going to be examined with regard to his mental condition, that the statements he may make may be the basis for commitment, and that he does not have to speak to the psychiatrist.

The Supreme Court's vacating of the *Lessard* decision on two occasions was based on a finding that the *Lessard* court's judgment order failed to comply with the specificity provisions of Rule 65(d) of the Federal Rules of Civil Procedure. This requires, essentially, that a court be "specific in outlining the terms of the injunctive relief granted." Nevertheless, the case has not been overruled, but has

been reaffirmed by the Wisconsin Federal court. Since it represents the law in Wisconsin, it is frequently cited. It shows the high-water mark as the most thoroughgoing expression of the philosophy that commitment must be a highly protected process, with the view that only veritably and imminently dangerous people should be subject to involuntary holding.

The emphasis by the *Lessard* court on the protection of the civil rights of the patient is reflected in its resolution of the question of the measure of proof required in commitment hearings. The *Lessard* court decided that to establish committability, the criminal justice standard of proof beyond a reasonable doubt should be used, rather than the traditional civil commitment standard of proof by a preponderance of the evidence. This higher standard was adopted by the District of Columbia in a 1973 case, *In re Ballay*.[13] Ballay had appeared at the United States Capitol and claimed he was a Senator from Illinois; he was committed to Saint Elizabeths Hospital, briefly, on a temporary medical commitment, and was discharged. After two subsequent apprehensions, both at the White House, where he claimed to be a Senator from Illinois and the husband of Tricia Nixon, concerned about her announced forthcoming marriage, he was civilly committed in a jury trial in which the judge had instructed that the preponderance of the evidence standard should be used to determine both the elements of committability, the presence of mental illness, and the likelihood of harm. Ballay claimed that he had been deprived of due process of law because the higher standard of beyond a reasonable doubt had not been used. The court ruled that in a civil commitment case, proof of mental illness and dangerousness must be established beyond a reasonable doubt, rather than by a mere preponderance of the evidence, pointing out that Ballay had never been convicted of a crime, and that he had a great deal to lose by commitment—his liberty.

Although courts in a number of jurisdictions have moved to make the commitment process more stringent, in one recent case, a three-judge district court ruled in favor of the traditional rather than a restricted role for the psychiatrist in predicting dangerousness. The case concerned the constitutionality of the Illinois statute which provided for the commitment of a mentally ill person on the grounds of dangerousness to himself or others or inability to care for himself. The statute did not require that the reasonable expectation of incompetency be proved by a recent overt act, omission, or threat—the basis for the attack on the constitutionality of the statute. Plaintiffs argued that the statute was unconstitutional because it did not comport with due process and it allowed weight to be given to a subjective and arbitrary opinion of a testifying

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physician, while due process would require an objective standard for determining dangerousness. The court stated that the expert testimony presented to it on the question of the psychiatrists' reliability indicated, "first, that, as we might expect, it is extremely difficult to predict future behavior, and, second, that there is a considerable disagreement among experts in the field on whether dangerousness, or inability to care for oneself, can be predicted absent of an overt act or omission, or a threat." The court said, "In the present state of scientific knowledge it would be impossible for a trier of fact to satisfactorily resolve this controversy. . . . " The court concluded that the due process clause does not prevent the State from protecting against a dangerous act or omission, before that act or omission occurs, providing there is a test for determining dangerousness based on a rational appraisal of the scientific knowledge available, and it further concluded that a medical opinion meets that standard. ". . . The State has a valid interest in protecting its citizens and . . ., in view of the uncertainty in predicting future behavior, the challenged statute is a rational attempt to meet the goal. . . ."[14]

One result of new restrictive admission and commitment policies for mental hospitals—together with a legal approach to require effective treatment while in the hospital, and court and legislative requirement for a frequent review of status that produces shorter stays—is that more mental patients are being treated in the community. A literature is developing, citing the plight of the mentally ill who have been forced out of hospitals or denied access to hospitals. Dr. Darold A. Treffert, Director of the Mental Health Institute, Winnebago, Wisconsin, has used the term "dying with their rights on" to describe patients who are neglected psychiatrically because of legal restrictions; his theme is that "In our zeal to protect basic, human freedoms, we have created a legal climate in which mentally ill patients, and sometimes the people around them, are dying with their rights on" (Treffert 1974). He cites the danger to the individual and gives examples of suicides and a death from anorexia nervosa, the danger to others from an out-of-control mentally ill person, and, also, the destruction of family life:

> Sometimes the family of a psychotic mother may literally disintegrate while vainly trying to construct some form of routine family life around mother's bizarre and often psychologically destructive symptoms. In addition, the wife of a mentally ill man may finally abandon her struggle to keep the family going, wearied by fruitless attempts to patch together the semblance of a normal marriage.

A recent issue of *Psychiatric Annals*, with the theme "Psychiatry Under Siege," considers the problems of running mental hospitals

under both ideological and legal attack. One article, entitled "The Chronically Mentally Ill Shuffle to Oblivion" (Reich and Siegel 1973), describes the reaction in New York to a 1968 memo from the Department of Mental Hygiene, stating that it is the duty of State Hospital directors to ascertain, in the case of every patient and, especially, in the case of elderly patients, that State hospital care is the most appropriate treatment.

> Word got around, quickly, to municipal and voluntary hospitals, that the State hospital system was, by and large, only accepting the acutely mentally ill. To protect themselves from clogging acute general hospital psychiatric beds with chronic cases, the general hospitals, as well, began to refuse admission to the chronically ill, who were turned back to the community. Many of these patients had no families, or were too disturbed for normal family living, and, so, the welfare system had to find places for these sick people to live.
>
> The "new policy" has taxed to the limit already over-burdened facilities in the community. Tremendous hardship has been sustained by the families of discharged patients and, where families do not exist, by the community in general. Many incidents of physical violence have occurred. In the streets, of course, the problem is more profound and widespread. Alcoholics further deteriorate; young schizophrenics are deprived of their only chance for some guidance, support, and treatment; and recluses are not even thought of, because they don't bother anyone and do not ask for help. Patients are lost to followup, discontinue medications, and, in deteriorated conditions, sleep in the streets or the subways. They often cannot care for their own needs, and frequently pose a threat to themselves or others. The age of phenothiazines, and liberalized psychiatric thinking, has released patients from their straitjackets and back wards, into the oblivion and slow desperation of furnished rooms, rundown hotels, and subway station domiciles.

The problem of the homeless, mentally disabled is with us, and legal pressure continues for still further reductions in hospital populations. A paper presented at the Canadian Psychiatric Association states:

> If . . . large numbers of patients discharged from mental hospitals have joined the ranks of the homeless and prison populations, the radical changes in management of severe psychiatric syndromes in western countries during the last decade may prove to have had a less satisfactory impact upon patient status than commonly supposed (Eastwood 1973).

One problem with policies of maintaining psychiatric patients outside of hospitals is that communities often do not want them.

Exclusionary tactics—both ordinances that prohibit them from geographical areas, or administrative policies that foster "ghettoization"—may relegate the mentally ill, in the words of one article, "to back alleys" of the community (Aviram and Segal 1973).

There have already been some second thoughts. California, which had announced plans to phaseout its State mental hospitals by 1982, now plans to keep State institutions going for the "foreseeable future" (*Psychiatric News* 1973). The author has reviewed the literature on the effect of tightened commitment standards and earlier discharge, in a chapter in the Ahmed and Plog book on the deemphasis on the State hospitals, *State mental Hospitals: What Happens when They Close?* (Robitscher 1976a).

Another legal difficulty affecting commitment is the personal financial liability that is assumed by the physician. This can be brought into play when a doctor hospitalizes someone without sufficient rationale or for too long a period, or it can be invoked when a patient is not hospitalized and, thereafter, does harm to himself or others. The courts are beginning to narrow down the area for decisionmaking for the psychiatrist, by assessing large money damages for mistakes at either end of the spectrum. On the one hand, two Florida psychiatrists were ordered to personally pay $38,500 for holding a patient in a State institution too long without adequate treatment;[15] on the other hand, the United States Government lost a suit, and was found liable for $100,000 for damages resulting when a patient was released "prematurely" from Saint Elizabeths Hospital (*Wash. Evening Star* 1973). This latter case involved a patient who was released 55 days before he murdered his wife. Originally, the patient had assaulted his wife, and had been hospitalized for a determination of competency to stand trial. The court concluded that the release of the patient from the hospital was premature and was "proximately connected" with the murder. The former case is the famous *Donaldson* case, which eventually reached the Supreme Court and resulted in that court's first attempt to deal with the appropriateness of civil commitment.

Kenneth Donaldson was committed to a Florida State hospital in 1957, at the instigation of his father, who said Donaldson suffered from delusions. He was held for 15 years in the hospital; he received little or no treatment, both because as a Christian Scientist he did not perceive the usefulness of treatment and, also, because of great deficits in the hospital's facilities and personnel. (The 1,300 inmate section, at one time, had only one doctor on its staff.) Nineteen times during 14 years of commitment, Donaldson unsuccessfully petitioned the courts for a writ of habeas corpus to review the appropriateness of his detention; Florida State and Federal courts and the United States Supreme Court (on four occasions) denied

the petitions in spite of the fact that, during the last part of his detention, Donaldson had town privileges and had never shown any instance of violent behavior during his entire stay in the hospital. In July 1971, after the fourth refusal of the Supreme Court to hear his case, Donaldson was released by the hospital when, on his 20th attempt, a Federal court set a pretrial hearing to see if his writ of habeas corpus should be granted, and the hospital then proceeded to discharge him (Birnbaum 1974).

Donaldson's successful suit against hospital officials for damages for the deprivation of rights led to an appeal to the Supreme Court which, at long last, considered the criteria for civil commitment. The Court ruled that involuntarily comitted, nondangerous, mental patients must be released if they are capable of surviving outside the hospital, if that hospital does not provide psychiatric treatment. The Court has, thus, given some recognition to the dangerousness standard, which set forth, in 1845 in the *Oakes* case and in many subsequent cases, that dangerousness is a criterion for involuntary commitment. (The Supreme Court, however, did not deal with the troublesome questions of whether nondangerous but psychotic patients can be involuntarily committed if they are receiving adequate treatment, or whether dangerous patients can be held without treatment.)[16] Although the *Donaldson* case was returned for a new determination of the liability of the doctors, and the defendants in that case may not have to pay,[17] the case puts doctors on notice that patients do have a right to redress for unnecessary confinement, and it sets a precendential value regarding commitment criteria.

Everyday newspapers report cases of people who do harm, or who, though behavior arouses concern, have not been hospitalized, or who have been released from hospitals. "Vet Goes Berserk, Kills Self." "Man Indicted Here in Threat to Kill President." "Londoner, 26, Charged in Attack on Anne." "Eight Murders Laid to a Californian." "Man Killed in Hijack Try was Nixon-Threat Suspect."[18] The pressure is, upon psychiatry simultaneously to hold patients and to release them.

Inevitably, the legal focus on the problem of committability has centered on two major questions: the concept of the adequacy of treatment being offered, which has its own literature, and which I have discussed elsewhere (Robitscher 1972), and the question of commitment criteria. The term "mental illness" has been seen by some as the key concept: ". . . the finding of mental illness, is the most important (element), for without such proof being established there is no power to commit, notwithstanding evidence of other illness" (Baynes 1971). Even when there is a definition, it is often not helpful, usually because it is vague and cast in terms of such

behavioral manifestations as needing treatment, requiring care, a lessened capacity for customary self-control, or other indications of a threat to self or others. The Interstate Compact on Mental Health defines mental illness as "a mental disease to such an extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others in the community" (Interstate Compacts Compilation 1966). The new Massachusetts Mental Health Code, however, does not define mental illness. As McGarry has said, "After decades of experimenting with the phrase in commitment statutes all over the country, there is still no consensus as to a definition that can be 'frozen' into a statute." The Department of Mental Health is directed to define categories of mental illness by administrative regulation, and Regulation No. 1 states, "For purposes of involuntary commitment, 'mental illness' shall mean a substantial disorder or thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life . . ." (Joost and McGarry 1974).

The second requirement for commitment, "dangerousness," has received the major share of recent attention. One primary concern is whether dangerousness is a medical or legal concept, whether it is to be determined largely by a doctor in the course of his evaluatory workup, or is to be a determination for the court. The *Lessard* court is one of a number of courts increasingly denying the authority of the physician to decide dangerousness. Judge Franklin Flaschner, Chief Justice of the District Courts of Massachusetts, has said, "When 'dangerousness' is the singular issue of commitment, then that is a social and not a medical issue. We must convince the judges to become activists in assertion of these rights" (*Psychiatric News* 1974).

The problems that exist in the conceptualization of dangerousness are complex. Besides the vagueness problem, we have the following difficulties.

Dangerousness can be recognized retrospectively, but the prospective determination of dangerousness is inexact. The prospect of future dangerous behavior can be a legitimate concern when we are considering cases en masse, but the prediction may be irrelevant concerning any individual case. Some data indicate that there is no reason to believe that former mental patients will behave more dangerously than the population as a whole (Hastings 1958; Brennan 1964; Zeidler 1955; Rappeport and Lassen 1965). Steadman, in particular, has documented the inadequacy of the determination of dangerousness (Steadman 1973). Another study at Bellevue suggests somewhat contrary results, indicating that postdischarge mental patients have higher arrest rates than the rates for corresponding

groups in the community (Zitrin, et al. 1976). One problem is that many of the studies indicating nondangerousness of former mental patients rely on arrest rates, which are notoriously inaccurate and which underreport criminal behavior. It might be said that much deviant psychiatric behavior is either noncriminal or is dealt with according to the "sickness" model rather than the "social deviancy" model, and, therefore, is not represented in police reports. Since many of the studies on the dangerousness of former mental patients deal with older people who have spent long periods in hospitals before being released (as in the Baxstrom situation, where the population consisted of prisoners who had become mentally ill during their sentences, and were now end-of-sentence men), we may be relying on data on older and burned-out, mentally ill people, to "prove" nondangerousness, although such data do not tell us anything about the behavior of the young, or the acute patient, at the time of commitment (Robitscher 1976b).

Dangerousness is a standard that has both objective and subjective elements. If the determination is not allowed to include the subjective reactions of the evaluator, many patients who are seen as seriously mentally ill will not be hospitalized. Dangerousness is conceptualized differently by various observers. The problem of "standard of proof" is the legal expression of this controversy. Some psychiatrists are much more ready than others to pin the dangerous label on a patient.[19] For these and other reasons, the suggestion is being made that the dangerousness criteria be abandoned in favor of a more carefully worked out criterion. As one authority says, "Notwithstanding the inherent difficulty in formulating standards which are capable of precise application, where empirical data are, or can be, made available to construct a demonstrable feature of human experience, it is not an unacceptable burden to require the legal system to collaborate and respond accordingly" (Wiehl 1973).

Perhaps the burden is unacceptable at this stage of the development of law and psychiatry. The fact that the search for better criteria and more definable concepts has been unavailing is some indication that there is an amorphous quality to mental illness and an ambiguity in society's attitudes about commitment. Is mental illness a disease like other diseases? Are the rights of the individual more important than the rights of society? In the absence of clearcut answers to these questions and in an era of increasing emphasis on individual rights, the commitment criteria will receive increased attention. Patients will secure increased legal protection. More close cases will be called in favor of the protesting patient, and criteria using "mental illness" and "dangerousness" will continue to be the standards under which psychiatrists

and courts hammer out guidelines and precedents. We will deal with these concepts for a long period of time. It is appropriate that we are giving them closer attention, but the attention must be devoted not only to the legal definitions, but also to the social context in which they are used.

Footnotes

1. *Five Records of the Governor and Company of the Massachusetts Bay in New England 80*, 1854, cited by S. Brakel, and R. Rock, eds., *The Mentally Disabled and the Law* (Second edition, Chicago: University of Chicago Press, 1971) p. 5.
2. *Matter of Josiah Oakes*, 8 Law Reporter 123 (Mass. Sup. Ct. 1845). Discussed in Brakel and Rock, *supra*, note 1, pp. 6-7.
3. *Colby* v. *Jackson*, 12 N.H. Reports 526, 1942.
4. Standards and Procedures for Commitment—Excerpts from *Amici's* Brief in *Wyatt* v. *Stickney*. In: B. Ennis and P. Friedman, eds., *Legal Rights of the Mentally Handicapped*, (New York: Practicing Law Institute, 1973), p. 245 notes.
5. *Heryford* v. *Parker*, 396 F.2d 393, 10th Cir. 1968.
6. North Carolina Laws §122-58.3, 58.4, 58.6, 1973.
7. The Lanterman-Petris-Short Act, *California Welfare and Institutions Code*, §5000 et seq., 1969.
8. *Baxstrom* v. *Herold*, 383 U.S. 107, 1966.
9. *Dixon* v. *Attorney General*, 325 F. Supp. 966, M.D. Pa., 1971.
10. *In re Gault*, 387 U.S. 1, 1967.
11. *Prochaska* v. *Brinegar*, 251 Iowa 834, 838, 102 N.W.2d 870, 872, 1960.
12. *State* v. *Attorney General*, 325 F. Supp. 966, M.D. Pa., 1971; *Lessard* v. *Schmidt*, 349 F. Supp. 1078, E.D. Wis., 1972, *vacated and remanded on other grounds*, 414 U.S. 473, 1975, *reinstated*, 413 F. Supp. 1318, E.D. Wis., 1976; *Lynch* v. *Baxley*, 386 F. Supp. 378, M.D. Ala., 1974; *Bell* v. *Wayne County General Hospital*, 384 F. Supp. 1085, E.D. Mich., 1974; State *ex rel Hawks* v. *Lazaro*, 202 S.E.2d 109, W. Va., 1974; *Kendall* v. *True*, 391 F. Supp. 413, W.D. Ky., 1975.
13. *In re Ballay*, 482 F.2d 648, U.S.C.A.D.C. 1973.
14. United States *ex rel Mathew* v. *Nelson*, Commitment of the mentally ill based on finding of dangerousness is constitutional, even though dangerousness is not inferred from a recent, overt dangerous act, 7 *Loyola University Law Journal* 507, 1976.
15. *Donaldson* v. *O'Connor*, 493 F.2d 507, 5th Cir., 1974.
16. *O'Connor* v. *Donaldson*, 422 U.S. 563, 1975.
17. *Donaldson* v. *O'Connor*, 519 F.2d 59, 1975.
18. *Atlanta Constitution* (February 1, 1974) p. 4-B; *Atlanta Constitution* (March 21, 1974) p. 13-A; *Atlanta Constitution* (March 22, 1974) p. 18-A; *New York Times* (October 21, 1973) p. 44; *Atlanta Journal and Constitution* (February 24, 1975) p. 2.
19. A pilot study on differences in psychiatrists' concepts is described in M. Brodsky and J. Mauldin, Legal safeguard for the determination of dangerousness, Emory University Law School, unpublished.

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CHAPTER 5

Legal and Social Aspects of the Concept of Dangerousness

Ralph Kirkland Schwitzgebel

The concept of "dangerousness" has been used and misused during the past century in America to achieve a variety of ill-defined and sometimes illegal objectives. Because the concept of "dangerousness" is not clearly defined in behavioral terms, it can be used to describe nearly any socially undesirable behavior. Behavior has been legally labeled as "dangerousness" when: (1) physical harm has been inflicted upon others; (2) physical harm has been inflicted upon oneself; (3) a victim has suffered psychic trauma or mental distress; and (4) a patient has recklessly spent the savings of a family (*U.S.* v. *Charnizon*).

A clear example of the misuse of the concept of "dangerousness" is shown in a survey of mental health facilities in Arizona (Wexler et al. 1971). A 78-year-old female patient was found who had been committed to the Territorial Asylum for the Insane at Phoenix in 1912, shortly before Arizona became a State. When committed, she was a 19-year-old who, according to the official records, had several major "symptoms" which led to her commitment for dangerousness. Among her "symptoms" were: laughter, singing, a desire to dance, and a willingness to talk to anyone. These are behaviors not unlike those of a teenage girl who has, as the saying goes, fallen in love. Falling in love is not yet a crime in our country; nor is it dangerous to anyone except, perhaps, the person affected.

The abuses which flow from an ill-defined concept of dangerousness are not difficult to find and have been well-documented (Steadman and Halfon 1970). On the other hand, the concept of dangerousness has also at times been constructively used. It has permitted the brief, civil confinement of persons who might otherwise have inflicted serious bodily harm upon themselves or others. Because the civil law in most States permits the confinement of a person for expected, future conduct, the State can prevent harm. Criminal law proceedings for confinement usually may be initiated only after the harm has been done. If a man is loading a machine gun in his backyard and aiming it toward the local convent, the State may intervene.

It does not need to wait until the first round has been fired. This preventive authority of the State, when combined with the vague concept of dangerousness, can result in extensive and systematic abuses of civil liberties. The potential for abuse might, however, be sharply limited if dangerous behavior could be accurately defined and measured.

Definitions of Dangerousness

Traditionally, the central focus of legal definitions of dangerousness has been upon the individual actor. The origin of dangerous conduct was assumed to lie primarily within the individual. This fits well with psychoanalytically oriented theories and is reflected in several well-known psychological scales used to assess sociopathic personality traits. More recently, a view has been emerging which focuses upon the interaction of a person and a social situation in producing behavior labeled as dangerous. Such a view maintains that there must be a unit of behavior, a social context in which the behavior occurs, and an observer who is in some position of power or influence to label the behavior (Shah 1974). This position has important public policy and legal implication.

The proverbial "little old lady" who accidentally leaves the gas jets turned on after using the stove is commitable under many State statutes as dangerous to herself and possibly others. It can be questioned whether this legal dangerousness lies within her, within her environment, or both. The dangerousness in this case is correctable, not only by committing this woman to an institution for treatment (which may, in fact, be preventive detention in disguise), but also by replacing her gas stove with an electric one. This is more humane and less expensive than committing her to an institution.

Some people may be dangerous only in particular situations (barrooms), under particular conditions (intoxicated), and in particular interpersonal contexts (threats to self-esteem). Too often, clinicians infer enduring personality traits from behaviors which are, in fact, responses to specific environmental conditions. A child may hit another child when he is struck first or is insulted. This aggressive behavior may persist if it is reinforced by praise for being "tough," or by the other child's crying or surrendering of territory. The importance of antecedent and consequent environmental events has been frequently observed and demonstrated in experimental studies with children (Patterson and Cobb 1973).

The conceptualization of dangerousness as a person-situation interaction is not enough, however, if we are to translate social policy

objectives such as the reduction of physical harm into tangible social programs. Verbal games will not themselves reduce the rising crime rate.

The legal concept of dangerousness is so broad and diffuse that it is not a well-defined area of study within the major social science disciplines. In these disciplines, there are rather discrete areas of inquiry which have varying degrees of relevance to the concept. There are, for example, fairly well-developed theories in sociology about subcultures of violence, in which the physical harming of others is socially approved (Wolfgang and Feracuti 1967). In experimental psychology, the concept of aggression, or aggressive behavior, is becoming an area of systematic inquiry.

Within psychological studies, aggression has often been defined as the presentation of aversive stimuli which occur when one person attacks, administers electric shock to, or insults another person. Problems arise with this definition of aggression (Kahn and Kirk 1968), particularly when contextual stimulus conditions (social settings) are not considered. Thus, the administration of an injection by a physician to cure a patient may involve aversive stimuli, but it would not ordinarily be considered an aggressive act. However, if the physician intended to kill the patient, the same behavior might be considered aggressive. Some of the problems of intent might be dealt with by considering the actual consequences of the behavior. A consistently careless hand-gun user, or automobile driver, may produce as much injury as a person with consciously aggressive intent.

Knutson (1973) has suggested that aggressive behaviors be defined in terms of their particular patterns, the stimulus conditions under which they occur, and their consequences. This is compatible with current thinking which questions the usefulness of a general definition of aggressiveness (let alone the broader concept of dangerousness). Instead, specific types of aggression would be defined. In animal studies of aggression, Moyer (1973) has used categories such as fear-induced, sex-related, irritable, and instrumental. This approach seems more promising than a broad, general definition for producing research results, which may be comparable across studies.

The term "aggression" does not cover all forms of behavior designated as dangerous by the law. Recklessly spending the savings of the family, though characterized as dangerous, may be the result of poor judgment, and quite different from deliberately attacking strangers with a weapon. Yelling "fire" in a crowded theater as a joke may not, in ordinary language, be considered aggressive, but it is dangerous.* Similarly, reckless driving may not appear

*This behavior could be considered "aggressive" in the sense of presenting aversive verbal stimuli to others (Knutson 1973).

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aggressive, but it is dangerous, or hazardous, to the driver and others.

Problems in defining the concept of "dangerousness" will not be solved here, but a first step might be the clearer specification of both the particular behavior labeled "dangerous" and its observable consequences. Behavior resulting in physical harm may be dealt with differently than those behaviors resulting in emotional, economic, social, or political harm. Some types of harm may not be appropriate objectives for legal intervention. Finally, as previously discussed, the particular situation or stimulus condition in which the behavior occurs should be considered. The use of these three definitional elements (the pattern of behavior, the situation, and the consequences) might considerably assist in the diagnostic evaluation of potentially dangerous persons, as well as facilitate communication among the disciplines.

Measurement of Dangerous Behavior

What one measures with regard to dangerous behavior will depend, in part, upon one's theory of what produces or eliminates the particular behavior. Bandura (1973) has provided a comprehensive survey of various theories related to aggressive behavior. From an operant learning theory point of view, "dangerousness" like "courtesy" can be characterized as a "response class." A variety of behaviors may be subsumed under the term "dangerousness." These behaviors may be maintained by different consequences in the person's environment.

Baer (1966, p. 10) has provided a useful example of a response class in his paper, "Reinforcement Grows Up." He describes a teenage boy who, if observed in everyday circumstances, would probably show many behaviors labeled as "courtesy." The facts of this boy's case are as follows: He is reliable in the use of verbal courtesy because his mother reinforces such behavior with her approval. He uses his silverware, napkin, and mouth correctly at the table, because his grandmother who lives with him nags him interminably every time he fails to do so. He holds doors open for ladies and allows them to precede him here and there, because his father has told him it is a part of good seduction technique. In terms of the responsible reenforcement contingencies, the "courteous" young man actually is three young men: a maternal approval-seeker; grandmaternal disapproval-avoider; and a sexual-hopeful. Should grandmother leave home, for example, one component of the young man's apparent courtesy would extinguish quite promptly if no one else reenforces it; but the other components would remain.

The boy functionally possesses three traits in this example, but the observer sees their topography—their physical form—as one. For the *observer*, perhaps, all these behaviors are a unified class; for the boy, they are three classes.

The law tends to deal with dangerous behavior as though it were one response class and then attributes the cause of this behavior to the individual. However, we know that the form or topography of a behavior may not be nearly as important as the consequences of that behavior in determining its future likelihood. The appearance of behavior is relatively unimportant, except to the observer whose behavior we are not trying to explain. What behavior accomplishes by way of consequences is all important in understanding its existence and its future (Baer 1966).

The stimulus events preceding an aggressive behavior may also be important factors in determining the subsequent likelihood of the behavior. These stimuli may act either as discriminative stimuli, or they might more directly elicit an aggressive response, as in the classical conditioning paradigm. Stimuli may be discriminative if they set the occasion for the behavior to occur. These stimuli usually inform the person that the behavior will be reenforced or punished. The presence of a policeman may indicate the likelihood of punishment for the act.

Through the use of classical conditioning procedures, previously neutral stimuli may elicit aggressive responses. By pairing names or the appearances of people with unpleasant or hostile words, negative attitudes and aggressive responses have been elicited (Staats and Staats 1958; Berkowitz 1973). The frequent pairing of certain appearances with negative words or behaviors in some subcultures may, therefore, inadvertently classically condition prejudice and acts of violence.

A stimulus which is a part of a complex chain of closely integrated behaviors may serve several functions. A smile from the boss may elicit a smile in return, and a request for a raise. An insult or threat from a stranger may elicit a defensive reaction and set the occasion for an escape to safety.

It is frequently said that some dangerous behaviors are rare events and are, therefore, more difficult to measure, or to predict, than are more frequent events such as smoking or sexual behaviors, usually treated by therapists. Surely, the killing of one's spouse is an unusual and infrequent event. A person who does this rarely does it again. He may have difficulty in getting married again, thus foreclosing the opportunity. Behaviors assumed to be infrequent may, in fact, be quite frequent for certain people. The assumed low frequency may merely reflect the inadequacy of present procedures for observing and recording behavior in natural social settings. It is

not realistic, for example, to assume that the sexual behaviors which result in the involuntary confinement of pedophiles occur only on the occasions when they are officially reported. That may be true in some cases, but it is likely that sexual activity with children occurs rather frequently prior to its official recording. The police solve a low percentage of the offenses reported, and victimization studies suggest that an even lower percentage of offenses are reported to the police. The daily observation of behaviors would probably produce much higher frequencies of offenses than officially reported, or even mentioned informally, to therapists. Better observational and reporting methods, e.g., use of self-observation procedures, are needed.*

If behaviors cannot be observed directly, their likelihood can sometimes be inferred from other information. A high blood-alcohol level suggests a high probability of drinking alcoholic beverages. In the case of pedophiles, sexual preference has been assessed by measuring sexual arousal to photographs of young children (Laws, Moore, Burkhardt, Donohue, Parker, and Reams 1972). If a previously convicted pedophile has been in the community for several weeks on parole, and begins to show sexual arousal to photographs of young children instead of adults, there may be an increased probability of pedophilic behavior. This inferred probability may not be great enough to justify commitment or coerced therapy, but it might be sufficient to justify a request for the daily self-recording of relevant behaviors. Alternatively, supervision might be increased and additional treatment resources made available to him in the community.

It might also be possible to test, repeatedly, persons involved in more direct, physically harmful activities. Frequent periodic testing of a released offender, under those conditions which usually elicit or reenforce aggressive behaviors by him, might greatly increase the accuracy of the prediction of these behaviors. Such testing might, for example, include the measurement of vascular arousal and preferred modes of response to threatening situations.

Need for Research

There is clearly a need for more research on methods of assessing aggressive or dangerous behavior in laboratory and natural social settings. Not only could this assessment help in the development of more accurate predictive instruments, but it could also assist in

*A discussion of various procedures and equipment for observing behavior in natural settings can be found in Schwitzgebel and Kolb (1974).

guiding individual therapy programs. An illustration is provided by the work of Patterson and his associates (Patterson 1974; Patterson and Cobb 1973; Reid and Patterson 1973). In a series of studies involving boys between the ages of 3 and 16, researchers and parents observed the boys' behaviors in their homes, using systematic behavioral sampling procedures. Behaviors such as crying, commanding, laughing, playing, teasing, working, and yelling were observed. By teaching parents to rearrange the consequences of the child's aggressive behaviors, extremely aggressive behaviors were markedly reduced in a substantial number of cases.

Promising exploratory research has involved the measurement of physiological reactions associated with aggressive responses. A sharp reduction of systolic blood pressure levels may be found, in some cases, following aggressive responses. Reduction of arousal, i.e., relief from a stressful physiological condition, may be one reason why some aggressive responses are difficult to extinguish in certain subjects. Some investigators have found that a nonaggressive response, which effectively reduced the opponent's aggression, was also effective in reducing vascular arousal (Hokanson, Willers, and Koropsak 1968; Stone and Hokanson 1969). This raises the question as to whether it might be possible to train aggressive persons to emit socially accepted responses, rather than aggressive responses, to reduce their arousal. Hearn and Evans (1972) have used tape-recorded relaxation instructions to reduce anger responses to a hierarchy of scenes. Further study is required to determine whether the results of these procedures can produce observable changes in behavior in natural settings.

If aggressive responses cannot be changed, it might be possible to bring them under more appropriate discriminative control. Striking another person in anger is not prohibited in a boxing match. Other therapeutic strategies might include the reinforcement of behaviors incompatible with aggressive behaviors (Brown and Elliott 1965), or the conceptual restructuring of the social environment to facilitate the perception of increased response options (Harvey, Hunt, and Schroder 1963; Giebink, Stover, and Fahl 1968). Another approach could involve the teaching of empathy through vicarious conditioning, as suggested by Rosenhan (1974).

Preventive intervention can also be focused upon the environments of dangerous persons. Just as road dividers can be used to protect drivers from other careless or aggressive drivers, so some consideration can be given to developing prosthetic environments for reducing other forms of dangerous behavior. This approach may be particularly appropriate when individual treatment is not successful or practical (Jeffrey 1971). For example, the number of hand guns might be reduced, citizen alert and rescue systems might be

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utilized, and equipment might be developed to monitor and record particular behaviors in natural settings.

In view of the importance of the problem, there is relatively little innovative research being done in the area of dangerous behavior. It almost appears as though our society is unwilling to encourage, or permit, the imaginative, courageous, and sometimes fruitless research which may be necessary. Consider for a moment the possibility that for some individuals the frequency of certain dangerous behaviors is closely related to an excessive intake of alcohol (Daniels, Gilula, and Ochberg 1970). For these individuals, some of their dangerous behaviors might be state dependent. While not intoxicated, it may be difficult for them to recall events and negative consequences related to their aggressive behaviors while intoxicated. Studies of state-dependent learning would suggest poor generalization (Goodwin, Powell, Brement, Hoine, and Stern 1969) and, thus, the poor treatment results which are generally found. We are, therefore, currently exploring the possibility of what might be called "state-dependent therapy," in which a patient is treated in the alcoholic or drug state in which the unwanted behavior usually occurs. In one case involving aggressive behavior, the patient, while moderately intoxicated, was systematically desensitized to insults.

Dangerous behaviors may have to be dealt with directly as are speech disorders, phobias, and enuresis. There is finally a need to encourage and coordinate the fragments of promising studies into a general pattern of research so that important areas providing linkage between studies will not be overlooked.

Legal Implications

If the major issues briefly discussed above were more fully developed and given serious legal consideration, the impact upon the mental health system would be quite large. There is considerable agreement among researchers studying dangerousness and aggression that the definitions or referents for these terms need to be more precise. Nevertheless, the term "dangerous" in statutes remains vaguely defined and is often used inconsistently. Some statutes use a commitment standard, based upon a person's need for care and treatment, which usually implies some form of potential harm to self or others. The kind and amount of harm are unspecified.

The apparent agreement among many court and clinical personnel committing people under vague dangerousness statutes is largely illusory. The concept of dangerousness is elastic enough to meet the perceived professional needs of various groups dealing

with people who might harm themselves or others. In the absence of the rigorous procedural safeguards of a criminal trial, a "dangerous" person may be committed by civil procedures to a secure mental health facility. Society is thus protected from a real or an imaginary harm. Legal personnel have thus fulfilled one of their perceived social functions. They seldom receive feedback about those persons presumed to have been dangerous, who were in fact not dangerous.

Mental health personnel may find a vaguely defined concept of dangerousness helpful because it permits them to do what they think is necessary for the protection of the patient, or others, without needing to demonstrate the validity of their conclusions. There is, therefore, little incentive within the mental health system to change its operation.

When skilled professional groups show reluctance to change an ongoing social system, it should not, however, be assumed that they are acting only out of self-interest. With proper legal regulation, a civil commitment statute might achieve some of its intended beneficial objectives. This discussion began with the case of a 19-year-old girl committed as dangerous for 59 years in an Arizona institution. The following case illustrates a different outcome.

Not long ago, a pleasant, affable college student, in a large class, began participating in class discussions far more frequently than usual. Over a period of 2 to 3 weeks, his comments became increasingly animated, incoherent, and centered around the themes of light and love. Two of his roomates, who were taking the same course, approached the teacher after class and informed him that their friend was seldom eating and was wandering through the streets for long periods of time. The teacher suggested that they encourage him to go to the school infirmary for a complete physical and psychiatric examination.

By unknown means which may have even involved some threats or force, the student's friends "persuaded" him to go to the infirmary, where he was further "persuaded" by the staff to stay overnight for some additional tests. The following day, he was transferred and confined, clearly against his will, in a large mental hospital, under provisions of a Massachusetts statute. Love turned to rage. He angrily protested his capture and attempted to harm the staff who prevented his escape. This resulted in his being further confined in a small isolation room. Late that evening, his language became largely a "word salad," interrupted by angry, fearful screams. It was, however, his behavior which was most troubling. Not only had he removed all of the paper clothes given to him (paper clothing was used to reduce the possibility of suicide by strangulation), but he was also trying to climb a pipe in a corner

of the room. It was a large, heavily padded steam pipe which extended from the floor to the ceiling, where it was joined by a metal band to a smaller padded steam pipe. Where these pipes were joined, two sharp bolts protruded a few inches apart. He was attempting to gouge his eyes out on these bolts. He was then physically restrained by the staff and given enough medication to produce sleep. There was no evidence of drug intoxication or physical impairment, nor could any other cause of his problem be found. Fortunately, the remission of the problem was even more rapid than its onset. Within 3 to 4 days, he was talking coherently and planning to return to school. Within 2 weeks, he was again attending classes and doing well academically. Although he was angry about the possible deception and coercion used in his situation, he was very grateful for his sight.

It is likely that the Massachusetts statute (M.G.L. c.123), which permits 10 days of involuntary commitment for emergency care on the basis of dangerousness to self or others, was intended to handle cases such as the one just described. Definitions of dangerousness should be compatible with public policy objectives and legislative intent, e.g., emergency care. Sometimes policy objectives and legislative intent are not clear, or are in conflict. The potential for the abuse of civil liberties then becomes great.

It is interesting that, in the criminal justice system, prohibited behaviors are usually clearly defined. Sentences vary for intent to rob, robbery, robbery with force, robbery with a dangerous weapon, and burglary. Even situational variables may be made part of the definition of the offense. Burglary during nighttime often has a longer minimum sentence than burglary during the daytime. Legislatures seem to have the ability to define behaviors rather precisely, when required to do so by courts to avoid constitutional prohibitions against vagueness in criminal law. Perhaps equal skill should be required in the area of civil law, which also involves involuntary commitment.

Some suggestions were made earlier for clarifying the meaning of dangerousness by specifying dangerous behavior in terms of its patterns, situational contexts, and consequences. This could in turn clarify legislative intent and prevent some misuses of commitment statutes. Clear evidence of having engaged in the defined behavior might be required as one, but not all, of the criteria required for involuntary commitment. People may not be criminally committed for undefined "unlawfulness," nor should they be committed for undefined "dangerousness."

If one assumes that the initial commitment of a dangerous person is appropriate and legally valid, that person should then receive adequate treatment and, when no longer dangerous, be released.

One of the major, persistent problems, however, of indeterminate sentences is that the evaluation of the person's dangerousness is difficult and perhaps at times impossible. Dangerous behavior may occur only in specific social settings outside of the hospital and, thus, observation in a hospital setting may not provide a valid assessment of the likelihood of the behavior. It would be desirable to observe closely the patient's behavior in these settings, on a temporary basis, while protecting the community. The decision for long-term release could then be based upon relevant observable behaviors.

The use of such a "conditional release" with a sex offender was considered by an appelate court in Illinois in *People* v. *Thingvold.* After 6 years of confinement, the appelant claimed that he had recovered from being a sexually dangerous person. Four psychiatrists were unable to determine if he had recovered sufficiently, and all indicated that some type of release might be feasible. The court based its decision on an Illinois statute which read: "If the court finds that the patient appears no longer to be sexually dangerous, but that it is impossible to determine with certainty, under conditions of institutional care, that such person has fully recovered, the court shall enter an order permitting such person to go at large, subject to such conditions and such supervision by the Director, as in the opinion of the court, will adequately protect the public. In the event the person violates any of the conditions of such order, the court shall revoke such conditional release, and recommit the person under the terms of the original commitment." The court requested the trial court to consider the placement of the appelant in a halfway house, under such provisions as the trial court would consider proper to protect the public.

Conditional releases for short periods of time, with close supervision, would seem preferable to long-term confinement on the basis of an uncertain probability of future dangerous conduct. Treatment such as *in vivo* desensitization could then be conducted in these settings, and the patient returned to the institution until positive treatment results are observed.

Conclusion

The concept of dangerousness has been misused, particularly because its meaning is unclear. The term "dangerousness" is not closely linked with relevant concepts guiding research in disciplines such as sociology, psychology, and physiology. The specification of types of aggressive behavior in terms of the behavior's patterns, situational context, and consequences, might serve as a model for

the definition of dangerous behavior. This would help to integrate research findings across disciplines and at the same time clarify legislative intent as expressed in the statutes. While fragmentary, but promising, research efforts are being encouraged and conceptually integrated, decisions will need to be made about persons who are presently considered dangerous. As in criminal law, a specific dangerous or aggressive act might be judicially required as one of the criteria for civil commitment rather than a generalized concept of dangerousness.

The accurate prediction of dangerousness is very difficult and in a hospital setting may be, at times, impossible. For committed patients, consideration might be given to their "conditional release" under close supervision. Under conditional release, a patient might be exposed to those situations which were previously associated with his dangerous behavior. Observations of his behavior in natural settings could then be used to make estimates of future dangerous conduct. It would also permit the conduct of treatment in daily life situations.

Some people unnecessarily inflict serious physical harm upon others. Man is unfortunately one of the few species which takes his own kind as prey, and this should be prevented. In doing so, care should be taken not to label as dangerous the socially accepted behaviors of a 19-year-old girl who laughs and sings (Wexler et al. 1971). There is a vast difference between violence and singing. Surely we can require our mental health system to make at least that distinction.

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CHAPTER 6

Dangerousness and the Discipline of Psychology—The Stream of Thought of a Patient's Lawyer*

Herbert M. Silverberg

Every year in the District of Columbia, about 2,200 people are taken out of their homes, or off the streets, and presented to the mental health system for involuntary confinement. In every single case, if the law is being followed, that kind of intervention results from someone's having good faith and reasonable belief that the person involved is, as a result of mental illness, likely to injure self or others if not immediately detained.

The District of Columbia is not unique in this regard. More than a dozen jurisdictions have laws that make "dangerousness" or "likelihood of injury" the basis for involuntary commitment. In many other jurisdictions the criterion is nominally a "need for care or treatment," but the context in which commitment decisions are made makes it clear that dangerousness is what they, too, have in mind.

Across the country, literally scores of thousands of people every year are deprived of their liberty on the basis of some other person's belief that, mentally ill, they represent a danger. We are, therefore, talking about scores of *centuries* people-years spent in State mental institutions. Seldom have the rights of so many been curtailed to so vast an extent on the basis of a concept so amorphous, so capable of being shaped to the individual will of the psychiatrist, psychologist, social worker, or judge who feels that commitment is the solution.

The lawyer's main problem with dangerousness, then, is that dangerousness is a *very* existential term. Like the Queen in *Alice in Wonderland*, people who use the term, people who live by it and build their careers upon it, will tell you that dangerousness simply means what they say it means, what they need it to mean in order to get the job done. It is simply a button that must be pushed at the right time, in proper sequence, to accomplish an outcome

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determined in advance to be appropriate. Little wonder, then, that to an extent clearly unparalleled in the history of disciplines that ride on the reputation of science, predictions by so-called experts fail to withstand the simplest scrutiny (as Henry Steadman and others have been telling us for all too long now).

Statistics, such as those that are yielded by the *Baxstrom* case, studied and reported in depth elsewhere by Steadman et al. (1972, 1973), may shock naive academics, querulous newspaper reporters, unsuspecting politicians, and unthinking judges. However, they can come as no surprise whatever to anyone who spends even a little time really watching the mental hospitalization process, civil or criminal, as it grinds and clanks to its almost inevitable result, day-by-day. Some interesting data illustrating these points are taken from Steadman and the author's own work while serving in the Public Defender's Office in the District of Columbia.

By and large, the notion that dangerousness is a well-understood concept, suitable for use in the social decisionmaking process and amenable to legitimate usage by scientists and other experts, is the protege of psychiatry, rather than psychology. Nevertheless, some of us fear that in psychology's headlong rush to achieve equal status with psychiatry, and to free itself from any delimiting and pejorative stereotypes as testers and rat-runners, it is proving all too adept at the same cynical end-justifies-means, who-are-you-to-question-me outlook that is emerging as one of the major disgraces of the profession of psychiatry.

It is hoped that psychologists, who practice their profession in cooperation with institutions in which people are being held against their will, will reject the course that has brought psychiatry so deeply into conflict with the law and has driven such a wedge between the two professions.

The more insistent psychologists become on forsaking what this author believes to be the most valuable aspect of that discipline—its commitment to the scientific method in favor of a more idiosyncratic practice of the "healing arts," the more likely those professionals will find themselves in trouble with the law. On the other hand, to the extent that a commitment to the scientific method is honored and valued, psychology may well have the last clear chance to retrieve a modicum of respectability for the practice of involuntary commitment to mental institutions.

The core of the scientific method is accountability. If this author understands the legal profession's increasingly acute concern over the dangerousness-centered commitment process correctly, it is in large measure a quest for accountability for what the process does to people. The days when family, friends, lawyers, judges, and nearly everyone else bowed deferentially to the magic of a psychiatrist's

Table 1. Descriptive and analytical overview of sampled male Baxstrom patients (N=199)

Descriptive characteristics (Who are they?)		
Mean age at transfer	47	
Racial distribution		
Black	49%	
Nonblack	48%	
Unknown	3%	
Median grade of education	7th	
Ever married	39%	
History of violent crime conviction	58%	
Mean number of previous arrests	4.3	
Behavioral record (How did they do?)		
In-hospital, prerelease assaultiveness	15%	
Any assaultive behavior (1966-1970)	20%	
Released to community	49%	(98/199)
Arrested after release	20%	(20/98)
Rehospitalized	44%	(43/98)
Returned to Matteawan/Dannemora (1966-1970)	3%	(26/967)

Some relationships and nonrelationships (factors associated with behavior)

Significant relationships

Age	and assaultiveness (inverse)
Legal Dangerousness Scale	and assaultiveness (positive)
Age and LDS (combined)	and assaultiveness
Family Interest	and release (positive)
Psychiatric Evaluation	and release (positive)
Length of Hospitalization	and release (inverse)

Nonrelationships

Assaultiveness in-hospital and hospital release
Assaultiveness in-hospital and assaultiveness in community

"clinical judgment," never wondering, never questioning, never thinking it through for themselves, are virtually over, and rightfully so. The days when mental hospitals were warehouses for thousands of people-years of isolation from the world are fading fast.

In the face of this inexorable change, psychiatry is moving toward increasing accountability, with a passive-aggressiveness rivaling that of the most dyed-in-the-wool neurotic. In the process of deinstitutionalization, we are in serious danger of throwing out the baby with the bath water, because psychiatry has utterly failed to open up involuntary hospitalization to a participatory partnership with the body politic, based on professional candor and public accountability. Psychology could, if it chose, lead the way in

Table 2. Comparison of Pre-Baxstrom and Baxstrom male patients

Characteristics	Pre-Baxstrom (312)	Baxstrom (199)
(1) Mean age at time of transfer	57	47**
(2) Mean years continuous institutionalization interrupted by transfer	21.8	14.7*
(3) Race: % black	29.8%	48.7%***
(4) History of violent crime convictions: any	22.1%	51.3%***
(5) % Assaultive in civil hospitals following transfers	5.8%(18)	15.1%(30)***
(6) % Ever released from civil hospitals	36.9%(115)	49.2%(98)**
(7) % Released ever rehospitalized	26.6%(34/115)	43.9%(43/98)**
(8) % of released ever subsequently arrested	13.0%(15/115)	20.4%(20/98)

*Difference significant at .05.
**Difference significant at .01.
***Difference significant at .001.

Table 3. Psychiatric findings of dangerousness by alleged offense

Psychiatrically dangerous	Alleged offense							
	Violent vs. person		Potentially vs. person		Against property		Other	
	N	%	N	%	N	%	N	%
Yes	75	71.4	46	59.0	23	48.9	11	42.3
No	30	28.6	32	41.0	24	51.1	15	57.7
Total	105	100.0	78	100.0	47	100.0	26	100.0

$Chi^2 = 11.559$ $p < .01$ $\phi^2 = .045$

creating such a partnership, however. The issue of dangerousness offers a prime opportunity to make the point dramatically.

Simply put, it is a rare State mental institution that keeps followup statistics on its predictions of dangerousness. It is a rare State hospital psychiatrist who keeps such statistics. It is a rare judge or mental health board member who follows his own or the system's overall track record. Literature published as the result of such self-monitoring is virtually nonexistent.

With psychiatry operating in such a reassuring atmosphere of nonintrospection, it will come as no surprise that the patient's lawyer hears some amazing behavioral hypotheses, propounded in all medico-scientific solemnity, leading to substantial deprivation of individual freedom, without an iota of cited scientific authority or testing. These statements are usually made with a sanctimonious air

that defies the listener to express disbelief, or to ask for support in recognized authority. What passes for accountability, if anyone has the termerity to ask, is the cynical contention, "it's my clinical judgment." How far would that get you if you were propounding a hypothesis in the area of learning theory or intelligence testing, or the outcome of an election?

Let us illustrate further by citing examples of the kinds of reasoning made by psychiatrists. "This person is dangerous to himself because normal people are afraid of bizarre people, and their fear could lead them to hurt him." On the other hand, "This person is dangerous because he is afraid and suspicious of other people, and his fear may lead him to hurt them." (This "preemptive strike" doctrine works toward commitment both ways, then, depending on the needs of the situation, or those of the hypothesizer).

"This person is dangerous to himself and his wife and children because as a result of mental illness he is forsaking an opportunity to make a lot of money as an economist. He is writing rock songs instead, and even if they are selling now, someday they may not be, and he will be sorry he changed careers."

"This person is dangerous because he is manic, and you cannot say for sure that a manic will not decide to fly off a building, or walk on water."

"I cannot prove it, and the person has never done anything dangerous, I admit, but I am telling you that there is vast rage there that is bound to come out, and he is surely going to hurt someone. Even the nursing attendants are afraid of him, and they know when someone is dangerous."

"If this person does not have the operation (blood transfusion, special diet, special medication, group therapy), the situation will deteriorate until (fill in the blank)."

"Financial irresponsibility can be dangerous." "Only substantial physical harm is dangerous." "I cannot predict dangerousness unless some dangerousness has already been demonstrated." "In my clinical judgment, this person will be dangerous unless treated. I do not care what he has done or not done in the past." "This person may never hurt anyone, physically, but he is a threat to the emotional health of his family, and that is dangerous, as far as I am concerned." "No healthy adolescent indulges in sex. She cannot control her impulses. She is dangerously mentally ill, because premarital sex is promiscuous." "He is so strange that he causes crowds to gather, which creates a dangerous situation."

A lawyer representing mental patients hears these sorts of things all of the time; so do judges and juries. It is the legal system that ultimately has the responsibility for sorting out the competing considerations that such statements inevitably invoke, for deciding what is

and what is not committable dangerousness due to legally cognizable mental illness. (For provocative illustrations see tables 1, 2, and 3.)

At the moment, responsible legislators, lawyers, and judges are looking at the present system, recoiling in horror, and cutting back on the professional freedom of mental health professionals with such technical devices as "proof beyond a reasonable doubt," "threat of substantial physical harm," "proof of prior dangerous acts," "threat of *imminent* harm unless *immediately* hospitalized," time-limited commitments, etc.

The author is in substantial sympathy with this movement as matters now stand. The legal system has no alternative, given the general state of accountability in the involuntary mental health care system and, in particular, the difficulty surrounding the concept and prediction of dangerousness.

It is too early to give up entirely and take an abolitionist position. What the system needs is refinement of key concepts, redefinition of roles, and rededication to accountability, not just for fiscal decisions, but for the pronouncement of human-behavior hypotheses that determine chief trends in mental hospitalization and, therefore, major milestones in the lives of human beings.

If professionals will provide data, replicable, assessable data, on the validity of their hypotheses and the accuracy of their predictions, the law will quickly respond with clear definitions of what should and should not be done, and we can go on to make what changes may be needed. In learning their calling, psychologists have been trained to record, verify, compare, analyze, report, replicate, validate, and only then, to prognosticate. To the extent that psychologists steadfastly continue to do so and refuse to intervene in people's lives, our professions can join in a needed and useful revitalization of an unnecessarily moribund institution.

On the other hand, to the extent that psychologists insist on the psychiatrist's claimed prerogative to run a closed shop and to account only within the guild (if at all), it can be *confidently* predicted that there will be a danger to the profession's advancement in the public sector, and a danger to our clients as well.

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CHAPTER 7

The Lanterman-Petris-Short Act With a Focus Upon Dangerousness

Nicholas C. Petris

Who is dangerous or not dangerous? Who is mentally ill? For that matter, who is mentally well? Superficially, these may appear to be foolish questions with obvious answers, but they are not when examined in some detail.

In the San Francisco Bay area, there was an underground publication entitled "Madness Network." It had as its central editorial thesis the notion that either we are all mad, or none of us is mad—a provocative thesis!

By whatever label—madness, insanity, mental illness, idiosyncratic behavior, odd, different, unique character, soul, or individualistic—our personalities are worth preserving. This is the basic idea of the California Lanterman-Petris-Short Act (LPS). This act rejected uniform standards for mental health and for mental illness. It said, simply, that the mentally ill, whether self-defined or involuntarily committed, are people first and patients second.

In the investigations which led to the drafting of the LPS Act, we discovered, and were shocked and ashamed, that our State mental hospitals were, in large part, warehouses for the idiosyncratic, the aged, the senile, the odd, and the different. We learned that the statement, "a person is mentally ill," is, immediately, a commentary on the behavior of the individual and the society in which he resides. We decided that no law could safely set normative standards for mental health. We remembered that throughout history some of today's madmen can become tomorrow's heroes. We had been particularly harsh on the elderly, 2,000 of whom were committed each year, who were not mentally ill either under the legal or the medical definition. Eighty percent of them died within the first year; yet, no person who has visited a mental health facility can deny the serious needs, both temporary and permanent, of the mentally ill. We cannot wish away the mental disburbances of some of our brothers, but neither can we forget our own biases toward uniformity and conformity. We must carefully and

cautiously balance the manifest treatment needs of the mentally ill and the desire to protect civil rights.

Most obviously, there is the question of mental illness and dangerousness. It has been shown conclusively that the layman's fears about the mentally ill are highly exaggerated. A definition of danger is used here which includes violent, criminal activity, since this is the focus of our concern. It is unnecessary to remind professionals that many studies show discharged mental health patients having a lower arrest rate than the general population.

Let us recall a short passage from "The Dilemma of Mental Commitments in California," the report which led to the LPS Act:

> For hundreds of years, people have equated mental disorders and violent behavior. It is true that *some people* with mental disorders may also be dangerous, but the stereotyped view is that mentally ill people are uncontrolled "raving lunatics." If this assumption were true, a finding of "mentally ill" would be equivalent to a finding of "dangerous." If this assumption were true, one could find no fault with a court system that replaces legal proof of danger with a diagnosis of "mentally ill" for the purpose of removing dangerous people from the community. If this assumption were true, one could find no fault with a custodial hospital system for all those labeled as "mentally ill," but the assumption is unproven. [The Dilemma of Mental Commitments in California: A Background Document. California Assembly Ways and Means Subcommittee on Mental Health Services, November, 1966.]

We heard repeatedly in our public hearings from mental health and legal experts that society is not made safer by the isolating of the mentally ill. Despite public opinion to the contrary, a person labeled mentally ill is as likely as the next fellow to commit or not commit a violent act. As we have noted elsewhere (1969), there is no cause for massive preventive detention of the mentally ill.

Preventive detention of the mentally ill, or anyone, might make sense, putting aside jurisprudence for a moment, *if* we could predict human behavior. We can't. We try, but we fail. This author does not propose that we must have an absolutely perfect system of prediction before utilizing such a system, but we are far from achieving even modestly acceptable prediction rates.

A study at the University of California by Monahan (1973) has convincingly documented our inability in this area. Another study by Wenk et al. (1965) was done for the California penal system to determine a scale for the prediction of violence. Eighty-six percent of those identified as potentially violent committed no violent acts while on parole. A similar effort was attempted by Wenk and his associates in 1968, with 326 incorrect assessments for every

successful prediction. A third study by Kozol et al. (1972) showed an eight to one false-to-true prediction rate. Kozol and his colleagues gathered data from Massachusetts over a 10-year period, disclosing that 65 percent of the persons identified as dangerous did not commit a dangerous act. Hence, we may assume that the state of the art is guesswork.

Worse than that, the tendency is to overpredict violence. Repeated studies, such as those reported by Steadman elsewhere in this monograph, all concur on this point. There is good reason for a mental health professional to overpredict dangerousness. He or she is in a classic conflict-of-interest situation: (a) A miscalculation by the professional which results in a violent act will bring criticism and charges of incompetency; (b) a mistake in favor of incarceration (involuntary treatment) is likely to go unchallenged; (c) the clinician may genuinely believe an individual needs treatment, yet the person may refuse it, and the label "dangerous" may be the only legal recourse; and (d) the professional sees only the successes of his prediction, since the individual who is detained obviously does not pose a societal threat and, once released, is considered nonviolent by reason of treatment.

All of this is sad, indeed. We are dealing with people who are, for the most part, powerless. It is easy to tolerate our mistakes because our victims, whom we attempt to help "for their own good," are generally incapable of mastering the resources to resist society's clumsy efforts at self-protection. So, LPS tried to resist the temptation to overpredict dangerousness in the mentally ill, yet still provide top quality community mental health services.

Given the concerns of the authors of the LPS Act, what happened following 1969 when this new legislation took effect? In January of 1974, the California State legislature overrode a gubernatorial veto, for the first time in 28 years. The vetoed bill would have prohibited the administration from closing State hospitals, without specific legislative approval and without a plan for each patient. Prior to the override of this veto, seven separate measures had been introduced in the legislature to express dissatisfaction with the implementation of the LPS Act.

What went wrong with our plans to implement the noble goals of the LPS Act? We learned from a series of extensive legislative hearings on the implementation of the LPS Act. First and foremost, it was discovered that without the cooperation of all branches of State government, any effective mental health system will be subverted.

A primary aim of the authors of the LPS Act was to bring about a change in the attitude of the public toward more understanding of mentally ill. Fiscal need must be consistent with program needs to

accomplish such a change. Moreover, we have come to believe that it is necessary to overcome any strictures of the "bookkeeping mentality" at the local Government level, which traditionally places limitation of expenditures above human needs. Regrettably, we encountered limitations of this type in the California system. Here are some examples of this narrow bookkeeping approach to Government:

(1) The mental health budget was cut by 18 million. Fortunately, the public and legislative reactions supporting mental health resulted in the restoration of $12 million. In the meantime, we felt that this "cut, squeeze, and trim" philosophy was eroding services. Many instances were reported about inappropriate activities. At one of the hospitals for the mentally retarded, nurses were reduced to driving trucks, and the patients received baths only once every 2 weeks.

(2) In January, 1973, the governing administration in California planned to close every State mental health hospital except that for the criminally insane. The mentally ill were to be evicted by 1977, and the mentally retarded by 1981. The LPS Act provided no authorization or mandate for wholesale hospital closures.

(3) The State administration did not assist with the development of local mental health programs. For example, only 1 week's notice was given to county officials when the decision was made to end admissions to one State hospital. In the author's own county, 537 State hospital chronic patients were released in 1 year, and 80 percent of these mentally ill were discharged before the county's rehabilitation teams were in operation. In a neighboring county, a mentally ill ghetto sprang up with more than 1,100 ex-State hospital patients in a downtown area who were living in rooming houses and other inadequate places. This procedure occurred despite specific legal requirements that every patient must have a written discharge plan prior to release. Those who favored the fiscal retrenchment of mental health programs took the position that communities were not required to prepare an implementation plan to discharge patients. In another county with a population of 1,070,000, not one long-term psychiatric bed existed.

(4) In the first year of a large scale reduction of the State hospital population, $7.5 million were placed into the State's general fund, instead of being spent in local mental health programs.

(5) A method of bookkeeping, designed to save money, was put into effect which gave county officials a bounty for not sending patients to State hospitals. The Department of Health set an arbitrary number of patient-days for a county's use. If the county exceeded that number, it received no extra State aid and, hence, not only was entitled to "keep" the unexpended funds, but also

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received a $15 per patient-day bonus. This dollars quota system, of course, had no relationship to either treatment needs or patient rights.

(6) The LPS Act specifically mandated that local mental programs utilize private facilities. As a result, mental health dollars have been channeled to hundreds of nonprofit, charitable institutions, which also receive private donations. The executive branch made the decision to reduce the State's share to these charitable institutions by one dollar for every private dollar received. The result was no improved programing and no incentive for private contributions. In retrospect, it became clear that we should have required dual funding of State and local programs prior to the closure of State hospitals. Any businessman knows that switching from one product or process to another is capital incentive.

In the intense desire to insure the civil rights of the potential and actual mental patient, treatment rights are often neglected. As recent cases cited by Brooks, Frederick, and Shah elsewhere in this monograph illustrate, there is a need to write the law in order to insure that those who desire it, and those who are committed, will get treatment. Too often we have heard stories in California of a person in need being bounced from agency to agency. Such a lack of coordination results in a "pinball machine model" of services. In part, this usually happens for monetary reasons, but many times it is caused by an oppositional attitude or disinterest in patient rights. The law should firmly guarantee, to those who wish it, the aid they deserve. A fundamental right to treatment should be written into the law.

We are still left with the basic dilemma of involuntary incarceration of truly dangerous persons for the protection of all concerned, on the one hand, and the provision of mental health treatment for those in need, on the other. The chief difficulty has stemmed from an attempt to combine two different social objections—custody of the dangerous and treatment of ill or disturbed—into a unitary system. It is a matter of properly considering both individual health and public safety.

Court committment may be viewed in two ways: First, it can supply a legal process for the restraint and removal of genuinely dangerous individuals from society to confined treatment facilities. When danger to a community is the foremost consideration, and custody of a dangerous individual is the objective, professional treatment considerations become secondary. Danger should be substantiated through a legal process, with confinement required to give protection to the community and treat the offender. Courts and State hospitals are still frequently expected to perform both protective and treatment tasks.

When seen in the second way, the courts supply a means of obtaining professional assistance for mentally disturbed individuals who do not wish to accept treatment. When finding mental illness is the essential issue, and giving treatment is the objective, legal considerations then become secondary. Accurate psychological and social evaluations are crucial to determine the nature of the disorder and an appropriate treatment effort. Commitment courts and State hospitals are also required to carry out these functions as a part of due process. The point is that it is unrealistic to expect the accomplishment of both legal and psychological objectives with the same committment system.

The LPS authors found the need to strike a middle ground between involuntary commitment and no care at all. As a supplement to the LPS Act, a mandatory outpatient process, under judicial review, would stop institutionalization of patients, provide treatment and care, and only minimally infringe upon civil liberties.

As a definition of gravely disabled, one of the two LPS criteria for commitment has been offered, namely assessment that an individual is suffering from mental illness to the extent that there is a reasonable possibility he will become a danger to himself or others. Sadly, we found that a narrow interpretation of gravely disabled creates a revolving door syndrome. Illustratively, with respect to chronic alcoholism, the person is drunk when remanded to a 72-hour treatment and evaluation center, but stone sober upon release. He needs aid but technically cannot be held after 72 hours because at the time of release he is not gravely disabled. The cycle then repeats itself. Clearly, we have no desire to await permanent brain damage before intervening. The LPS authors intend to watch the results of this proposal carefully to guard against wholesale commitments. We believe that the mandatory outpatient process will help in these cases as well.

We hope to construct a patient advocacy system, staffed by experts with both legal and medical training. The mental health patient needs more than a guardian in the legal sense. He, or she, needs an advocate who personally cares about each patient, and who knows how to negotiate the system. The advocate will follow the progress of the patient from the first intake to discharge, insuring legal rights and treatment rights; handling family and personal complications to make sure that the patient does not become a lost statistic.

In California we have not been resting on our past progress in the mental health field, nor will we in the future. Assemblyman Frank Lanterman, Senator Alan Short, and the author are proud of their work; but they know that the treatment of the mentally ill is a

continuing process. It needs constant attention and revision. It needs, just as the patients it serves, love.

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III. Policy, Treatment, and Social Implications

CHAPTER 8

Community Followup and Dangerous Mental Patients

Terence P. Thornberry*

Introduction

While the topic of this Symposium is concerned with the general topic of dangerousness and the mentally ill, this paper will deal with one aspect of that phenomenon. The concern of this article is with the postinstitutional dangerousness of mentally ill offenders—its extent and characteristics—as well as the facility with which it can be predicted. While dangerous behavior that occurs before or during periods of confinement are of interest, we will only be concerned with them as they impinge upon the central issue of this paper—postinstitutional dangerousness.

Further, it should be pointed out that this discussion is couched in terms of an ongoing research project—"The Release of Dangerous Mental Patients: The Dixon Case"—which is a followup of the approximately 600 patients who were released from a maximum security mental hospital as a result of a Federal court decision. Because of this, it seems reasonable to start by describing the people who were affected by the decision and the decision itself.

The Dixon Case

On July 25, 1969, Donald Dixon and six other named plaintiffs, "individually and on behalf of all inhabitants of Farview State Hospital (Farview) situated life unto them" (Dixon Decision 1971:967), filed a class action suit alleging the unconstitutionality of their confinement. On March 30, 1971, the court ruled in favor of the plaintiffs and ordered all members of the Dixon class released from Farview to other State hospitals for reevaluation and ultimate disposition. The reasons and basis for this decision can best be understood after the Dixon class is described.

*The author wishes to express his appreciation to his colleague, Joseph E. Jacoby, for his substantive and stylistic comments on earlier drafts of this paper.

The members of this class had three basic characteristics in common. First, as a result of criminal activity, they had all been enmeshed in the criminal justice system before they were judged to be mentally ill or mentally disabled. They were persons ". . . committed as incompetent to stand trial, committed after acquittal by reason of insanity, committed while serving sentences in State correctional institutions, or, in the case of a few dangerous patients, transferred from other State mental hospitals." (Law Review Note, 1961:80).

Secondly, all of them were confined at Farview State Hospital—the only mental health facility in Pennsylvania designed and designated to provide maximum security care for the criminally insane. "No mental institution in Pennsylvania other than Farview presently accepts . . . persons who are under criminal sentence, or individuals requiring confinement under conditions of maximum security because they are, or are believed to be, dangerous to themselves or others." (Dixon Decision 1971:969).

Finally, the Dixon patients had one other common characteristic which became the basis of their legal suit. The members of this class were confined at Farview ". . . after the original authority for their confinement predicated on criminal convictions or charges had terminated." (Dixon Decision 1971:967). When that terminal date occurred, the staff at Farview had them civilly committed to Farview under Section 404 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. The manner with which this was accomplished is worth noting:

> (a) The applications for these recommitments were not made by a relative or guardian, or person standing in loco parentis to these people. (b) The applicant for recommitment was the Director of Social Services of Farview, or another member of the Farview Staff. (c) The applications were supported by certificates of two physicians who were members of the staff of Farview. (d) The applications were submitted to the Superintendent of Farview, who "received" the persons named in the application. (e) The persons thus committed were not consulted concerning their wishes about continued confinement or given notice of the filing of the applications by the Director of Social Services, or others on the staff at Farview. (f) No relative, guardian, or friend was consulted by the Director of Social Services, or others on the staff at Farview, concerning the continued confinement of these persons. (g) The persons thus committed were not represented by counsel in the proceedings leading to their recommitments. (h) These persons had no independent psychiatric diagnosis or psychological evaluation in connection with either the decision of the Director of Social Services to apply for

> commitment, or the certifications by physicians that they were mentally disabled and in need of care. (i) No court made a finding that these recommitted persons required inpatient care. (j) There is no period fixed by the statute after which persons committed under Section 404 must be released. (Dixon Case 1971:968).

To the author, and apparently to the court, the most striking thing about this procedure is its routinized, bureaucratic nature, almost entirely devoid of due process considerations. In terms of our interest in dangerousness, these actions by the Farview staff can be interpreted at two levels.

At a *minimum*, these actions indicated that, in the staff's medical judgment, the members of the Dixon class were mentally disabled and in need of care. That is, they were mentally sick and incapable of existing in noninstitutionalized settings, but not necessarily dangerous to themselves or others. The *maximum* claim was that the Dixon class members were not only mentally disabled and in need of care, but also were believed to be dangerous offenders, so dangerous, in fact, that standard penal institutions or mental hospitals could not care for them. In general, it appears that the actions of the Farview staff were produced because the staff acted on the basis of what this author has called the maximum claim. In other words, it may be argued that the actions of the Farview staff justifies the *assumption* that the medical staff at Farview implicitly made the *prediction* that these individuals were dangerous and, unless confined, would engage in dangerous behavior if permitted to live in a less secure setting.

Regardless of how the Farview staff viewed the members of the Dixon class, the court viewed them in rather simple, straightforward terms. It viewed them as individuals unconstitutionally confined at Farview and, hence, ordered their release to civil mental hospitals throughout the State. The decision of the court created a rather special subgroup of mentally ill offenders. In effect, this was a group that, according to the Farview staff, should be confined in a maximum security hospital because of their potential dangerousness, but who, *in fact*, were either confined in less secure hospitals or were released to the community.

Thus, the decision of the Federal Court in the Dixon Case changed the Dixon class from a legal grouping to a natural experimental group in a field experiment. The Farview staff had made the prediction that, at a minimum, the Dixon patients were in need of continued care and, at a maximum, were dangerous, mentally ill offenders, who would prey upon the community when released. The court's decision, based on an entirely different set of criteria, ignored this prediction, thereby allowing for the empirical testing

of the accuracy of the prediction. Indeed, the general thrust of the author's research emanates from the conflict between the court's decision and the hospital's prediction in examining the aftermath of the judicial decision and its effect on the members of the Dixon class and society at large.

The Present Research

The author has gathered information from the records of the hospital that received the patients following their transfer under the Dixon Decision, from Pennsylvania State Police records, and from personal interviews with the subjects and relatives or close friends of the subjects. Given these data, perhaps two rather general research questions can be answered. The first is the assessment of the personal and social impact of a mass transfer and release of a group of mental patients who were believed to be dangerous. The second is the assessment based on background and institutional behavior, of the postinstitutional dangerousness of these mental patients.

These two general research questions are derived from what may be called the minimum and maximum claims of the Farview staff. The assessment of the personal and social impact of the release relates to the minimum claim and is essentially aimed at seeing whether and how well the Dixon class members can adjust to life in less secure hospitals and in the community. Although aspects of criminal and dangerous behavior will be considered in this area, they will be dealt with only as one aspect of generalized adjustment.

At this point a qualifying note should be made. At the present time, the author's research project is still in the data collection and coding stage, preventing a presentation of final data and results in relation to dangerousness and the Dixon class. Thus, preliminary thoughts on the matter are presented, including working assumptions and an outline of how the research will proceed.

Assumptions on Dangerousness

The conceptual, medical, legal, and methodological problems that are involved in any definition of dangerousness make any brief discussion inadequate. A lengthy debate on definition has been presented elsewhere (Steadman 1972, and Steadman n.d.). This discussion contains an operational definition that indicates the perspective of our research.

Since our concern is with an empirical assessment of postinstitutional behavior, we define dangerousness as any criminal offense,

regardless of its legal title, which involves physical injury to a person. Our concern is not with deciding if certain types of offenses are "dangerous," but with empirically determining if any person was injured during the commission of a criminal offense. (In other contexts, of course, we gather data and present findings on all criminal offenses, regardless of the presence of injury.)

With this definition of dangerousness in mind, the first assumption can be stated: namely, that postinstitutional dangerousness, committed by mentally ill offenders, is essentially a *rare event.* It has a low frequency of occurrence, both in the proportion of expatients who engage in it, and in the absolute number of acts committed.

Of the 1142 exmental patients who were examined by Giovannoni and Gurel (1967), only 156, or 13.7 percent, were arrested during the 4-year followup period. It is difficult to estimate the rate of dangerousness as it is defined here because of problems of separating incidents and individuals and because of the crime categories used in the study. It seems, however, that the rate of dangerousness as measured in terms of injury to the person approximates 4.7 percent (54 incidents committed by a possible 1142 people).

Similar results can be seen in the work of Rappeport and Lassen (1965), who study "all male patients over 16 years of age discharged during fiscal 1947 and fiscal 1957 from all Maryland psychiatric hospitals." There were 708 patients in the first group and 2152 in the second, all of whom were followed up for a 5-year period. This study used a definition similar to ours in that data were collected for murder, negligent manslaughter, rape, robbery, and aggravated assault. Of the 708 people in the first cohort, five committed offenses after release, and of the 2152 people in the second cohort, 56 committed offenses. Thus, these data indicate that 0.7 percent of the first group and 2.6 percent of the second group engaged in postinstitutional dangerous behavior.

The results of the research conducted by Tong and MacKay, in England, are less clear-cut, but in the same general direction as the above. "All male patients who had been removed from the hospital in the years 1945-1956 were 'followed up' in late 1957 to ascertain those who had either been returned to the hospital or who had been convicted of criminal offenses . . . "(Tong and MacKay, 1959). Of the 587 case studies, over this varying length of followup, 171, or 29.1 percent, had relapsed. Although a complete breakdown by offense is not presented, the authors do indicate that 19 of these offenses were violence. If this constitutes all or most of the offenses that involve injury to the person, then we are again left with a small percentage, 3.2 percent of exmental patients engaging in dangerous behavior.

Finally, we can look at the more recent work of Steadman involving the Baxstrom case, which closely parallels the Dixon case. Again, we see a low rate of postrelease dangerousness. "The total number of criminal police contacts (during an average followup of 17.4 months) for 84 patients was 18. These 18 criminal contacts were made by 13 different patients . . ." (Steadman, 1972*a*). Thus, 15.5 percent of the Baxstrom patients (13 of 84) were arrested for all offenses. If only offenses involving injury were included, the percentage would probably be a good deal lower. As Steadman concluded: "At this point, it does not appear that the Baxstrom patients were, as a group, dangerous, but this conclusion will have to wait until information about the additional 37 released patients not known to the aftercare system have been studied" (Steadman 1972*a*).

The author's conclusion, based on this brief literature review, is quite similar to Steadman's. It does not appear that exmental patients or exmentally ill offenders engage in dangerous behavior to any substantial extent. The estimates of dangerous behavior presented here range from 0.7 percent to 4.7 percent, and these rates certainly cannot be considered substantial. Furthermore, by adding up the number of patients and the number of offenses reported in these studies, as a very rough indication of the magnitude of the problem, it can be shown that 18.7 percent of the exmental patients were rearrested, but only 2.9 percent of them were rearrested for committing offenses that involve injury to the person. Because of numerous methodological problems, these general percentages cannot be considered accurate estimates of the parameters, but they do serve to highlight the point: Postinstitutional dangerousness by exmental patients is a rare occurrence. This is not to say that the question of dangerousness should be ignored or the behavior that it represents condoned. It simply means that the behavior under discussion appears to be a relatively rare event and that this fact has to be considered in any attempt to deal with the problem.

A second assumption about postinstitutional dangerousness is that, regardless of its quality as a rare event, the behavior of the clinicians at Farview and similar hospitals indicates that they are working under the opposite assumption. In other words, the inference to be drawn from their behavior is that they are implicity predicting that large numbers of their patients will engage in dangerous behavior after release.

The support for this assertion comes from a variety of sources. The first is the author's interpretation of the facts presented in the Dixon case and summarized earlier. The routine, bureaucratic fashion by which the Dixon class members were shifted from criminal to civil commitment status leads to the interpretation

that the Farview staff assumed these people should not be released because of their potential dangerousness.

Furthermore, the section of the Pennsylvania code under which the Dixon patients were civilly committed provides that each patient's case "shall be reviewed annually by a committee appointed by the Director from the professional staff of the facility wherein the person is detained, to determine whether continued care and coomitment is necessary" (Dixon Decision, 1971-969, fn.2). The Farview staff not only made an initial decision to confine each member of the Dixon class, but repeatedly reaffirmed that decision during the course of the individual's confinement.

A similar phenomenon seems to have occurred in New York State prior to the Baxstrom Decision. Steadman (1972*a*) reports that the male members of the Baxstrom class who were studied ". . . had been transferred to the New York civil hospital after a median of 13.4 years of continuous hospitalization. . . . The median year of expiration of the maximum sentence . . . was 1958. In other words, the Baxstrom patients had been kept an average of 7 years in two special security institutions, without judicial justification." Again, there seems to be a tendency on the part of the professional staff of maximum security mental hospitals to make a universal prediction of dangerousness.

This discussion, of course, illustrates Steadman's (1972*a*) conception of the psychiatrist as a conservative agent of social control. "Rather than take a chance that one patient in ten will assault another person in a civil hospital, or someone in the street while out on bail awaiting trial, the dominant psychiatric view is to confine ten. Here we have what appears to be a form of preventive dentention."

Juxtaposing the two working assumptions produces the following position: Dangerousness among former mental patients is, in fact, a rare event, yet, for whatever reasons, clinicians in State mental hospitals have acted on the basis of a prediction of near universal dangerousness. Given this situation, it seems that one of the major tasks before us is to improve our abilities to predict which individuals are most likely to engage in postinstitutional dangerous behavior so that we can respond accordingly. As Flynn and Ohlin (1974) have said: "There seems to be general agreement that a residential group of offenders, dangerous to themselves and others, requires secure confinement and possibly intensive treatment . . . . The key question is how such offenders are to be identified and by whom." We are using the Dixon case research project in an attempt to respond to this key question.

Clinical v. Statistical Prediction

The answer to the problem does not lie in the continued exclusive use of clinical prediction. This position is based only in part on the earlier discussion concerning the tendency of clinicians in State hospitals to make universal predictions of dangerousness, for there is the possibility that those apparent actions of prediction could more accurately be described as bureaucratic inactions resulting in failure to discharge patients. Nevertheless, the fact that systems for releasing patients based on clinical evaluations and dangerousness resulted in court decisions such as *Baxstrom* and *Dixon*, has to temper our enthusiasm about the future usefulness of clinical predictions of dangerousness.

Added to this is the pessimism of Robert C. Hunt, who supervised "Operation Baxstrom" in 1966. As an expert witness at the Dixon case, Hunt was asked if he thought it was possible" . . . for a staff at a maximum security institution to fairly evaluate its patients with respect to dangerousness." He answered: "Not in a maximum security situation, no. 1 would rather put it in terms of the conditions of the observation rather than the staff. The staff may be perfectly competent to evaluate, but the conditions in which the observation is done, in my opinion, preclude any accurate prediction of what behavior will be in a different situation" (Dixon Case Transcripts 1970).

In addition to these somewhat specific problems of clinical predictions of dangerousness there is also a more general one which concerns the overall accuracy of clinical predictions when they are compared to predictions based on statistical techniques.

There is some evidence, based on the work of Paul Meehl (1954), to indicate that clinical predictions are not as accurate as ones based on statistical techniques. Meehl, himself a clinical psychologist, after considering 20 studies involving a range of issues including a criminal recidivism, educational achievement, and the outcome of psychiatric treatments, concludes:

> In spite of the defects and ambiguities present, let me emphasize the brute fact that we have here, depending upon one's standards for admission as relevant, from 16 to 20 studies involving a comparison of clinical and actuarial methods, *in all but one of which the predictions made actuarially were either approximately equal or superior to those made by a clinician* . . . In about half of the studies, the two methods are equal; in the other half, the clinician is definitely inferior (Meehl 1954).

Given this type of evidence, it is difficult to support mental health systems that are based solely on clinical evaluation and predictions for releasing patients.

Furthermore, it should be noted that the behaviors being predicted in the studies reviewed by Meehl are ones that are relatively evenly distributed and can, therefore, be easily predicted. For example, in any population of prisoners there will be a large proportion of recidivists and nonrecidivists. The phenomenon of interest here, postinstitutional dangerousness, is a rare event which makes prediction efforts far more difficult since the procedure resembles locating the proverbial needle in a haystack. If, in general, clinical predictions are not as accurate as statistical ones, as the Meehl data indicate, then we must face the possibility that they are even less accurate in the current situation given the rarity of postinstitutional dangerousness.

In sum, the past history of hospitals like Farview, the pessimism of experts like Hunt, and the questionable accuracy of clinical predictions, all raise questions about the wisdom of the continued *exclusive* use of clinical predictions in this field. This is not to say that such predictions are useless and should be totally abandoned; such a conclusion is neither theoretically nor practically warranted. It is time to consider the development and utilization of statistically based prediction devices in relation to the release of mentally ill offenders. Perhaps, in combination with clinical techniques, they will create a more logical and humane system for evaluating mentally ill offenders for discharge.

Prediction in the Dixon Case

To this end, one of the major aspects of the Dixon case research project is concerned with the issue of prediction. Data are being collected from the files of the transfer hospitals and the files of the State Police, which allow us to separate the research population into those who engaged in postinstitutional dangerousness and those who did not. Given these criterion groups, research then attempts to create a predictive model which would account for the differences between the groups and which would have some utility for predicting the same behavior for different groups.

Although there is a variety of ways and methods used in approaching this topic in our research, only two relatively novel aspects of it are discussed here. The first concerns the type of predictors to be employed, and the second concerns the type of statistical analysis to be used.

The prediction studies that exist, and there are virtually none that attempt to predict postinstitutional dangerousness of mentally ill *offenders* (Greenland 1971), have not, to our knowledge, incorporated variables based on behavior observed during periods of institutionalization as predictor variables. The only study available in this general area seems to be that of Steadman in relation to the Baxstrom case. Steadman (1972*a*) examined the relationship between assaultive behavior in the transfer hospitals and the careers of the Baxstrom patients, concluding that "assaultiveness after transfer seemed to have little to do with decisions to initially release these patients, but it was related to whether patients would eventually require readmission and continued detainment." What Steadman did not do was to examine the influence of such assaultive behavior on postinstitutional dangerousness.

In the Dixon case research, data are being collected on behavioral incidents, especially assaultive incidents, as they are recorded in the files of Farview Hospital and the files of the transfer hospitals. In both cases, this is being done by examining "incident reports" in the patient's record and abstracting from the "ward notes" evidence of dangerous and assaultive behavior.* Thus, a longitudinal picture of the type and frequency of dangerous behavior emitted while in confinement evolves.

As indicated, one of the major uses of these data will be as predictors of postinstitutional dangerousness. This is not to imply the naive assumption that there has to be a high concordance between institutional and noninstitutional dangerousness. Indeed, there are good reasons to believe that there will be a relatively low concordance. There is a possibility that this type of information will turn out to be a good predictor of the criterion, and that possibility should be explored here, especially since it has not been explored in the past. It should be emphasized that the Dixon case research specifically incorporates measures of institutional dangerousness as predictor variables.

The second aspect concerns the type of statistical techniques to be employed. A number of previous efforts in this general area have encountered problems in providing accurate predictions because of the large numbers of false positives predicted. For example, Greenland (1971), discussing the work of Rosen (1954) on suicide prediction, notes that "... about five people would have to be restrained unnecessarily in order to reduce the risks of a

*The procedure for abstracting this information from the ward notes was developed by the project staff and our psychiatric consultant, Dr. Richard Lonsdorf.

single person committing suicide." One of the major reasons for this seems to stem from the fact that the events being considered are rare events. As Greenland notes: "If predicting suicide is so difficult, it follows that the chances of developing a predictive index for homicides, a much rarer event, are not good." Given our earlier discussion of postinstitutional dangerousness as a rare event, we are clearly confronted with the same problem.

In other words, there is the distinct possibility that the failure of previous attempts is tied to the statistical techniques employed, as well as the phenomenon that was being predicted. To deal with this problem, we plan to explore the use of prediction techniques specifically designed to deal with rare events and to compare the effectiveness of standard routines (e.g., regression analysis), with these more specialized procedures in our attempts to predict postinstitutional dangerousness.

Since this particular stage of the project is in its infancy, however, we cannot report on it in any detail, other than to indicate one possible approach: namely, logistic discrimination, which is a technique designed for ". . . situations where discrimination is required between two or more populations on the basis of discrete variables, possibly with some continuous variables as well" (Anderson 1973). From the perspective of this paper, it is important to note that "another application of the logistic methods developed here is in epidemiology, investigating factors related to diseases with low incidents" (Anderson 1973). Clearly, this is the type of research problem to be confronted, and the author intends to explore further logistic discrimination and related techniques to see if they are appropriate in predicting postinstitutional dangerousness. At the present, the specific technique to use has not been selected, but it does seem apparent that it is time to experiment with prediction techniques designed specifically to deal with rare events, such as postinstitutional dangerousness.

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CHAPTER 9

Employing Psychiatric Predictions of Dangerous Behavior: Policy vs. Fact*

Henry J. Steadman

From mid 1973 through early 1974, there were four cases in the courts of Albany County, New York, whose sequelae highlight many of the problems we are addressing in this symposium. John Richards was found incompetent to stand trial in 1970 on charges of stabbing two strangers. He was returned as competent in 1973, but neither victims nor witnesses could be located. Thus, Richards was released after pleading guilty to a weapons charge. The judge did so "reluctantly" and on the condition that Richards would continue to obtain psychiatric care. Within 1 month after this conditional release, Richards was arrested for the fatal stabbing of another man.

The second case involved Andrew Jenkins, who served a prison term in 1969 for the fatal beating of his common law wife. After completing his prison term, he was hospitalized in a civil mental hospital for 2 weeks in July, 1972. Approximately 1 year after his release from that State facility, he was arrested for beating to death his most recent common law wife.

Fred Giorgio allegedly shot two men in the leg while picnicking in a State park in July, 1972. He was found incompetent to stand trial and hospitalized for 1 year before being returned to trial. His first trial ended with the jury unable to reach a verdict. A few hours after his second trial commenced, Giorgio committed suicide by hanging himself in Albany County Jail.

The final case was that of Jeremiah German who was charged with the stabbing of another man in June, 1969. He was determined incompetent to stand trial and was hospitalized until May, 1973.

*The critical comments of Joseph Cocozza, the Co-Principal Investigator of the project MH 20367 from the Center for Studies of Crime and Delinquency, NIMH, under whose partial support this work was completed, on previous drafts of this paper are gratefully acknowledged.

Upon return to Albany County, local psychiatrists found him still psychotic and returned him for further hospitalization. In January, 1974, German was returned to stand trial while on medication. At his hearing in March, 1974, for 20 minutes German "fired a machine gun volley of words, many of them obscene, and jumbled sentences. He tapped one foot loudly as he ranted about killing, racism, drugs, and sex. He said he had once seen God" (Albany Times-Union, March 23, 1974). Two Albany psychiatrists testified that German was "dangerously psychotic" and preoccupied with sex and violence, and he was remanded for further hospitalization by the irate judge.

On the day after a story on German's courtroom antics, along with a resume of the other three cases, the following editorial appeared in the Albany newspaper:

> If the Albany County experience with these released psychotics can produce two alleged murders, a suicide and 20-minute court tirade in less than a year, what is going on on a statewide basis? How much crime and violence is there statewide that can be attributed to those who should be in mental hospitals and are not?
>
> The matter raises serious questions about the professional qualifications of those running the State mental health programs and the State facilities. If they are unable to recognize potentially dangerous or violent persons among those they release to society, they should not be in the positions requiring such determinations to be made.

Here is another vivid example of society's expectation that a necessary, albeit insufficient, skill of psychiatry is the prediction of future dangerous behavior. As this newspaper editorial would have it, if psychiatrists in State facilities cannot accurately predict future dangerous behavior, then they are not qualified to provide services.

In evaluating psychiatric roles in society, here specifically that of estimators of dangerousness, one is faced with the situation illustrated by the reactions to these incidents in this New York county. The public, the media, judges, and legislators, almost all assume that psychiatrists by training and experience can predict future dangerous behavior and they want psychiatrists to do just that. Even professional groups who are in the forefront of progressive policy-making often demonstrate similar confidences. The National Council on Crime and Delinquency's Model Sentencing Act, for example, requires that offenders who are determined to be dangerous be more harshly sentenced. A major feature of the determination of dangerousness is that "the judge must remand him to a diagnostic facility for study and report as to whether he is suffering from a

'mental or emotional disorder indicating a propensity toward continuing criminal activity of a dangerous nature' " (NCCD, 1969).

A logical explanation for this pervasive and high level of societal confidence in psychiatric abilities to expertly perform the tasks of predicting future dangerous behavior might be that their past performances warrant it. This group of medical professionals have been granted, or assumed, this powerful position of forecasting because they have been good predictors. Can psychiatric ascendancy as predictors of dangerousness be explained in terms of the expertise they have reflected in the past?

Having looked at the available research data on these critical questions, let us proceed to what may be some even more important questions related to: (1) whether society really cares how accurate psychiatric predictions of future dangerous behavior are; and (2) whether the answers to this latter question indicate that we may need to develop a new area of study — dangerology.

Assessments of Psychiatric Predictions

Psychiatrists make predictions of dangerousness under a wide variety of circumstances. These circumstances may be civil or criminal and they may relate to admission, institutional placement (within or between institutions), or discharge. However, regardless of the type of circumstances, by Halleck's conclusion, "If the psychiatrist, or any other behavioral scientist, were asked to show proof of his predictive skills, objective data could not be offered," is still accurate.

In a 1967 work, Rappeport and colleagues reviewed the existing literature on the dangerousness of the mentally ill with a primary emphasis on criminal activity after community release. They concluded that, "There are no articles that would assist us to any great extent in determining who might be dangerous, particularly before he commits an offense" (1967:79). In an extremely comprehensive, integrative review of a wider range of research on psychiatric predictions of dangerousness, Rubin similarly asserted, "This prediction (of probable dangerousness of a patient's future behavior) is expected of the psychiatrist — and psychiatrists acquiesce daily." This belief in the psychiatrists capacity to make such predictions is firmly held and constantly relied upon, in spite of a lack of empirical support (1972:397).

Both of these research reviews were completed before we had reported on our recent work on the "Baxstrom" patients (Steadman and Cocozza 1974). Our 4½ year followup of these 967 criminally insane patients, who were considered among the most

dangerous mental patients in New York in 1966, documented the psychiatric overestimations of their dangerousness and added additional support to the conclusions of Halleck, Rappeport, and Rubin. Of the 967 patients who were transferred from maximum security correctional mental hospitals to civil mental hospitals after the 1966 *Baxstrom* v. *Herold* decision of the U.S. Supreme Court, only 20 percent were assaultive in any way over 4½ years. This included incidents which may not have resulted in injury, but which were violent physical assaults on other persons and were not in self-defense. In this group of patients who had been detained on the average of 14 years in prisons and hospitals for the criminally insane, four times as many people were not assaultive as were. Also, only 24 of the 967 patients were returned to correctional security hospitals between 1966 and 1970.

A widely discussed exception to the consensus on psychiatric inabilities to make predictions of future dangerous behavior is the work of Kozol and co-workers on patients at the Center for the Diagnosis and Treatment of Dangerous Persons, at Bridgewater, Massachusetts. Working with a patient population mostly of convicted sex offenders, Kozol and his co-workers compiled data which they felt justified a conclusion that "It appears that dangerousness can reliably be diagnosed and effectively treated" (1972:392). The empirical basis for this conclusion was an 8 percent recidivism rate for violent offenses among those patients they evaluated and recommended for release by their diagnostic team, but whom the court nevertheless released. While these comparative figures are striking, there is a methodological flaw which raises serious questions about their strong conclusion.

As discussed by Cocozza (1973), 82 of the 386 patients recommended for release were so approved after an average of 43 months of treatment, giving them from 5 to 11 months at risk during the 48- to 54-month followup period. The data on the comparison group of 49 patients included 18 patients who were also treated, but who were at risk from 18 to 24 months, 13 months longer. In addition, there is no way to tell what the period of risk was for the other 304 "nondangerous" or the other 31 "dangerous" patients. Thus, without proper controls for length of time at risk by the patients in each group, it is impossible from the data Kozol and colleagues presented in their original piece, as well as in a subsequent rejoinder (Kozol et al. 1973) and news report (*Psychiatric News* 1973) to validly conclude that dangerousness can be predicted.

The most recent experimental data analyzing ongoing psychiatric predictions of dangerousness have been reported by Cocozza and Steadman (forthcoming). From data gathered on two groups of

incompetent felony defendants in New York State, one group evaluated as dangerous by two court appointed psychiatrists and the other group as not dangerous, a number of criteria behaviors over a 3-year followup period were examined.

In order to determine the accuracy of the psychiatric predictions of dangerousness, we obtained data on the defendants' assaultiveness from five sources: (1) the maximum security hospitals to which both groups were initially sent; (2) civil hospitals to which some members of both groups were transferred immediately after the maximum security facilities; (3) hospital readmission records; (4) inpatient records of all subsequent hospitalization; and (5) subsequent arrest records.

We examined whether the patients evaluated as dangerous by the psychiatrists actually displayed more dangerous behavior than those evaluated as nondangerous. They did not. On all of the indicators of dangerous behavior which we examined, the data revealed only slight differences between the two groups. None of the differences which did occur was statistically significant, and, therefore, all could be explained on the basis of chance alone.

On the inpatient indicators, the psychiatrically predicted dangerous group experienced slightly higher rates. Forty-two percent of them, as compared to 36 percent of the nondangerous group, were assaultive during their initial incompetency hospitalization; 8 percent, as compared to 0 percent, were assaultive in the civil hospital of transfer; 3 percent, as compared to 2 percent, were subsequently rehospitalized for a violent act, and 29 percent, as compared to 19 percent, were assaultive in the hospitals to which they were readmitted. None of these differences is statistically significant.

Conversely, the indicators on the dangerousness of the two groups once in the community reveal the nondangerous groups to be more assaultive, but again only slightly more so than the group predicted to be dangerous by the court psychiatrists. The gross measure of community behavior we used was the percentage of those released to the community, at some time, who were rearrested for a crime. It was found that 49 percent of the released dangerous group and 54 percent of the released nondangerous group were rearrested.

Perhaps the single most important indicator of the success of the psychiatric predictions is the number of these patients subsequently arrested for violent crimes. Yet even here only a slight difference is revealed by the data. Of those who had been evaluated as dangerous, 14 percent (13 of 96) of those released to the community were subsequently arrested for a violent crime. Of those who had been evaluated as nondangerous, 16 percent (11 of 70) of those released to the community were arrested for a violent crime.

How accurate, then, were the psychiatric predictions of dangerousness? On the basis of all of these indicators, the answer would be that they were not accurate at all. There was no significant difference between the two groups on any of the measures of assaultiveness examined. Those defendants evaluated by the psychiatrists as dangerous were not any more dangerous than those they felt were nondangerous.

Certainly, a major difficulty in any type of evaluative exercise such as this one is establishing a criterion of success. This difficulty is one of the major factors in many current controversies surrounding the accuracy of psychiatric estimations of dangerousness. Kozol (1973) addresses the criterion problem in a rejoinder to a letter (Monhahn 1973) which followed the publication of the article just discussed. Kozol and co-workers rested their claims, although internally invalid ones, of predictive success by comparing theirs to those of the court. As they recognized and as Monahan discussed, even in the high recidivism group (34.7 percent), the false positive rate of incorrect to correct predictions is nearly two to one — outstanding by some standards and entirely unacceptable by others.

A similar argument for evaluating psychiatric predictions of future dangerous behavior on a relativity standard was recently offered by McGarry (1974). In responding to a colleague whose "concern centered on the frequent inadequacy of the clinical history and the nonexistence of valid instruments for the assessment of danger in the mentally ill . . . [and] the importance of these inadequate assessments in governing the lives and the freedom of human beings," McGarry responded, "Who could do it any better?" This, however, as the author has argued elsewhere (Steadman 1974), is not the significant question. The issue is not whether psychiatrists are better predictors than other poor predictors, but whether they are sufficiently accurate to meet the standards implied in the civil and criminal statutes and procedures which mandate these predictions and permit detention because of them. Thus, the standard by which psychiatric predictions of dangerousness must be evaluated is an absolute one. Do they meet whatever this standard is?

The Irony of Poor Prediction and Public Support

The two major systems of social control in the United States are the criminal justice and the mental health systems. In the criminal justice system, the basic tenet of innocence until guilt is proven and its corollary, better to let 1,000 guilty go free than to imprison one innocent person, are very critical foundations in most procedures.

However, in the mental health system, it would seem that these basic American tenets of criminal justice are not even pretenses when dangerousness somehow becomes linked with mental illness. Although there are no data that seem to address this question, there is wide public support for the detention of large numbers of mentally ill patients under the aegis of dangerousness, far in excess of those who will actually display assaultive behavior. Such support comes to a great extent from the public's assumption that they are being protected, through psychiatric diagnostic expertise, from most of the mentally ill who would be assaultive. Actually, the poor record of psychiatric predictions of future dangerous behavior is masked both by the lack of opportunities to observe the many false positives and by the very small number of mentally ill, called dangerous or not, who exhibit dangerous behavior. Thus, the record of psychiatric overprediction is practically unblemished. With strong public and legislative support, tens of thousands of individuals are detained each year in the United States in various civil and correctional facilities who, were they in the community, would never display the dangerous behavior predicted of them.

Thus, ironically there is a strong case against ability of psychiatrists to make accurate estimations of dangerousness within acceptable statistical bounds, and yet, there is, apparently, broad support from the American public. How can such an antithesis be explained? What, then, has led to psychiatry's ascendancy to these responsibilities? Let us briefly consider what the history of the relationships between mental illness, dangerousness, and psychiatry in the United States can contribute to an understanding of psychiatry's social control role of predicting future dangerous behavior.

Comments on the Origin of Mental Illness and Dangerousness in the United States

As Deutsch (1949) and Szasz (1970) noted, major forerunners of concepts associated with mental illness were ideas of demonic possession and witchcraft. From the mid-fifteenth through the seventeenth century, the peak of the witch hunting mania in Europe, it is estimated (Deutsch 1949) that over 100,000 people were killed as witches possessed by the devil after having sold their souls to him in return for special powers. During the periods of 1647-1663 and 1688-1693, especially in Salem, Massachusetts, witch hunts and burnings at the stake were frequent. However, with the gradual decline in the impact of religion in secular affairs, and with the evolution of medical knowledge in the seventeenth and eighteenth

centuries, medical explanations and treatments for these behaviors developed. Trials and inquisitions for witchcraft were replaced by commitment as mentally ill and estimations of dangerousness. Torture and executions were gradually replaced by attempts at humane treatment and special institutions for the insane.

While the first mental hospital did not open in the United States until 1756, from colonial times, common law standards allowed for the arrest of seriously disturbed persons or those deemed too dangerous to be left free in society (Deutsch 1949). Such confinement was to be for the duration of the period of dangerousness. As Deutsch noted, "Insane persons recognized as such (namely, the violent and the dangerous) were dealt with by the police powers." In fact, the only type of insane patients specifically considered in early colonial legislation were those seen as furiously mad or dangerous to themselves or others. Deutsch reports as an example of this legislation the 1788 New York State provisions which were copied practically word for word from a 1744 English law:

> Whereas, there are sometimes persons who, by lunacy or otherwise, are furiously mad, or are so far disordered in their senses that they may be too dangerous to be permitted to go abroad; therefore
>
> Be it enacted, that it shall and may be lawful for any two or more justices of the peace to cause such person to be apprehended and kept safely locked up in some secure place, and, if such justices shall find it necessary, to be there chained.

Thus, dangerousness has always been a primary reason for detention. (For more complete coverage of this topic see Robitscher elsewhere in this monograph.)

From the beginning of mental hospitals in the United States through the late nineteenth century, there were few constraints on physicians' commitments of people to these facilities. During the eighteenth and nineteenth centuries, the signature of a physician on a slip of paper saying that the individual should be admitted was all that was required for involuntary admission. An early event in the movement toward some check on these unbridled commitment powers was an 1845 court case in Massachusetts for the release of Josiah Oakes from McLean Asylum in Massachusetts. The decision of the case was:

> 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 who, going at large, would be dangerous to themselves or to others. And the necessity which creates the law creates the limitations of the law. . . .

> The question must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration, or will be conducive thereto. The restrain can continue as long as the necessity continues. This is the limitation, and the proper limitation (Deutsch 1949: 422-3).

Thus, for the first time in the United States, the justification and limitations implicit in the common law concerning the restraint of the mentally ill were spelled out. If they were dangerous to the safety of themselves and others and were insane, they would be detained indefinitely.

First, witchcraft persecutions faded away, and attributions of insanity and dangerousness replaced them. Then, hospitals, with formal goals of treatment and the specialty of psychiatry, developed. Finally, commitment laws spelling out common law standards were promulgated to check the unfettered commitment power of the psychiatrists that had developed. These commitment laws specified dangerousness to the community, or self, as sufficient rationale for commitment. Since such laws, with their criterion of dangerousness, were developed as checks on psychiatrists, it fell to the psychiatrists to regularly predict dangerousness in order to hospitalize. The psychiatrist became the primary predictor of dangerousness in the United States, not because of any documented skills at such predictions, but because this standard has always been the primary one accepted for committing individuals to institutions run by psychiatrists.

From the first statements of U.S. common law drawn directly from English tradition and from the early precedents on commitment criteria for the mentally ill, dangerousness has been the main standard for involuntary treatment. As psychiatry lobbied in Benjamin Rush's era to become an accepted medical specialty for the treatment of conditions which became classified as mental illness, the prediction of dangerousness was appended to public conceptions of the skills of psychiatry. It was not because psychiatry presented a record of predictive achievement, but because it was taking on some functions of social control which society could no longer rest on the inquisitor and which society apparently demands of someone.

Given the fact that dangerousness has been on the mental health scene for so long and there is no indication that public interest in it is on the wane, the author would like to offer some thoughts and questions (maybe questionable thoughts would be a better way of putting it) for which no real answers are proposed.

Dangerology and Dangerologists

Certainly the psychiatric research which demonstrated the most accurate predictions of dangerousness from the data offered was Kozol's. However, in the efforts, what was more impressive than their weak research methodology was their evaluation program. As they describe it:

> Each diagnostic study is based on clinical examinations, psychological tests, and a meticulous reconstruction of the life history elicited from multiple sources—the patient himself; his family, friends, neighbors, teachers, and employers; and court, correctional, and mental hospitals' records.
>
> The clinical examinations are made independently by at least two psychiatrists, two psychologists, a social worker, and others.

The interdisciplinary nature of these procedures is similar to those at various professional meetings. The participants are psychiatrists, clinical psychologists, sociologists, attorneys, judges, legislators, social workers, and others. Surely the reason for this is that the concept dangerousness is not a psychiatric one; neither is it the exclusive province of any other discipline. It involves the whole person and the situations with which he/she interacts. Through the growing awareness that there is little that is uniquely psychiatric related to dangerousness, there has been recent reemphasis on the significance of situational factors reflected in Kozol's evaluation procedures and the contributions that can be made by the many related disciplines. As Monahan (1974) notes:

> At least part of the inability to predict violent acts may lie with the theoretical paradigms and research strategies which have constricted the psychological and psychiatric fields until very recently. Efforts to predict and modify violent behavior, like efforts to predict and modify all types of problems, have been almost exclusively focused on identifying *persons* who are likely to perform the behavior in the future (Mischel, 1968). It is becoming increasingly documented, however, that behavior is a joint function of personal characteristics and characteristics of the *environment* or *situation* with which a person immediately interacts (Mischel 1973; Moos 1973).

An expanded interest in situational factors, while continuing to study personality and biochemical factors, leads to a consideration of the feasibility of developing a new subfield, dangerology—the study of predicting future dangerous behavior. It would study not only how to make such predictons, but also the prediction processes, the impacts of the predictions on those evaluated, and the

search for the real, operative factors in such decisions beyond those necessarily stated. Dangerology would be an area incorporating segments of psychiatry, psychology, sociology, biology, biochemistry, and many other basic disciplines, as well as also intimately involving policy disciplines related to the applications of such predictions. This idea of dangerology and its specialists, dangerologists, is not a facetious one. The possibility of moving in such a direction must be considered as long as dangerousness remains a concept of social control, through either the mental health or criminal justice system.

Multidisciplinary teams have demonstrated some advantages in current attempts to analyze and predict future dangerous behavior. However, only rarely are any members of such teams actually trained to make such predictions. Instead, they are trained in some traditional discipline and then become employed in various institutional networks which require them to make such predictions as part of their duties. Then, because they are empowered to make such predictions on some assumption of competency, they often proceed without any specific qualifications. *If* we are to continue utilizing dangerousness, might it not be productive to train some people to make such estimations, label their jobs to be that which they are in fact doing, and legislate the necessary checks and balances, after having determined what are legally acceptable standards? While this author does not pretend to know, it seems evident that consideration should be given to where such avenues would lead.

The intent of this paper was twofold: (1) to update the documentation that psychiatrists are poor predictors of dangerousness when the ratio of false positives or criminal justice system tenets are considered, and (2) to raise for discussion the possibility of actually training some people to perform the task, if dangerousness is employed for social control purposes. Actually, this latter question is more important in the long run, but the questions of developing dangerology may be more realistic, given our political and legislative history.

Some findings pertinent to the issues of psychiatric reporting and criminal charges as evaluated by the author may be seen in Tables 1, 2, and 3.

Table 1. Reasons for findings of dangerous cited in court psychiatric reports

Reasons	N	Percent of cases* citing
Before or leading to arrest		
Current charge	45	30.2
Actual/alleged assaults	26	17.4
Previous mental hospitalization or mental illness	25	16.7
Previous criminal history	15	10.0
Suicide attempts	12	8.0
Impaired thinking	9	6.0
Mental hospital escapes	6	4.0
History of gun possession	5	3.4
Drug use	4	2.6
Other	12	8.0
After arrest		
Delusional/impaired thinking	83	55.7
Inferred assault potential	41	27.5
Unpredictability/impulsiveness	39	26.1
Suicide potential	23	15.4
Management problem	10	6.7
Actual assaults vs. others	9	6.0
Actual assaults on self	5	3.3
Threatened assaults vs. others	5	3.3
Threatened assaults toward self	3	2.0

*Total n = 149 with psychiatric reasons for dangerous. Percentages do not equal 100 percent since many cases listed more than one reason.

Table 2. Psychiatric findings of dangerous by diagnosis controlling for criminal charge*

Criminal charge and psychiatric finding	Diagnosis: Unspecified and acute psychosis N	%	Schizophrenia paranoia N	%	Other schizophrenia N	%	All other diagnoses N	%	Chi square†	P
Violent vs. person									8.2802	$p < .05$
Dangerous	8	88.9	33	84.6	18	52.9	15	71.4		
Not dangerous	1	11.1	6	15.4	16	47.1	6	28.6		
Total	9	100.0	39	100.0	34	100.0	21	100.0		
Potentially violent vs. person									3.9823	N.S.
Dangerous	8	72.7	19	76.0	12	46.2	7	63.6		
Not dangerous	3	27.3	6	24.0	14	53.8	4	36.4		
Total	11	100.0	25	100.0	26	100.0	11	100.0		
Other felonies									2.5412	N.S.
Dangerous	5	83.3	6	35.3	14	51.8	5	50.0		
Not Dangerous	1	16.7	11	64.7	13	48.2	5	50.0		
Total	6	100.0	17	100.0	27	100.0	10	100.0		

*Omitted from the table are 10 cases with no diagnosis and 8 cases diagnosed as mental deficiency whose numbers were too small for analysis.

†Corrected for continuity.

Table 3. Psychiatric findings of dangerous by criminal charge controlling for diagnosis

Diagnosis and psychiatric finding	Criminal charge						Chi square	P
	Violent		Potentially violent		Other felonies			
	N	%	N	%	N	%		
Unspecified and acute psychosis							.0865	N.S.
Dangerous	8	88.9	8	72.7	5	83.3		
Not dangerous	1	11.1	3	27.3	1	16.7		
Total	9	100.0	11	100.0	6	100.0		
Schizophrenia paranoia							14.508	<.001
Dangerous	33	84.6	19	76.0	6	35.3		
Not dangerous	6	15.4	9	2.0	11	64.7		
Total	39	100.0	25	100.0	17	100.0		
Other schizophrenia							.0297	N.S.
Dangerous	18	52.9	12	46.5	14	51.8		
Not dangerous	16	47.1	14	53.5	13	48.2		
Total	34	100.0	26	100.0	27	100.0		
All other diagnoses							3.670	N.S.
Dangerous	15	68.2	8	57.1	5	35.7		
Not dangerous	7	31.8	6	42.9	9	64.3		
Total	22	100.0	14	100.0	14	100.0		

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CHAPTER 10

An Assessment of California's Mental Health Program: Implications for Mental Health Delivery Systems

Albert H. Urmer

On July 1, 1969, California's new Community Mental Health Services Act, entitled the Lanterman-Petris-Short Act (LPS), went into effect. Based upon a previous report,[1] it included the broadest changes in the procedures for the involuntary commitment of the mentally disordered, since the process began in the early 1800s. The act initiated many procedural changes in the delivery of mental health services, but its most significant provisions were:

1. Limiting involuntary hospitalization to individuals who were observed to be dangerous to others (DO), dangerous to self (DS), or gravely disabled (GD), as a function of their mental disorder
2. Permitting involuntary treatment without court review for a maximum of 17 days, with provisions for an additional 14 days of involuntary commitment for individuals who were suicidal
3. Requiring court approval to allow an additional 90 days of treatment for persons who were found dangerous to others
4. Appointment of a conservator for 1 year, for individuals who were considered gravely disabled, which "means a condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter"
5. Defining the rights of the patients who were involuntarily committed, including a habeas corpus hearing, retention of personal property, right to refuse shock treatment, right to maintain their own clothes, etc.
6. Shifting control of State mental health funds from the State Department of Mental Hygiene to the local communities

The LPS Act was not only a major change in a State's attitude toward the mentally disordered, but reflected one of the first legislative efforts to consider mental disorder realistically, rather than responding to the public's fear of the mentally disordered.

Historically, the incarceration of the mentally disordered began as a convenient solution to the problem of "maintenance" of

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undesirable individuals. The confinement was usually accomplished through the same laws dealing with paupers and justified under the guise of "need to treatment." Even when specific mental health legislation was initiated, there was little concern regarding the justice and adequacy of the criteria for commitment.

California's legislature showed as little concern regarding the adequacy of mental health treatment as did other States. Until the 1940's, hardly any concern was shown regarding this population. The first legislative changes occurred in the early 1960's, but were initiated by the State mental health agency or other organized professional/citizen groups. The State's lawmakers' major function was to review, disapprove/approve, and alter these proposals, which originated outside the legislature. Occasionally, an individual legislator would initiate changes in mental health legislation, but such efforts were characterized as attempts to correct specific problems by changing some sections of the Welfare & Institution Code (W & I), or providing funds for a "pet" program. Until 1963, the legislature conducted few studies of what was considered executive branch administrative functions, related to the operation of State hospitals for the mentally disordered, and did not even maintain a standing committee to deal with specific responsibility for mental health programs.

The most interest manifested by the legislature in the mental health problems between 1940 and 1960 consisted of a legislative committee conducting investigations of alleged atrocities in State hospitals. These hearings provided sensational newspaper stories, but were usually focused on determining guilt or innocence of a hospital employee and generally failed to cope with any of the basic problems in the structure and programs in the mental health facility. During the course of such encounters, the legislature and the Department of Mental Hygiene were usually in an adversary relationship. The legislature found the Department defensive, and the mental health professionals considered the legislature to be unsympathetic, or, at a minimum, simplistic in its approach to very complex problems.

It was not until 1963 that the legislature initiated a major effort in the mental health/retardation field, which was the development of a special committee to deal with the problems in this area. The first result of this subcommittee was changes in the mental retardation delivery system, enacted into law in 1965. The subcommittee then focused upon the mentally ill and a year later issued its first report, entitled "The Dilemma of Mental Commitment in California." The report differed significantly from all previous efforts of modification in the mental health system, which traditionally emphasized adding new treatment personnel, spending,

assuring due process procedures in the courts, etc. The central proposals were the elimination of the commitment court and the absolute termination of indefinite periods of involuntary commitment. For the first time since the beginning of involuntary commitment, in the early 1800s, a legislative committee rejected the premise upon which all mental health involuntary commitment had been based, the public's erroneous equation of mental illness with dangerousness.

Even though the legality of confining someone for the "need of treatment" was accepted by the courts as early as 1836,[2] the criteria for involuntary commitment have been expanded over the years, usually to include the *threat* of danger to others, and/or suicide. Unfortunately, in practice, courts have the common characteristic of not defining the evidence, or behavior, required to find an individual dangerous or suicidal. As a result, the courts develop procedures accepting medical certification and/or testimony of the individual's "need for treatment" based upon clinical judgments. Depending upon the State, the method of providing the medical confirmation varies from a simple statement, in a preprinted form, to sworn testimony in open courts. The level of experience required for the certification varies from being a licensed physician to a board-eligible psychiatrist. When the California legislature reviewed the quality of care in the operation of the State mental hospital system, it came to the conclusion that the commitment process was the most critical factor shaping the mental health system. This process fostered the public's erroneous equation of mental illness with dangerousness, controlled the major treatment process by funneling most of the State's mental health budget into the State hospital system, and, thus, perpetuated a singular treatment approach that was frequently inappropriate and unsuccessful.

Restricting the commitment process was relatively simple when investigation indicated that most of the court procedures had common characteristics. Few of the testifying physicians/psychiatrists spent more than a few minutes with an individual, prior to classifying him as potentially dangerous. The judgment of dangerousness frequently was based on the fact that the patient fell into a gross diagnostic category, which included some potential of aggressive behavior rather than evidence of violent behavior in his immediate past behavior. Thus, the diagnostic label frequently was sufficient cause for an individual to be considered dangerous. In many cases, the psychiatric examination was perfunctory, and little attempt was made to verify the individual's side of an issue. The assumption was made that the potential patient (already labeled "crazy") cannot be coherent if he presents facts contradictory to what is expected or said by others. Charges, made by spouse, neighbors,

etc., were accepted, because these people were considered normal. Conversely, the individual who had already been labeled as mentally disordered had to manifest considerable control, and his verbalization of anger, aggressive thoughts, or frustration in regard to his predicament only served to support the contention that he was dangerous and required treatment.

Thus, the commitment hearing prior to LPS was a tribunal before which an individual had to prove his mental competence, even though the law mandated that the commitment decision should include the issue of the patient's dangerousness. His mental state was, in fact, the overriding factor leading to his commitment. The LPS legislation drastically changed these conditions by simply stating that prior to being admitted for evaluation it must be stated: ". . . in writing . . . the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, professional person, and stating . . . that the . . . person believes, as a result of his personal observations, that the person is, as a result of mental disorder, a danger to other persons or himself, or gravely disabled.[3] Thus, in a simple manner, the LPS legislation placed the burden of proof upon the applicant agency, and required at least observational evidence that the patient was, indeed, dangerous, suicidal, or gravely disabled.

Effect of the LPS Act

Admitting Procedures

There were two procedures for involuntarily admitting an individual for a 72-hour evaluation. One was through the filing of a petition with the superior court by any concerned individual. The second procedure could be evoked under emergency circumstances, when conditions did not allow sufficient time for processing a petition. Both of these procedures were retained in the LPS Act, but with significant modification in the process activated with each procedure. Under emergency admission procedures (Welfare and Institutions Section, 5880 pre-LPS, 5150 post-LPS) both pre- and post-LPS mental health professionals and law officers could request emergency admissions for a 72-hour evaluation. The only difference in post-LPS was that the request for admissions had to describe what behavior the requestor had *personally observed* that led him/her to believe the patient to be dangerous, suicidal, or gravely disabled. The major effect of LPS on the procedure was the rejection of a significant number of people brought to a hospital admissions'

desk as not meeting the LPS criteria. Most of these rejections were individuals referred by law enforcement officers lacking sufficient training to make the necessary clinical judgments.

During the first year of the new procedures, most of the rejected individuals did not receive alternative services and were left to function on their own. Frequently, they ended up being charged with a minor penal code infraction and sent to jail. More recently, many California counties have initiated referral procedures so that the individual rejected from inpatient treatment is referred to alternative treatment in the community. Although it was the intent of LPS to provide such alternatives, it took several years for these services to become available in the community.

Commitment for evaluation, using the court petition process, was altered significantly through LPS. The pre-LPS procedure (prevalent in most States) was to file a petition with the Superior Court requesting that the potential patient be committed for evaluation because of a belief that he was mentally disordered. This petition usually required a medical certification (not necessarily by a psychiatrist) concurring in the contention of mental disorder. Usually the courts accepted the petition, and the patient was committed for a 72-hour evaluation. Following this evaluation, a court hearing was held to determine further action.

Under LPS, after filing the petition, the court forwards it to a regional mental health facility which sends an interdisciplinary mental health team to the individual's home to evaluate him. If the team believes that the potential patient meets the legal requirements (danger to other, danger to self, and gravely disabled) for commitment, and that involuntary hospitalization is the most feasible procedure, this recommendation is forwarded to the court, which then orders the individual into the hospital for the evaluation.

Since the inception of the new petition process, there has been a 99 percent decrease in the number of petitions filed with the courts. The dynamics behind the reduction are related directly to the jeopardy that family members perceive in the new process. Before LPS, a family member could have a medical certification signed by a family physician filed with the court and the potential patient picked up by law enforcement officers, without prior knowledge by the potential patient that a petition had been filed. If the potential patient was severely disordered, the probability was high that he would be committed for an indefinite time, without ever leaving the custody of the mental health system. Under LPS procedures, the petitioner became visible to the potential patient during the prepetition screening and believed that the visibility placed him in jeopardy. Such anxiety discouraged petition filing. The new procedures did not necessarily restrict eligible patients

from receiving treatment; those who were actually in crisis were admitted through the emergency procedures (Welfare and Institution, Section 5150).

Treatment Duration Limits

One of the major LPS innovations was the *imposition of finite time limits on the duration of involuntary treatment and the elimination of mandatory court review* for the first 14 days of confinement. An individual who is involuntarily committed for evaluation must be released after 72 hours, or be certified by a psychiatrist (in writing) as requiring further treatment. If the certification is issued, the individual can be detained for involuntary treatment for an additional 14 days, without mandatory court review. This is a major departure from pre-LPS procedures (and those prevalent in most other States) when court intervention occurred at the end of the 72-hour period. At the end of the 14-day period there are different procedures to be applied to DO, DS, or GD admissions.

If an individual is admitted as DO, there are two options: release, or if the individual is still dangerous, based on observable behavior, a request can be filed with the court for postcertification for an additional 90-day period. Postcertification is an adversary procedure and requires testimony and evidence that the individual is dangerous to others and requires further treatment. If the postcertification has not been granted at the 14-day time limit termination, the individual has to be released. The 90-day postcertification procedure is seldom used, primarily because of the difficulty of testifying in court and providing evidence of the patient's dangerousness. While this reason appears plausible, it is partially based on the inability of professionals in public institutions to become sufficiently familiar with the patient to make a valid prediction of the patient's future behavior, and the general inability to predict an individual's behavior for some undefined time. Under these conditions, professionals are unwilling to expose themselves to the cross-examination of the adversary procedure, which requires that clinical judgment be supported by factual evidence.

If an individual is admitted as suicidal (DS), a psychiatrist can certify him for an additional 14-day period of involuntary treatment, without any court intervention. At the end of the 28-day period, all patients who were admitted as suicidal have to be released. If an individual is admitted and certified as GD, at the end of the 14-day period, the treatment facility can petition the court to have a conservator appointed for the individual. This is an adversary procedure, and, if a conservator is appointed, he has complete

power over the patient for 1 year. Conservatorships are renewable at the end of the 1-year period, through a repeat of the court procedure. The conservatorship procedure has not had a major impact on placement of treatment of the chronically disabled individuals, except in the change to community programs which has, generally, resulted in the placement of individuals into inadequate community facilities rather than into State hospitals. These individuals were long-term patients in State hospitals, now they are long-term patients in local nursing homes or board and care facilities. The lack of treatment continues unchanged. The results of limiting the duration of treatment have had little impact on either the treatment outcome or the public's safety.

A cohort of about 600 individuals who had been involuntarily committed were evaluated as to postdischarge function, behavior, etc. Three hundred of this group had been committed pre-LPS; 300 post-LPS. The results indicated little difference between the two groups as to functional level, aggressive acts, or suicide rate. Comparison of the prognosis at discharge indicated that the staff is no more accurate in its prediction when a patient is kept confined until discharge with medical concurrence, than when he is discharged due to legal mandate. Thus, research findings support the legislative contention that little is gained by either the patient or the community by extended involuntary commitments.

The mandatory reduction of involuntary treatment duration has had one major and unanticipated impact on the duration of treatment for voluntary patients, who can be kept in treatment as long as necessary. In the first 2 years post-LPS, the average treatment duration of *involuntary patients* dropped from 180 days to 15 days, while the average duration of *voluntary patients* dropped from 75 to 23 days. The reduction in involuntary patient treatment duration was expected because of the legal restrictions. The reduction-in-treatment duration for voluntary patients must be due to the influence of the rapid discharge philosophy, which permeated inpatient facilities and carried over into the voluntary treatment programs.

While LPS has eliminated the courts from reviewing commitments during the early stages of the process, the patients' rights have been protected by expanding the habeas corpus (W & I 5275)[3] procedure to any certified patient demanding release from treatment. To assure the patients protection, the court hearing must be held within 2 judicial days, or the patient released (W & I 5276).[3] The effectiveness of this procedure has been shown in the significant number of patients released within 48 hours of filing the habeas corpus petition. The early release of these patients is due either to the patients not being sufficiently disturbed to justify defending

the commitment in court, or their being within a few days of the mandatory discharge period.

Impact on Community Services

Pre-LPS, State funds supported the total cost of treating patients in State hospitals, but only 25 percent of the cost of treating them in local programs. Thus, the local communities have a fiscal incentive added to the public's desire to isolate the mentally disordered in State hospitals. Treating them in the community resulted in a local tax burden, while State hospital confinement did not add to it. LPS changed this pattern by combining all local and State mental health funds into a single budget, with both State hospitals' and local mental health services' costs being shared on a 90 percent-State/10 percent-local basis. The reimbursement is independent of the location of treatment. Inpatient costs in State hospitals and for outpatients in the local community are charged to the same budget and on the same formula. As a result, the percent of total mental health funds in the State spent on local programs increased from 32 percent to 74 percent in the first 3 years of LPS. Concomitant were an increase in outpatient and daycare services and a significant reduction in inpatient services. Thus, funding, more than any legislative mandate, influenced the development of community treatment services, reducing State hospital use.

Unfortunately, the increase in outpatient services is reaching a new group of clients who had not previously used public mental health services, rather than providing alternatives to those in jeopardy of involuntary commitment. The Legislation intended that the local programs would have as their target population those individuals who were high risks for hospitalization, and place a lower priority on other clients. Paradoxically, the legislative target population is not being reached by local programs, while a new population is being served.

For the chronic mentally disordered patient (but not DO, DS, or GD) the impact of LPS has been the increased difficulty in getting hospitalized without compensating services in the local community. Conversely, the inpatient facilities, particularly State hospitals, found that their patient population shifted from being relatively heterogeneous to being more homogeneous, dealing with the younger, more aggressive patients. While this provided considerable protection for the patients, it also resulted in the isolation of a number of chronically mentally disordered patients in the community, without treatment, who often ended up in legal difficulty.

Implications of the Law

Evaluation of the LPS legislation[4] has identified several important issues regarding the delivery of mental health services through the public system, as well as refuting some historical assumptions regarding treatment for which little empirical support exists. The following reflect some of the major implications derived from the LPS legislation.

Treatment Duration and Dangerousness

LPS, placing a finite time limit on the duration of treating the mentally disordered labeled as dangerous/suicidal, has provided an opportunity to evaluate the impact of treatment duration on postdischarge behavior. The findings indicate that there is little difference in the postdischarge rate of aggressive/suicidal behavior between the post-LPS patients who are mandatorily discharged at the end of 14 days, and the pre-LPS patients who are kept in treatment until considered ready for discharge through medical judgments. In both groups, the postdischarge incidents of aggressive behavior are relatively low and usually situation specific. Generally, it is found that when aggressive behavior occurs after discharge, it is in circumstances similar to those which initially brought the patient into the mental health system. These results could be due to one of two alternatives: either the duration of inpatient treatment has very little impact on the postdischarge behavior of patients classified as dangerous; or, the mentally disordered patient is labeled as dangerous as a result of previous behavior (reported or observed), rather than a prediction of future behavior. Either of these hypotheses raise serious questions regarding the large number of individuals who are confined as dangerous, and the threat they actually pose to the public safety. If the mentally disordered individual is involuntarily committed for treatment, based on the premise that upon discharge his hazard to the community has been reduced, then the California experience indicates that his may be an erroneous conclusion: He may not be any more dangerous before commitment than afterwards. We believe the real issue is that the mental health profession is unable to predict future behavior and condones the large number of commitments, partially because of a lack of alternatives for responding to the public's fear of the mentally disordered. The California experience has raised some serious doubts regarding the criteria for equating mental disorder and dangerousness. Major reevaluations of commitment processes and criteria must be initiated for both the welfare of the patient and the fiscal implications to the public.

The Commitment Process

A major implication of the commitment process changes (associated with LPS) is that the removal of the courts from the initial commitment is neither detrimental to the patient, nor to the treatment process. Under LPS, total responsibility for both confinement and treatment during the first 17 days, falls on the mental health professional. Figure 1 reflects the differences in pre- and post-LPS procedures.

Before LPS, the court's decision points occurred during the petition process and at the end of the 72-hour evaluation, when need for indefinite commitment for treatment was evaluated. After LPS, the courts are almost completely removed from any decision processes (unless a habeas corpus hearing is requested by the patient) until the first 14-day certification period has passed. Even when a petition is filed, the court (post LPS) functions primarily as a referring source. It is the community mental health professionals who determine whether the patient requires hospitalization. The mental health professional's jurisdiction over the patient for the first 72 hours of inpatient evaluation did not change with LPS. The major LPS change occurred at the end of the 72-hour evaluation, by placing total authority and responsibility for continuation of the involuntary treatment on the mental health professional. It is only at the end of the 14-day period that a court review process is initiated and, then, only for additional involuntary treatment of "dangerous" patients.

The result of this procedure has streamlined the commitment process and, more importantly, has placed the commitment responsibility on the mental health professional who had the major impact on commitment before LPS. The legislation has eliminated the ability of both psychiatrist and judge to avoid the psychological responsibility for the commitment. Before LPS, judges could rationalize their concern regarding the vagueness of the criteria upon which they were committing individuals by intellectualizing that the commitment was based on the "clinical judgement" of medical experts. Conversely, the psychiatrist could repress any doubts about his clinical judgement, which frequently was based on insufficient patient contacts, by accepting responsibility only for the gross diagnosis and rationalizing that the ultimate responsibility for the commitment rested not on his medical judgement but rather on the authority of the court. One might suspect that the ability of judges and psychiatrists to project the ultimate responsibility for commitment upon the other profession may have assisted in the perpetuation of this inadequate commitment system. One would seriously question whether judges would render

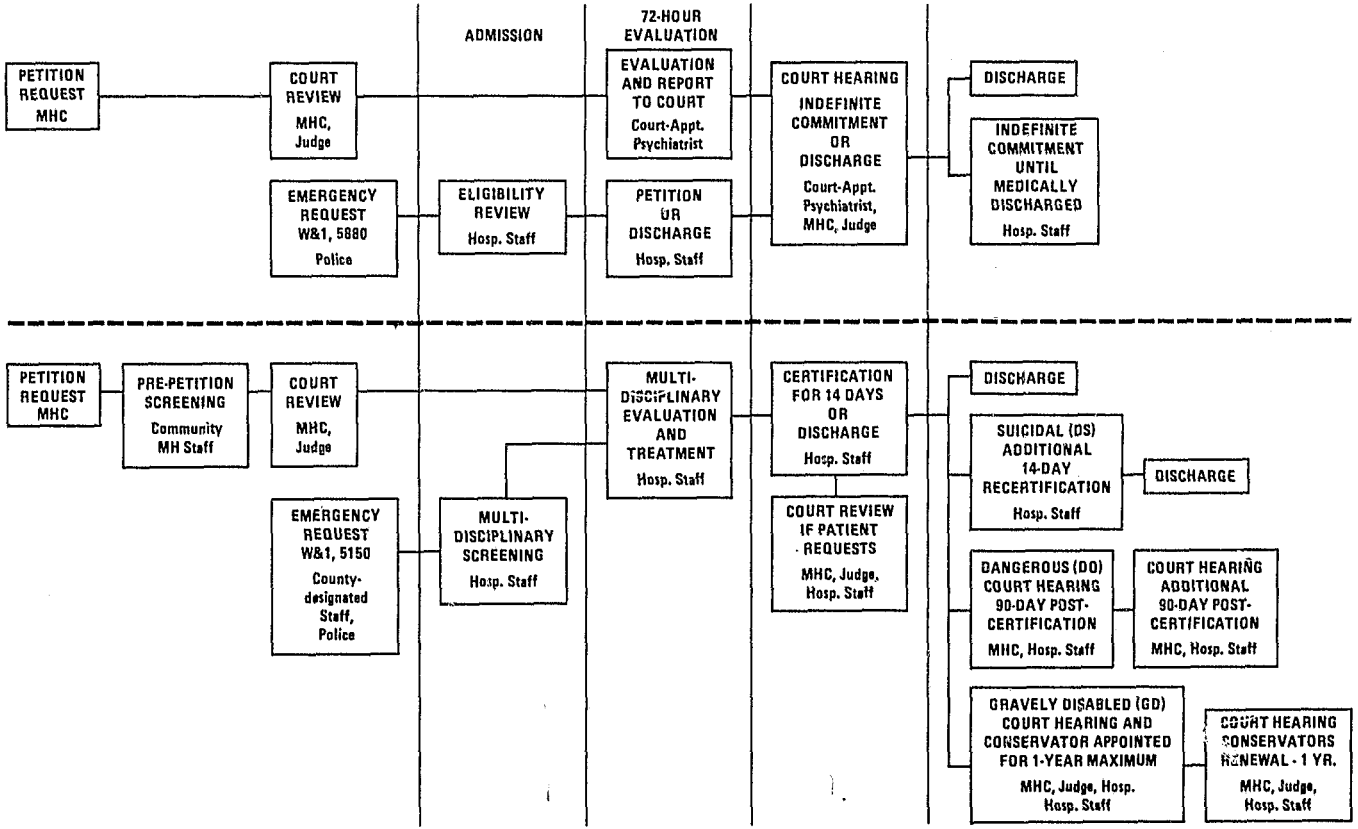

Figure 1: DECISION POINTS FOR INVOLUNTARY PATIENT FLOW

judgements in penal trials, with as little knowledge about the individual as they had in mental health cases; or whether a psychiatrist would develop mental treatment plans for his private patients, with as little contact and knowledge about the patients. If commitments are based upon patients' needs, then the responsibility should be that of the physicians. Conversely, if past behavior, not prediction of future behavior, is to be the criteria the courts should have responsibility for confinement. In California, the placing of responsibility unilaterally on the professional has been paralleled by a significant reduction in involuntary commitments, with increased referrals to alternative services, although only a fraction of those diverted receive the services. Similarly, after commitment, the professional, aware that he has to make a decision regarding the patient's future at the end of 14 days, has focused more and earlier concern on the patient and aftercare planning. Before LPS, patients in State hospitals could be without treatment or even contact with any professional staff for months, as there was little urgency regarding discharge.

Treatment Duration

The reduction in treatment duration to a finite time limit has not resulted in significant harm to either the community or the patient. The lack of outcome differences between patients who had been in long or short commitment may reflect a general lack of treatment in State hospitals, so that duration of confinement has little impact on overall behavior.

It is important, from the standpoint of the patient's civil liberties, that the California experience has shown that confinement has little impact on future behavior; therefore, little justification can be given for confining a patient for the safety of the public. Another result of the mandatory, reduced involuntary treatment duration is the reorientation of the mental health system's philosophy to rapid treatment and discharge which result in a concurrent reduction in the inpatient treatment duration of voluntary patients. Equally important are the fiscal implications of providing services in outpatient and daycare settings at one-third less of the cost of inpatient services.

Fiscal Implications

The California legislation shifted the control of all the State's mental health funds and program planning to local communities. In addition, the legislation placed fiscal incentives on the communities

to treat the patients locally, rather than to send them to the State hospitals. The result of this shift has been an increased development of mental health services has not been reduced, the number of different clients served and the total number of service units have increased several times since LPS. Most of the increase has been in outpatient and day care services.

The shift in service delivery system to the community was not paralleled by increased services as an alternative to hospitalization for the chronic schizophrenic patient, for intensive aftercare to reduce rehospitalization. Instead, the new service components reached a previously unserved population, a less chronic, less severely disabled population. The California experience indicates that, even though the LPS legislation specifically targeted the chronic patient for community treatment, legislation alone does not necessarily result in the desired service delivery system being developed. Partially, the problem in the mental health field relates to the fragmentation of services between agencies which leads the patient to be lost in transfer between agencies.

If the goal of mental health legislation is similar to LPS, then it is important that a delivery system have incentives and an ongoing evaluation component build in to assure that the community program becomes an alternative to hospitalization and not a delivery system for a new client population.

Conclusions

The legislation has broad-based implications which are not necessarily reflected in the empirical findings that are summarized above. Some of these implications are critical to States that may be considering the development of similar legislation, and to the attitudes of professionals toward the mental health delivery system. One of the broader implications is that legislatures should place more emphasis on development of policies in their legislation, rather than on detailed treatment procedures, as the LPS experience has shown the difficulty in implementing such details. Before this change will occur, the mental health professional will have to convince the legislative bodies that they have the skills to implement the policies and that, as a profession, they will attempt to meet the legislative goals.

It appears that there is relatively little correlation between treatment duration and treatment outcome. The procedures for delivery of mental health services as an integrated system must be reevaluated, and the components necessary for continuity of care must be clearly defined. There is some evidence that inpatient services need to be utilized only during crisis intervention, when isolation from

the environment is mandatory, and that the duration of inpatient treatment should be minimal. However, it is important that the treatment be continuous, and not necessarily tied to the domicile of the patient. The development of treatment plans must begin to separate treatment from the place of domicile — *involuntary treatment and hospitalization are not synonymous.* One must focus on the total milieu and consider the patient as only one aspect. With a global approach, the patient is considered part of the environment, and emphasis is placed on focusing energies on the most applicable aspect. In some cases, environmental manipulation will be found to be a more effective treatment mode than modification of the patient's response to the environment.

The finding of a very low correlation between professional prediction of behavior and actual behavior indicates that one cannot justify an extension of involuntary treatment duration as an inhibitor of future violence or suicide. It was society's implied demand for assurance from the professional that any patient allowed to remain in the community would not be violent. The professionals, being uncertain of their predictive abilities, tended to be conservative and recommend commitment. Thus, the professionals inability to predict was interpreted by the public as inability to assure nonviolence in the patient, leading to an indefinite commitment. LPS reversed the process, by requiring evidence of dangerousness, which resulted in the rapid discharge of patients.

The prediction dilemma arises because: (1) The public mental health delivery system does not provide sufficient contact between the professional and the patient to permit familiarity with the patient and his environmental stress reactions; and (2) the public has not defined what risks it is willing to accept relative to the injustices perpetuated on patients. As a result, with prognosis being poor, society condones incarceration under the guise of protection for society or the patient. Even with sufficient contact and understanding of the patient's dynamic, one is still faced with the problem of controlling the environmental conditions that might lead to undesirable behavior if the patient is adversely stimulated, but, at least, one knows the conditions under which society is at risk. The California experience has also shown that the mental health system is frequently used to house the socially incompetent individual, and, when this system becomes unavailable, alternative systems take over. For example, a significant proportion of individuals had been committed to State hospitals before LPS, not because they were violent or suicidal, but because they were bizarre and a nuisance to society; although one suspects the traditional fear of the mentally disordered is always present. Since LPS, these individuals are ineligible for involuntary commitment, but they manifest

sufficient deviant behavior to bring them to the attention of law enforcement agencies.[5] They violate some minor penal code (i.e., disturbing the peace, trespassing) and are arrested and jailed. Although the duration of their incarceration in the penal system is short, they recycle frequently. This problem has developed because neither society nor the professionals were willing to accept the reality that the mental health system had been used as a convenient resource to isolate the socially incompetent, and they made little preparation for the influx of this group into society. Society has to accept that this group needs both a protective environment and assistance in daily living.

A less obvious but important change brought about by LPS is the elimination of the courts in the early commitment process, with the placement of responsibility on the psychiatrist. Evaluation of this procedure has shown that it is effective and results in a more critical evaluation of the need for commitment. One could have anticipated this result, as the pre-LPS commitment process divided the commitment responsibility between judge and psychiatrist, and, psychologically, neither profession had to accept the ultimate responsibility for the commitment. However, LPS legislation placed that responsibility on the physician who, after all, makes the ultimate recommendation on which the courts should base their judgment.

LPS has also shown that a rapid and unplanned shift of funds from the State hospital system to community-based programs does not necessarily result in the development of effective precare or aftercare programs as alternatives to hospitalization. It is important that legislative goals be clearly defined and effectiveness criteria be included in the legislation. Also, all components of the mental health delivery system should be carefully evaluated to define their roles and to assure continuity of care for the patient. If one segment of the system does not meet its goals, its operations and programs should be evaluated — not the institution itself. Presently, it is popular to attack State mental hospitals because of poor conditions for patients and the lack of programs. This is unrealistic, as State hospitals have a role in the total delivery system, just as do skilled nursing homes, day care, outpatient services, and out-of-home placement facilities. The California experience has shown the need for multiplicity of services, as well as the importance of combining them into a continuous *system* of mental health services.

Footnotes

1. *The Dilemma of Mental Commitments in California:* A Background Document, Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, California Legislature, 1966.
2. Moss, Rev: Stat. Chapter 48, SS 7-16 (1836).
3. *Welfare and Institution Code.* State of California.
4. A Study of California's New Mental Health Law (1969-1971). ENKI Research Institute, ENKI, 1972.
5. *The Burden of the Mentally Disordered on Law Enforcement.* ENKI Research Institute, ENKI, 1973.

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CHAPTER 11

Dangerousness and Mental Illness: Some Conceptual, Prediction, and Policy Dilemmas

Saleem A. Shah

Concerns about the alleged or presumed dangerousness of an individual are raised in a variety of sociolegal contexts, e.g., involuntary commitment of the mentally ill, adjudication and commitment of defective delinquents and sexual psychopaths, the confinement and release of persons acquitted of criminal responsibility by reason of insanity, and the sentencing and release of "dangerous" offenders. The dangerous behaviors of greatest social concern in the above situations are those which are believed to pose a threat to members of the community, viz., dangerousness to others. However, commitment laws for the mentally ill typically use the phrase "dangerous to self or others." Thus, two conceptually different bases for State intervention (viz., to protect the individual's welfare under the parens patriae powers of the State and to protect the community against harm under the police power authority) tend to get thoroughly confounded.

Within the vast range of social behaviors and conditions that pose serious threats to the lives and welfare of citizens, only some elicit formal societal responses in efforts to curb and control the perceived dangers. These differential societal responses relate to the values and power held by influential groups in a society (Shah 1977).

This discussion is concerned with a number of issues pertaining to "dangerous" behavior toward others and, although a major focus is on the commitment and release of the mentally ill, the issues have broader implications and relevance. The major topics pertain to: (1) some definitional and conceptual issues; (2) some technical problems associated with the prediction of dangerous and violent behaviors; (3) the use of actuarial or statistical approaches for predicting "dangerousness"; (4) an illustration of the manner in which social control and treatment objectives become confused and confounded; and (5) some implications and suggestions for clinical practice relevant to the foregoing topics.

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Some Definitional and Conceptual Issues

Definitional Issues

It has been suggested that "dangerousness," like beauty, lies in the eye of the beholder. Certainly, the term is rather vague and often appears to have surplus meanings. Another problem with the term is that it seems to imply a trait which is a relatively enduring and stable characteristic of persons so designated. Some of the problems associated with such a notion are addressed later in this discussion.

As used in this chapter, *dangerousness* refers to a propensity (i.e., an increased likelihood as compared to others) to engage in dangerous behaviors. *Dangerous behavior* refers to acts that are characterized by the application or overt threat of force and are likely to result in injury to other persons. The above statement would also define violent behavior. Thus, as used in this chapter, dangerous behavior is considered synonymous with violent behavior.

This usage is very close to the usual dictionary meaning of the word dangerous, but it certainly does not approach the specificity typically required of operational research definitions. However, my concern here is not with research definitions, but with the broader range of behaviors and events that the law for its purposes subsumes under the notion of "dangerousness." More precisely, acts that commonly are defined as *crimes of violence* exemplify the behaviors of major concern in the foregoing definition. The core behaviors or offenses of concern to the law are probably represented in the Uniform Crime Reports (UCR) of the FBI (Kelley 1976). The category of violent crimes includes: murder, aggravated assault, forcible rape, and robbery. Along with these offense categories are the so-called inchoate crimes, viz., attempts to commit violent crimes.

Of course, one could well go beyond these categories of violent crimes and include various other criminal acts such as assault and battery, arson, kidnaping, extortion, all serious felonies, or even lesser categories of criminal conduct (Goldstein and Katz 1960). In any event, the range of "dangerous" acts to be included under formal legal and other societal responses remains basically a matter of public policy and has to be addressed by appropriate policy-makers, viz., legislatures and courts.

Consideration of an individual's dangerousness is raised at many decision points in the criminal justice and mental health systems:

1. Decisions concerning the granting of bail (or release on personal recognizance) to persons accused of crimes; also the level at which bail is to be set.
2. Decisions concerning the waiver of juveniles charged with serious crimes to adult courts.
3. Sentencing decisions following criminal convictions, including decisions about release on conditions of probation.
4. Decisions pertaining to work-release and furlough programs for incarcerated offenders.
5. Parole and other conditional release decisions for offenders.
6. Decisions pertaining to the commitment and release of persons handled via a number of quasi-criminal statutes concerned with "sexual psychopaths," "sexually dangerous persons," "mentally disordered sex offenders," "defective delinquents," and the like.
7. Determinations of dangerousness for all indicted felony defendants found incompetent to stand trial (e.g., in New York State[1]).
8. Decisions regarding the special handling (including transfer to special prisons) of offenders who are disruptive and dangerous in regular penal settings.
9. Commitment of drug addicts because of fears that they will commit violent crimes to support their drug habit.
10. Decisions concerning the emergency and longer term involuntary commitment of mentally ill persons considered to pose a "danger to self or others."
11. Decisions concerning the "conditional" and "unconditional" release of involuntarily confined mental patients.
12. Decisions concerning the hospitalization (on grounds of continuing mental disorder and dangerousness) of criminal defendants acquitted by reason of insanity.
13. Decisions regarding the transfer to security hospitals of mental patients found to be too difficult or dangerous to be handled in civil mental hospitals.
14. Decisions concerning the invocation of special legal proceedings or sentencing provisions for "habitual" and "dangerous" offenders.
15. Decisions concerning the likelihood of continued dangerousness of persons convicted of capital crimes, as a basis for determinations regarding the use of the death sentence.[2]

Despite the serious consequences for persons officially designated as "dangerous," it is astonishing to note the absence in far too many instances of clear and specific definitions and criteria for use of the key terms in the various relevant laws. (The topic of legal definitions of dangerousness with regard to the mentally ill is addressed at some

length in this monograph in the chapter by Prof. Alexander Brooks. See also Shah 1977.) Moreover, even though "dangerousness," as used in various laws and regulations, is clearly a *legal* term requiring determinations by courts and other designated triers of fact, often such crucial determinations are actually made by mental health experts. This situation has been criticized with regard to the apparent arrogation by psychiatrists and other mental health professionals of determinations that are fundamentally legal. However, it must be noted that the above problem is a reflection more of judicial default than of the arrogance of mental health professionals (Shah 1974).

Some Conceptual Issues

A major consideration in efforts to assess, predict, prevent, and change dangerous behavior pertains to the manner in which behavior is conceptualized. Behavior — whether defined as dangerous, friendly, constructive, or antisocial — is often viewed as stemming largely, if not entirely, from *within* the person, i.e., as being a stable and fairly consistent characteristic of the person. In other words, behavior is viewed in the traditional *trait* perspective, determined largely by the individual's personality. Thus, the assumption often is made that the samples of "dangerous" behavior are fairly typical of the individual and are likely to be displayed in other situations. Hence, through a conceptual shortcut, certain aspects of the individual's *behavior* are initially defined as dangerous, then the individual is described as possessing the *trait* of "dangerousness," and finally the *individual himself* comes to be viewed and labeled as dangerous.

The *trait* model of behavior has been a dominant force in personality research, theory, and clinical practice. According to the classic personality trait model, traits are considered to be the prime determinants of behavior and help to explain the apparent consistencies of behavior in different situations. The trait model assumes that the rank order of individuals with respect to a specific personality variable will tend to be the same across different settings and situations. Thus, even though the model recognizes the impact of situational factors, there is an assumption that persons described as "friendly" or "dependent" or "honest" or "aggressive" will tend to display such behaviors across a variety of situations. That is, such traits are believed to reflect fairly general and enduring personality and behavioral characteristics (Endler and Magnusson 1976).

Psychodynamic theories are much like the trait model inasmuch as they assume a basic personality core which is believed to serve as a predispositional base for behavior in various situations. It is in the

stress upon person-related factors that the psychodynamic model is analogous to the trait model (Endler and Magnusson 1976).

In contrast to the foregoing, a *situation-focused* model places major emphasis on the external stimuli and variables in the setting and situation as the basic determinants of individual behavior. Although recognizing individual differences, *situationism* is basically a stimulus-response (S-R) approach which focuses major attention on the stimulus factors influencing subsequent response (Endler and Magnusson 1976). However, the weakness of this model lies in the fact that it tends to ignore, or at least to underemphasize, individual-related factors as they influence the perception, interpretation, and response to the environment.

Much theoretical and empirical work has been done in recent years with respect to an *interactional* model of behavior. This model emphasizes the importance of ongoing person-situation interactions in efforts to understand both personality and behavior. It is held that behavior involves an indispensable and continuous interaction between individuals and the various situations that they encounter (Shah 1966). And, as Endler and Magnusson (1976) have recently noted:

> Not only is the individual's behavior influenced by significant features of the situations he or she encounters but the person also selects the situations in which he or she performs, and subsequently affects the character of these situations. (p. 958)

Even though it has been reflected only to a limited degree in clinical practice until fairly recently, and even more infrequently in the forensic and legal areas, the aforementioned interactionist perspective has a rather long tradition in psychology (Kantor 1924, 1926; Lewin 1935; Angyal 1941). Several other theoretical perspectives are also relevant in this regard: e.g., social learning theory (Bandura 1973; Bandura and Walters 1963; Mischel 1968; Patterson 1971; Rotter 1954); developments in ecological psychology (Barker 1968); and more recent innovations referred to as environmental psychology (Proshansky, Ittelson and Rivlin 1970).

During the past decade, there has been a major resurgence in the fields of personality and social psychology with regard to the interactionist perspective. Following some earlier debates among those emphasizing person-related and others emphasizing situation-related factors, the accumulating empirical evidence has demonstrated rather clearly that individual-situation interactions need to be considered and are much more useful in helping to understand and to predict behavior, than either of these sets of variables alone (Endler and Magnusson 1976). Accordingly, the field has moved ahead, and there is now a general recognition that questions about the relative

importance of one or the other set of factors are futile — both are unquestionably important, especially in the particular ways in which they interact. (Bem and Allen 1974; Bowers 1973; Ekehammer 1974; Mischel 1973; Moos 1969, 1973.)

It must be emphasized, however, that the available evidence does *not* imply that different persons will not indeed act differently and also with some degree of consistency across situations. Rather, the evidence strongly indicates that the particular classes of settings and situations must be taken into account far more carefully than they have been in the past (Mischel 1973).

Just as individuals vary with respect to the range and types of behaviors they are likely to show in particular situations and also across situations, similarly the many complex social settings of life also vary in the degree to which they prescribe and limit the range of expected and acceptable behaviors for persons in particular roles and situations. Thus, some social settings are highly structured in that the rules and prescriptions for enacting specific role behaviors impose rather narrow limits on the range of possible behaviors (e.g., in church, at school, in a job interview, during a wedding ceremony, etc.). In other situations (e.g., informal social gatherings, a party, and other relatively unstructured social situations) the range of possible behaviors and roles is broad, and individuals have much more leeway in selecting and cognitively constructing and reorganizing situations with minimal external constraints. Mischel (1973) has described a number of cognitive social-learning person-related variables that help in understanding how the individual will tend to perceive, construct, and respond to various environmental situations. Similarly, Bowers (1973) points out that "... situations are as much a function of the person as the person's behavior is a function of the situation." (p. 327). In the same vein, Pervin (1977) notes that personality is coming to be seen as expressing both stability and change, and that it is the *pattern* of stability and change in relation to specific situations that needs to be understood better.

This point is vividly demonstrated in a rather unique study of violence-prone men that was done by J. Douglas Grant and Hans Toch (Toch 1969). This study involved 128 men (police officers, men who had assaulted police officers, prison inmates, and parolees) who had shown patterns of repeated violent encounters. Attention was focused on the chain of interactions between aggressor and victim and on the sequential developments as the encounters resulting in violence unfolded. Based on this research, Toch, a social psychologist, points out:

> ... consistencies in a person's approach to others can produce situations in which violence always results — sometimes

without the person being aware of the fact that he is the instigator of destructive (or self-destructive) games. (p. 6)

Based upon detailed interviews with aggressors and their victims, as well as intensive study of relevant reports of the violent incidents, Toch developed a 10-category typology of violence-prone persons. These categories were given rather descriptive titles such as: "Rep Defending," "Norm Enforcing," "Self-Image Defending," "Self-Image Promoting," etc. The following are some brief basic descriptions of persons with certain consistent patterns of violent interactions.

> The *rep defending* . . . person commits violence because his social position, physical size, or group status obligates him to do so — a matter of "noblesse oblige," so to speak. This sort of person is expected to have violent involvements, and he has therefore come to expect the same himself; he is aware of his role and of the need to defend it or to sustain it or to live by it. (p. 149)
>
> A *self-image promoter* is a man who works hard at manufacturing the impression that he is not to be trifled with — that he is formidable and fearless. He goes out of his way to make sure that people understand how important he is and how important it is to him that he is important. (p. 137)

Toch surmises that perhaps a majority of violence-prone persons whom he studied could be described as deficient in verbal and other social skills. Thus, he points out "In some instances, violence is clearly related to clumsiness, as in cases of armed robbery where the bluff is unconvincing, or in situations where forcible rape substitutes for courtship and seduction" (p. 153). Such individuals, categorized as "pressure-removers," are described as:

> . . . the type of person whose repertoire of available interpersonal strategies is limited, or at least insufficient to cope with some situations. Where others may be able to solve a problem through nonviolent techniques, such as verbal persuasion, the pressure remover feels himself smothered, walled-in, or subject to overwhelming odds. He may try to cope with this dilemma with brief desperate, half-hearted, floundering moves, but it is usually clear that he had arrived at the bottom of his resources before he started. (p. 154)

Toch's study of violence-prone men provides a rather vivid illustration of the point that some individuals have consistent interpersonal orientations which enable them to perceive, construct, and to respond to a variety of interpersonal situations in a manner which produces high probabilities of violent interactions. These persons respond aggressively to certain interpersonal stimuli which arouse

no such responses from other individuals. In a very real sense, therefore, such "violence-prone" individuals manage to *create* their own situations with minimal external cues or provocation.

The foregoing conceptual issues with regard to personality and behavior have been discussed at some length because the implicit or explicit conceptualization that one uses has implications for the manner in which the tasks of assessment, prediction, and handling of dangerousness will be approached. Thus, traditional practice (following the aforementioned trait and psychodynamic perspectives) is to focus attention primarily on the individual's major personality and behavioral traits and inferred psychodynamics. Relatively little attention is focused on the particular setting and situational factors, and on the patterns of individual-specific interactions which may differentially affect the occurrence of certain behaviors. Use of an interactionist perspective, however, requires that greater attention be focused upon the particular setting and situational conditions which have in the past and which are likely in the future to elicit, provoke, and maintain certain violent or other problemmatic behaviors. More attention also needs to be focused on the particular social settings and contexts in the community in which the person will live; assessments of likely functioning and problems must consider the availability and nature of the supportive, stressful, and other relevant factors likely to affect the person's functioning in the community. It has been shown, for example, that accurate predictions of posthospital adjustment of mental patients in the community hinged on knowledge of the particular environment in which the expatients would be living, the availability of jobs, family and related support systems—rather than on any measured characteristic of the individual's personality or his inhospital behavior (Fairweather 1967).

Some Technical Problems Associated with the Prediction of Dangerous Behavior

Traditionally there appear to have been two major assumptions underlying most laws authorizing indeterminate (and even preventive) confinement of the mentally ill, and also of persons variously designated as "sexual psychopaths," "sexually dangerous persons," and the like (Brakel and Rock 1971). The first assumption is that dangerousness (to self and others) is a characteristic typically, or at least frequently, associated with mental illness. Secondly, it is possible to make reliable and reasonably accurate assessments of persons likely to engage in dangerous behavior. While

there has been a paucity of sound empirical evidence to support these assumptions, in recent years increasing evidence has accumulated to challenge such beliefs. These assumptions do not have the degree of empirically supported validity that would provide necessary and reasonable support for related public policies and practices.

Several earlier studies found that persons who had been hospitalized in public mental hospitals had postdischarge arrest rates considerably lower than those for the general population (Ashley 1922; Brill and Malzberg 1962; and Cohen and Freeman 1945; Pollock 1938). However, more recent studies indicate that the arrest rates of exhospitalized mental patients tend to equal and even to exceed such rates for the general population (Durbin et al., 1977; Giovannoni and Gurel 1967; Rappeport and Lassen 1965, 1966; Zitrin et al. 1976). And, while various methodological problems can be noted in the various studies (see, e.g., the chapter in this monograph by Jacoby), it is quite evident that major demographic and other social developments have brought about vast changes in the characteristics of persons being confined to and discharged from mental hospitals. Moreover, as the criteria for commitment of the mentally ill are further tightened and rely increasingly upon the more demanding criterion of "dangerousness to self or others," the above more recent findings will undoubtedly receive further support.

However, there still remain many problems with the underlying assumption that the mentally ill constitute one of the most dangerous groups in our society. For example, analysis of the aforementioned studies indicates that higher arrest rates for exhospitalized mental patients are associated with some of the same factors that are related to criminal recidivism, viz., prior criminal record, personality disorders, and problems with alcohol and drug abuse. Thus, if indeed the major societal concern is with identifying groups that are clearly and demonstrably the most dangerous, then there is considerable evidence indicating that persons with repeated arrests and convictions for drunken driving (Alcohol and Highway Safety 1968; Mulvihill and Tumin 1969; Shah 1974) and offenders with three or more convictions for serious misdemeanors and felonies are quite demonstrably, not just presumably, very dangerous in terms of the probabilities of further involvement in serious crime (PROMIS Research Project 1977a, 1977b; Shinnar and Shinnar 1975; Wolfgang et al. 1972).[3]

With regard to the second assumption, the ability to make reliable and reasonably accurate predictions of dangerousness, there is impressive and convincing evidence pointing to the considerable technical difficulties inherent in predicting very infrequent events. Typically in such prediction situations there occur huge rates of

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"false positive" errors, i.e., persons predicted as likely to be dangerous but who will *not* in fact display such behavior.

Some of the literature relevant to the phenomenon of low base rates and the effects on the prediction of such events appeared more than 20 years ago (Meehl 1954; Meehl and Rosen 1955; Rosen 1965). The *base rate* refers to the proportion of individuals in some population who fall into a category that is to be predicted, e.g., persons likely to engage in violent behavior. Other relevant literature bearing on the difficulties of predicting events with low base rate has appeared in recent years (Wenk, Robinson, and Smith 1972; Wenk and Emrich 1972). Yet, strange as it may seem, many of the "experts" who appear frequently in court to testify on the "dangerousness" of various types of social deviants (viz., delinquents, criminals, defective delinquents, sexual psychopaths, and mentally ill persons facing involuntary hospitalization) seem unaware of this literature and related research findings. It would appear, as Meehl suggested about 15 years ago in a related connection, that many mental health professionals who claim "expertise" in predicting infrequent events seem to "maintain (their) professional security . . . by not reading the research literature" (Meehl 1960).

It is important, therefore, to consider some of the systematic errors that occur in the course of clinical assessments and predictions. The expression "systematic errors" will be used here, following Chapman and Chapman (1967), to refer to reliable (i.e., fairly consistent) sources of inaccuracy in certain assessment and prediction tasks. Two such sources of error will be discussed: (1) illusory correlations, and (2) ignoring statistical rules in making predictive judgments.

Illusory Correlations

In some very elegant and important research, Chapman and Chapman (1967, 1969) have demonstrated the occurrence of what they refer to as illusory correlations, viz.,

> the report by an observer of a correlation between two classes of events which in reality (a) are not correlated, or (b) are correlated to a lesser extent than reported, or (c) are correlated in the opposite direction than that which is reported (Chapman and Chapman 1967, p. 194).

Popular and even stereotyped associative connections were shown by these investigators to be one such source of systematic error in observations of correlations between symptom statements and features of projective test protocols (viz., projective drawings and the

Rorschach). Not only were both novice and experienced clinicians subject to these errors, but even lay persons (viz., those without any psychological training) displayed similar types of error. On projective drawings (Draw-a-Person Test) and the Rorschach, the clinical significance of certain test "signs" was found to correspond to the rated associative strength between certain symptoms and test features, rather than to the *actual* occurrrence of such relationships. For example, emphasis on the eyes in the figure drawings was consistently associated with suspiciousness and paranoia, and Rorschach responses pertaining to the buttocks were consistently associated with male homosexuality. Chapman and Chapman found that these illusory correlations demonstrated remarkable persistence and survival strength even in the face of negative evidence provided in the experiments. Indeed, the systematic errors based upon associative connections seemed somewhat impervious to the contrary influence of valid relationships.

The above findings cannot be dismissed as exceptional. Golding and Rorer (1971), in a modification of the Chapman and Chapman Rorschach study, replicated the illusory correlation phenomenon. Similar results have been demonstrated by Starr and Katkin (1969) using the Incomplete Sentences Blank, and by Sweetland (1972) with regard to assessments concerning the degree of "dangerousness" and "nondangerousness" reflected in various personality characteristics. Sweetland's findings suggest that widely held social stereotypes appear to be present among psychiatrists and members of the general public with respect to personality characteristics that supposedly are and are not associated with the likelihood of "dangerous" behavior.

Ignoring Statistical Rules in Predictive Judgments

Kahneman and Tversky (1973) have demonstrated that intuitive predictions (which would include many of the clinical assessments made by mental health professionals) rely on the judgmental heuristic of *representativeness*. That is, the tendency is to predict the outcome that appears to be most representative of the available evidence. In many situations representative outcomes are certainly more likely than others. However, since this is not always the case, particularly when relatively rare and episodic events are involved, systematic errors are likely to be made. In addition, factors such as prior probabilities of outcome (i.e., the base expectancies) and the reliability of the available evidence must be considered with respect to the likelihood of the expected outcome.

For example, a fundamental rule of statistical prediction is that *expected accuracy* must control the relative weights assigned to the specific evidence being used for predictions (e.g., various clinical indices and "signs") and to the prior information, viz., the base rates. As the expected accuracy of the predictions decreases (e.g., in situations where the base rates are very low and the available evidence is not very reliable), the predictions should become regressive and shift closer to the base rates. For example, if only 10 percent of a particular group are expected to engage in future violent behavior on the basis of prior probabilities, and if the specific evidence concerning the predictions is of poor reliability (e.g., clinical assessments and certain psychological test indices), then the predictions should remain very close to the 10 percent base rate. The greater the move away from the base rates under the above conditions the greater will be the probability of error (Kahneman and Tversky 1973; Tversky and Kahneman 1974.)

Experiments conducted by Kahneman and Tversky (1973) have demonstrated that individuals engaged in predictive tasks commonly disregard information concerning prior probability when some specific current information is provided. There is a tendency instead to resort to the "representativeness heuristic," even to an extent that involves gross departures from the prior probabilities. Thus, Kahneman and Tversky (1973) have observed:

> Evidently, people respond differently when given no specific evidence and when given worthless evidence. When no specific evidence is given, the prior probabilities are properly utilized; when worthless specific evidence is given, prior probabilities are ignored. (p. 242)

Even though these authors were not referring specifically to clinical predictions of dangerous behavior, similar problems certainly seem to be involved in these situations. Yet, it is doubtful whether most clinicians who function in correctional, forensic, and related mental health settings are aware of these systematic errors. In fact, one might even wonder about the extent to which professional training and related clinical experiences tend to socialize (or even to indoctrinate) clinicians into practices in which exaggerated and possibly erroneous credence is given to specific information about persons in the form of various "clinical" and "pathognomonic" signs, even though the base rates involved may be low and the reliability of certain "signs" quite poor.

The implications of these types of error are considerable for clinical assessment and prediction efforts, especially with regard to the low base rate event of "dangerous" behaviors. Moreover, since the above discussion has indicated that the errors involved tend

to be *systematic*, such problems cannot simply be attributed to careless clinical practices. Such systematic errors need to be remedied by making clinicians very aware of and sensitive to such problems; this would require various continuing education and inservice training efforts. And, the formal training of mental health professionals should place greater emphasis on informing students about such systematic errors and inculcating in them greater familiarity with, and increased use of, fundamental statistical rules when predicting events with low base rates.

Actuarial or Statistical Approaches to Prediction

Given the liberty- and life-affecting decisions often influenced by clinical judgments concerning future "dangerousness," there should be consensus that such judgments need to be made as reliable and accurate as possible. However, it has already been noted that prediction of behaviors with very low base rates is typically accompanied by high rates of "false positive" errors. In addition, it has been pointed out that certain systematic errors also appear to be involved. From this it follows that attention should be directed toward various approaches that could help to decrease the problems and errors associated with the usual clinical predictions.

During the past 20 or more years, a sizeable literature has developed regarding actuarial or statistical approaches to prediction (Degroot 1961; Goldberg 1965, 1968, 1970; Gough 1962; Holt 1958; Lindzey 1965; Meehl 1954, 1965; Meehl and Rosen 1955; Grebstein 1963; Sawyer 1966; Pankoff and Roberts 1968). In actuarial approaches to prediction, the individual is placed in a class, or several sets of classes, on the basis of data concerning his life history, particular characteristics, scores on behavior rating scales or psychological tests, etc. The combination of these sets of information allows a classification which, when assessed in reference to appropriate actuarial tables, provides an expected probability that the individual in question belongs to a group that will or will not display the predicted behaviors.

The term "prior probability" is used to refer to a prediction that can be made in the absence of any information about a specific individual. For example, it may be known that only 10 percent of all persons diagnosed as suffering from psychotic disorders are likely to engage in assaultive or violent behavior. This means that, before anything else is known about a mentally disordered person who has been so diagnosed, there is a "prior probability" that this

person has one chance in ten of engaging in some future violent behavior.

The term "conditional probabilities" is given to factors that are empirically demonstrated to *modify* the prior probability. For example, relevant empirical research may demonstrate that psychotic mental patients who have displayed assaultive and violent behavior in the past tend to have certain distinctive characteristics. For purposes simply of illustration, let us assume that it is found that psychotic patients who have particular psychiatric diagnoses, who have a history of criminal arrests, who are males below age 35, and who also have a record of alcohol or drug abuse, comprise 40 percent of a violent patient group and only 8 percent of a nonviolent group. We could then say that a mentally ill person diagnosed as suffering from a psychotic disorder and with the aforementioned specific characteristics belongs to a class that is five times more likely to be violent than patients in the other group.

The "conditional probabilities" can therefore be used to modify the "prior probabilities" in order to arrive at a predictive index called the "posterior probability." Thus, even though base rates may suggest that only 10 percent of psychotic persons are likely to be assaultive (the "prior probability"), when other factors (the "conditional probabilities") are taken into account, the base expectancy for psychotic patients with certain characteristics may be significantly higher than for other psychotic patients. (For further details regarding actuarial approaches to prediction, and the results of one application of this approach, see Didenko et al., 1972.)

In essence, then, estimates of future behavior cannot be made with certainty. Rather, statements are made regarding the probability associated with certain predictions. Stated differently, predictive judgments may be viewed as probability statements about future events, even though a particular judgment may not be phrased explicitly in terms of estimated probabilities. For example, when a sentencing judge decides that a prison term is indicated for an offender in order to protect the community (rather than a period of supervised probation), he may be saying in essence that there is a high probability of criminal recidivism. Similarly, decisions about the involuntary hospitalization of a mentally ill person on grounds of "dangerousness to others" reflect the expectation that, if not hospitalized, the individual has a high probability of engaging in some "dangerous" behavior.

When judgments are based simply on an expectation that some future behavior will or will not occur, such decisions are either *right* or *wrong*. The judgments thus have a dichotomous YES/NO character, are apt to be very subjective, and may vary considerably from decisionmaker to decisionmaker. In contrast, probability

statements (on a scale of say zero to one hundred) can be evaluated, not as being either right or wrong, but as being *reasonable* or *unreasonable*. The decisionmaker retains responsibility for the final judgment regarding the degree of probability considered to be appropriate or reasonable for making particular decisions. Objective rules may also be developed to aid decisionmaking in light of known probabilities and the expected consequences of the types of error that can result. For example, various legal decision rules such as "preponderance of the evidence," "clear and convincing evidence," "clear, cogent, and convincing evidence," and "beyond a reasonable doubt," are essentially statements concerning the degree of certainty (probability) that should guide particular determinations (Didenko et al. 1972; Gottfredson et al. 1974).

This discussion is designed to suggest that greater attention should be given to ways in which actuarial methods could help to improve the very difficult predictive tasks being addressed in this chapter. Empirically derived base expectancy tables could provide decisionmakers with objective and reliable information about prior probabilities, known conditional probabilities, and the estimated risks associated with certain choices. Needless to say, such tables must regularly be checked and updated in light of actual experience in order to improve predictive accuracy.

However, consistent with the interactionist perspective discussed earlier, it is most essential that the base expectancies not be derived only from the past characteristics of the individual. Such predictive approaches should also include variables pertaining to the particular settings and situations in which the behaviors of concern are expected to have increased or decreased probability of occurrence. Further, even though certain historical features will remain unchanged for an individual (viz., trouble with the police since an early age, prior incarcerations, record of alcohol abuse,, etc.), care must be taken to *also* include more recent factors which are found empirically to modify the previous predictors (e.g., cessation of alcohol abuse, a stable marriage and occupational adjustment, older age, etc.).

Of course, actuarial approaches will not provide any easy solution to the difficult judgments confronting decisionmakers. For example, knowledge that Mr. Smith belongs to a group that has a 70 percent probability of serious criminal recidivism (as compared with a general base rate of 10 percent), still does *not* indicate whether Mr. Smith will be among the 70 percent who are likely to show serious recidivism or the 30 percent not likely to do so. In the final analysis, the decisionmaker will still have to exercise his or her judgment in light of other social values and objectives and keeping in mind considerations of public policy.

It has been emphasized that a major technical problem inherent in the prediction of events that have very low base rates is the high rate of "false positive" errors. One approach for reducing such errors would be to try to increase the base rates of the groups for expected future violence by screening out persons with very low likelihood of engaging in such behaviors (e.g., persons over age 40 years, those without prior criminal records, and persons without a history of problems with alcohol or other drugs). The higher base rates for the remaining group should make the predictive task somewhat easier in that the rate of "false positives" would be reduced. One might also wish to focus especially on subgroups with *markedly* increased probabilities for engaging in serious and violent crimes. For example, Walker, Hammond, and Steer (1967) found that with each successive conviction for a violent offense, the probability that the offender would engage in further violent crimes was markedly increased. Forty percent of the 45 men with two previous convictions for violence were reconvicted for a violent offense, and 55 percent of 11 men with four or more previous convictions for violence were reconvicted for a violent offense. Similarly, the PROMIS Research Project (1977*a*, 1977*b*) in the District of Columbia found that if a defendant had five or more arrests prior to the current arrest, the probability of subsequent arrests began to approach certainty. (See also Shinnar and Shinnar 1975; Wolfgang et al. 1972.)

In sum, given the many sources of differences among decision-makers, the increased use of actuarial approaches for making various predictive decisions would certainly improve the consistency and uniformity of such decisions based upon explicitly stated criteria. And, even though there would continue to be difficulties with predictive accuracy, at the very least one could achieve greater "equity" and "fairness" by ensuring that individuals are treated more equally as compared with others who are sufficiently similar in terms of the characteristics and criteria used for the decisions (Wilkins 1975, 1976).

The Confounding of Social Control and Treatment Objectives

It has been pointed out that there are several instances in the handling of the mentally ill and certain other categories of social deviants where our legal systmem tends to confound social control objectives designed to protect the community (viz., police power concerns) with the asserted parens patriae aims of providing proper

treatment for the deviant individuals (Shah 1975, 1977). Rather typically, the individual whose fate is being determined pays a heavy price as a result of the confounding of the stated purposes. More specifically, assertions of benign and therapeutic concerns seem to provide the rationale for exercising a degree of social control (viz., indeterminate and preventive confinement) that could not be used via the usual criminal sanctions.

This section will discuss an example of such confusing and confounding of different social purposes and associated legal rationale. The handling of persons who have been acquitted of a criminal charge by reason of insanity will serve to illustrate these problems. The specific practices to be discussed prevail in many jurisdictions, including the District of Columbia.

To begin with, the doctrine of exculpatory insanity derives from certain moral, social, and legal considerations which hold that in our system of justice it is neither fair nor proper to punish individuals who cannot be held blameworthy for the commission of criminal acts. Hence, despite the commission of a voluntary act which contravenes criminal laws (*actus reus*), this alone does not constitute a crime. There has, in addition, to be the requisite criminal intent (*mens rea*) in order for the act to constitute a *crime* and, barring other relevant legal defenses (e.g., self-defense), for a conviction to result. In other words, there has to be the "concurrence of an evil-meaning mind with an evil-doing hand" (Goldstein 1967). Thus, the rationale for use of the insanity defense is provided by relevant legal doctrine and the finding of "not guilty by reason of insanity" (NGRI) constitutes a *legal* determination with respect to prescribed sociolegal processes involved in criminal and adjudication.

It should also be noted that courts have repeatedly pointed out (e.g., *McDonald* v. *United States*[4]), that the concepts of mental disease or defect, as used by legislatures and courts for certain public policy and legal determinations, are *not* synonymous with the psychiatric meanings and uses of these terms.

The defense of insanity raises questions about the defendant's mental condition at the time of the alleged offense. And, there has been much recent judicial opinion that a determination of exculpatory insanity does not automatically nor even necessarily imply *present* "insanity" (i.e., following the NGRI adjudication). Thus, applying principles derived from the Supreme Court's decision in *Baxstrom*,[5] the U.S. Court of Appeals in *Bolton* v. *Harris*[6] held that a finding of "not guilty by reason of insanity" (NGRI) could *not* lead to an automatic commitment of the individual (acquitee) to a mental hospital. Rather, the Court held that

> After acquittal by reason of insanity there is also need for a new finding of fact: the trial determined only that there was a reasonable doubt as to the defendant's sanity in the past, present commitment is predicated on a finding of present insanity. (p. 650)

Thus, the *Bolton* ruling required that persons acquitted as NGRI must be given a "judicial hearing with procedures substantially similar to those in civil commitment proceedings" (p. 651). (See also: *United States* v. *McNeil*;[7] *United States* v. *Ecker*;[8] *State* v. *Carter*;[9] *State* v. *Krol*.[10])

For purposes of illustrating the various confounding problems with regard to the handling of NGRI acquitees, let us assume: that we have an individual with a long criminal record who was found to be suffering from paranoid schizophrenia at the time of the present offense; that the offense (assault with a dangerous weapon) was adjudged to be related to the defendant's schizophrenic disorder; that the postacquittal judicial hearing (viz., the *Bolton* hearing) found the person still to be suffering from the schizophrenic disorder and thereby likely to pose a danger to others. The latter finding would meet the usual civil commitment criteria in the District of Columbia and, as a result, the acquitee would be committed to Saint Elizabeths Hospital for an indeterminate period.[11]

Release from indeterminant confinement must be based on the conditions and criteria provided in the D.C. Code. The statute requires that the hospital superintendent must certify

> (1) that the person has recovered his sanity, (2) that in the opinion of the superintendent, such person will not in the reasonable future be dangerous to himself or others, and (3) in the opinion of the superintendent, the person is entitled to his unconditional release from the hospital. . . . (p. 1641).[12]

Under provisions of Sec. 24-301 (e), the superintendent can also provide a certification recommending the patient's "unconditional release" when the individual's functioning is not such as to warrant unconditional release.

Following the superintendent's certification, the court may on its own discretion or upon objection of the Government hold a hearing to consider the evidence relevant to the recommended release. And, in order to authorize unconditional release, the court must find that the aforementioned criteria in the superintendent's certification have satisfactorily met the statutory requirements.

Since an extended discussion of the topic and many related concerns is not possible here, and since a number of complex and technical legal issues are also involved, the aforementioned confusing

and confounding features will be addressed in reference to the following specific questions.

Is the NGRI acquitee committed to the mental hospital for treatment of his "insanity," and/or for his offensive conduct?

Keeping in mind the specific case being used here for purposes of illustration, the above question translates itself into a query about whether the NGRI acquitee is to be treated for the paranoid schizophrenia—which condition provided the basis for the insanity acquittal, or whether he is also to be treated for his offensive behavior (viz., assault with a dangerous weapon) and for any criminal propensities.

We might recall that the legal determination resulting in the insanity acquittal was based upon a finding of a mental disorder adjudged to constitute "insanity," and a further finding that there was the legally required connection between the "insanity" (paranoid schizophrenia) and the offensive behavior. However, although this determination conforms to relevant legal doctrine and requirements, it does *not* necessarily mean that once the person's schizophrenic disorder has effectively been treated there will be no further criminal behavior. Clearly, the vast majority of persons who engage in various types of aggravated assaults and other serious criminal acts do not suffer from paranoid schizophrenia, nor any other psychotic disorder (Guze et al. 1962; Guze et al. 1969). Likewise, the great majority of persons suffering from paranoid schizophrenia do not engage in criminal behavior. Moreover, if there are public policy and legal concerns that the NGRI acquitee be successfully treated for his offensive and dangerous behavior (the assault with a dangerous weapon), then it should be evident that mental hospitals are not the facilities which either claim, or which could even reasonably claim, to provide effective treatment for criminal behavior. There is no sound empirical research indicating that mental hospitals have had any demonstrated success in "treating" criminal behavior. In those particular instances where a criminal act resulted very directly from a psychotic delusion, one might assume that, absent the delusion, a similar criminal act would not be likely to occur. There might well be other instances where the connection between the mental disorder and the criminal act was so direct and specific that effective treatment of the former could reasonably be expected to prevent the occurrence of the latter. It must be remembered, however, that the adjudication resulting in the insanity acquittal was related to certain moral values and legal doctrine—and *not* to considerations of psychiatric treatment (nor even the treatability) of the mental disorder and the hoped for effects on subsequent criminal behavior. Yet, *legal* decisions involving criminal adjudication and insanity acquittals tend rather typically

to be confused and confounded with mental health and psychiatric considerations relevant to effective treatment.

In regard to the adequacy and effectiveness of treatment, Schwitzgebel (1975) has pointed out that the "adequacy" of treatment should be determined in terms of its *effectiveness* in producing the intended results, e.g., in achieving the improvements that could bring about the person's return to the community. Therefore, when an involuntarily confined patient receives even "adequate" treatment which offers little hope of improvement (e.g., with respect to further "dangerousness"), serious due process and equal protection questions would seem to be raised. For lacking effective treatment for the "insanity" and the "dangerousness" of the NGRI acquitee, there would seem to be little rational, or even reasonable, basis for a differentiation in the processing of the criminally insane and other criminals.

Schwitzgebel (1975) has stated the problem very well when he points out:

> Mentally ill patients who are considered dangerous are presumably confined for treatment of their dangerousness. If they are untreatable, their confinement constitutes preventive detention. The labeling of this type of confinement as "treatment" for its legal and political cosmetic effect should not be permitted to obscure the basic fact that untreatable and untreated patients are being involuntarily confined for potentially long periods of time. The state should not be permitted to accomplish by false labeling that which it could not accomplish by an honest use of legal procedures. (p. 125)

It would appear, then, that the mental hospital is placed in the rather untenable situation of being expected to treat not only the mental disorders that it can properly and in most instances effectively handle (viz., schizophrenia and other major mental disorders), but it is also expected to do that which it cannot, viz., to effectively treat criminal and dangerous behavior.

> According to the provision of the D.C. Code an NGRI acquitee seeking release must first be certified by the hospital superintendent as having "recovered his sanity."[13] Is the term "sanity" used in specific reference to the mental disorder found to be present at the time of the offense, or does it refer to *any* mental disorder?

The statute uses the appropriate legal term "sanity," and this presumably would refer to the specific mental disorder which was found to provide the *legal* basis for the finding of exculpatory insanity. In the case being used here for purposes of illustration, reference was made to a paranoid schizophrenic psychotic disorder.

Thus, at such time as this schizophrenic patient shows substantial recovery the superintendent could at least certify that the person has "recovered his sanity."

However, several confusing elements are present. It is not entirely clear, for example, whether the term "sanity" as used in the statute and as interpreted by courts refers to marked improvement in the specific mental disorder that provided the basis for the NGRI acquittal, or whether the term "sanity" is also used to require recovery from any and all other mental disorders that might be present.

Let us suppose that the NGRI acquitee in our illustration (who has a long criminal record predating the current incident) has recovered from the paranoid schizophrenia but is now back to his usual and longstanding level of functioning, which involves a personality disorder (viz., antisocial personality). What implications does this have for the superintendent's certification and also for the court's decision with regard to the criteria for conditional and unconditional release?

Relevant case law in the District of Columbia speaks in this connection of "persons who are dangerous *due to mental illness* . . ."[14] (emphasis added). Consistent with the foregoing analysis, in the case of persons acquitted by reason of insanity, the "mental illness" referred to should be the "insanity" found to be present at the time of the offense. However, the reference to "mental illness" should not include the many other conditions which might be so labeled by mental health professionals, especially since courts and juries are not to be "bound by ad hoc definitions or conclusions" as to what psychiatrists and other mental health professionals consider to be mental disease.[15] If the term mental illness is used in the latter and much broader sense (viz., not restricted to legal notions of "insanity," but including all personality disorders, sexual deviations, as well as problems associated with alcohol and drug abuse), such a wide net would easily include a very large percentage of convicted and penally incarcerated offenders (Guze et al., 1974; Piotrowski et al., 1976).

Since the individual in our illustration has a long criminal record, this fact, *standing alone*, might well predict further "dangerous" behavior in terms of criminal recidivism. However, this likelihood of recidivism would typically have little to do with the "insanity" (the paranoid schizophrenia), but would be expected in terms of the long criminal record and the personality disorder. If the indeterminate confinement of the NGRI acquitee is to continue even after the schizophrenic disorder is in remission, then very obviously the person is being held to a standard of release that is *substantially*, even vastly, different from that which would have applied had he

been subjected to the usual punitive sanctions of a criminal conviction and prison sentence.

There is also another point to consider. If indeed public policy requires that the community be protected from persons who are likely to pose a continuing and serious danger, it is difficult to see why this very understandable social concern should be limited to persons believed to be "dangerous due to mental illness." It seems evident that the critical and even controlling societal concern pertains to the dangerous behavior—and *not* to the mental illness. Hence, there would appear to be no "reasonable," and certainly no "compelling," State purpose in singling out the mentally ill and not looking for groups that are demonstrably the most dangerous in terms, say, of serious and continuing criminal conduct (Note 1974).

It appears that, like many other segments of the community, legislators and judges also share the belief stated explicitly some years ago in an appellate opinion:

> It is, of course, much easier to believe that a sane person will not in the reasonable future be dangerous to himself or others than to believe that an insane person will be.[16] (p. 464)

Regrettably, the above type of beliefs is as erroneous as it evidently is easy to acquire and to maintain. Such beliefs relate to the much-studied stereotypical and rejecting attitudes commonly held about the mentally ill (Bord 1971; Cummings and Cummings 1975; Dohrenwend and Chin-Shong 1967; Giovannoni and Gurel 1963; Nunnally 1961; Phillips 1963, 1964, 1967; Rabkin 1972).

It would appear, then, that the mentally ill tend to be discriminated against as a class (Note 1974; Shah 1977). If the real societal concern is to protect the community against persons most likely to engage in further and serious criminal recidivism, then a much stronger case could be made that recidivistic criminal offenders (viz., those with three or more convictions for serious misdemeanors and felonies) would, as a group, constitute a significantly greater threat to the community than the mentally ill (cf. footnote 4; PROMIS Research Project 1977*a*, 1977*b*; Shinnar and Shinnar 1975; Wolfgang et al. 1972). Certainly, one should expect major public policies and legal determinations to be based upon well-documented and empirically demonstrated evidence, and not on stereotypical attitudes and erroneous beliefs.

In recent years, the principles of *Baxstrom*,[17] *Humphrey*,[18] and *Jackson*[19] have been applied by many State and Federal courts to overturn procedures and standards for the involuntary confinement of NGRI acquitees (see, e.g., *Bolton* v. *Harris*, *State* v. *Krol*, and *Waite* v. *Jacobs*[20]). In *Waite* v. *Jacobs* the Court noted that

> Read together, then, *Humphrey* and *Jackson* indicate that, once the maximum sentence period has expired, it is unconstitutional to discriminate against an acquitee, as compared with a comitee [a civilly committed patient], for purposes of release from indefinite commitment. From that moment on, acquitees and comitees appear, in the Court's contemplation, to be on the same footing. (p. 399)

The aforementioned and similar court decisions have sought to provide remedies based upon comparisons of procedures used for handling mentally ill persons committed via the civil and the criminal commitment processes. However, it seems to me that similar comparisons should also be undertaken with respect to classes of persons subjected to various types of involuntary confinement based upon police power objectives, e.g., NGRI acquitees and convicted offenders. Even though persons found to be suffering from exculpatory insanity are diverted from the criminal process on the rationale that they should be protected from the punitive sanctions of the criminal justice system, there is reason to believe that in many instances the indeterminate confinement may well exceed the prison term likely to be served by the convicted offender.

The setting of durational limits on the indeterminate confinement of the NGRI acquitee does provide a long-needed step toward affording greater due process and equal protection safeguards to such persons. However, in relating the durational limits to the maximum criminal sentence provided for the offense, courts should remember that even after felony convictions, a significant number of offenders are placed on probation and very few prisoners actually serve the maximum sentence. For example, in 1974, about *46 percent* of defendants convicted in U.S. District Courts (including the District of Columbia) were placed on probation (Hindelang et al. 1977, Table 5.41).

Thus, as Goldstein (1967) pointed out some years ago with respect to the use of the insanity defense:

> The critical issue is not so much that of commitment but that of release. The manner in which it is handled determines whether the commitment is entirely therapeutic, whether it is an elaborate mask for preventive detention, or whether it is an awkward accommodation of the two objectives." (p. 146)

In sum, the confusing and confounding of police power and parens patriae objectives, and also of legal and mental health concerns, serve to place the mental hospital in a role much like that of a maximum security prison, but with the added feature of allowing indeterminate periods of confinement and using rather stringent standards for release. Thus, to paraphrase Justice Fortas, the NGRI

acquitee can end up receiving "the worst of both worlds" — he receives neither the full range of protections and the determinate confinement accorded to criminals, nor the adequate and effective treatment sought from the mental health system.[21]

Some Implications for Clinical Practice

Earlier in this chapter, traditional personality trait and psychodynamic perspectives on behavior were described as being insufficiently cognizant of the setting and situational aspects influencing behavior. It was also noted that a situationism perspective was inadequate in that it tended to ignore or to underplay individual characteristics that must indeed be considered for understanding behavior. It was suggested that an interactionist perspective provides a distinct improvement in the conceptualization of behavior; this approach also has several implications for improving the assessment, prediction, prevention, and treatment of certain types of behavior.

This section outlines some major questions and provides some suggestions relevant to the assessment, prediction, and handling of dangerous behaviors.

There needs to be some clear notion as to which specific acts (behaviors) fall within the legal definition of "dangerousness."

Determinations about the specific range of behaviors judged to constitute "dangers" to the community, within the meaning of the relevant laws, have to be provided by appropriate policymakers, i.e., legislatures and courts. These are fundamentally normative and public policy judgments, and they should *not* be left, whether directly or through default, to "experts." Thus, expert witnesses should not be asked by courts or other decisionmakers whether an individual is likely to be "dangerous," without some clarification and specification as to the range of behaviors of legal concern (e.g., acts of violence against persons, felonious crime, etc.). Open-ended questions invite experts to use their own personal and possibly idiosyncratic notions of what *they* consider to be "dangerous." Of course, mental health professionals need not be so willing to answer open-ended questions on this issue; however, they could and indeed should ask for further specification and do not have to cooperate in practices which may reflect varying degrees of judicial default (Shah 1974).

The courts should explain to experts what acts are considered to be "dangerous," based upon statutory provisions and relevant case law. In this regard, the efforts of the U.S. Circuit Court for the

District of Columbia (e.g., *Millard* v. *Harris*,[22] and *Cross* v. *Harris*,[23]) are quite notable. More recently, in *State* v. *Krol*, the Supreme Court of New Jersey provided further clarification about the meaning and scope of the phrase "dangerous to self and others." The Court noted:

> Dangerous conduct is not identical with criminal conduct. Dangerous conduct involves not merely violations of social norms enforced by criminal sanctions, but significant physical or psychological injury to persons or substantial destruction of property. Persons are not to be indefinitely incarcerated because they present a risk of future conduct which is merely socially undesirable.[24] (p. 301)

This type of judicial clarification has long been overdue, and further efforts along these lines are greatly to be desired.

Once dangerous behaviors have been defined, the next series of questions pertain to the likelihood that such behaviors may recur. Some of these questions are empirical in nature and could well be asked of persons who are familiar with the relevant clinical and scientific evidence and who have been accepted by courts as competent and knowledgeable "experts." Other issues remain essentially matters of law and have to be resolved by duly designated triers of fact. The following questions and related suggestions pertain to the assessment, prediction, and handling of behaviors that are considered to pose a danger to others.

(1) **What is the likelihood (probability) that the feared dangerous behaviors will occur or recur?**

This is the crucial and most difficult question with respect to predictive assessments. Rather typically, the answer seems to depend pretty much on the subjective, intuitive, and often "seat-of-the-pants" impressions of various experts. Moreover, there is often a failure to provide some objective description of the assessment process, of the specific criteria used, and of the cues and "clinical signs" used for making predictions of dangerousness. Thus, even though some clinicians may well be good predictors, it is very difficult to know precisely how they go about making their assessments. Disagreement among mental health professionals is rather common. Furthermore, when there do appear to be high levels of agreement about an individual's expected "dangerousness," it is difficult to know how much of this agreement might relate largely to the perceived social contingencies influencing the assessment (viz., concerns about the anticipated public uproar if the released person should again commit a dangerous act).

To reduce inconsistencies and disagreements among mental health professionals in predicting "dangerousness," Schwitzgebel

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(1977) has suggested that two or more experts be asked to make such assessments--but *independently*. In this way, factors that might be either overlooked or over-rated by one expert may be corrected by the other. It is essential, however, that the initial assessments be conducted independently, and *not* by having one person's assessment simply reviewed by the other. Also, the professionals should be asked to specify the particular factors and considerations which led to their conclusions. Such specification would allow more adequate review and scrutiny of the conclusions and predictions; also, such information would be more amenable to empirical research designed to improve predictive reliability and accuracy.

With respect to determining the likelihood of future violent behavior, as well as the frequency and likely social context of such behaviors, it is most essential to carefully ascertain the relevant history and pattern; e.g., whether there have been any such behaviors in the past; and, if so, whether the previous violent act(s) was part of a consistent or persistent pattern (cf. the earlier discussion regarding Toch's typology of "violence-prone" men), or whether it was a rare and possibly one-time event. If the violent behavior was quite untypical, the predictive task may well be impossible. The best that one could do would be to try to determine the particular person- and situation-specific factors which appear to have elicited the past violent act. Also, determinations should be made whether the same or very similar circumstances are likely to recur in the person's life situation. For example, in the case of a serious assault on a spouse, and where the violent act was part of a longstanding pattern of domestic arguments lubricated by considerable imbibing of alcoholic beverages, it will be important to determine whether the individual will be returning to the spouse, whether the previous pattern of heavy drinking by the couple is likely to continue, and whether the wife has obtained a legal separation or divorce or has otherwise moved away from the setting to which the man will return.

In some other cases the likelihood of repeated violent behavior may relate to some clearly discernible sequence of circumstances that can be ascertained from the relevant history. For example, in a case of child battering it was determined that the unmarried young woman was usually a very attentive and capable mother to her three small children all under 6 years of age. However, it was when her boy friends began to lose interest in her and she was left alone to care for the children in her state of worry and resentment, and also when she began to drink, that incidents of child battering had typically occurred. Such knowledge can be of much value to persons charged with assisting the woman under some form of

community supervision. For example, therapeutic and various other supportive help would most urgently be needed when the woman's life circumstances (such as those noted above) indicate a markedly increased probability of further child abuse and battering. As long as the necessary support and assistance could be provided in the community, confinement would neither be necessary nor even indicated.

A closely related question pertains to the period of time within which some probable dangerous acts might occur. That is, the decisionmakers would need to know the likely frequency of such acts and also the situational contexts that might facilitate or evoke such behaviors.

Again, the individual's past pattern of behavior and functioning, as well as knowledge of the social setting and circumstances in which he will be living, will typically provide more relevant and reliable information than the person's psychiatric diagnosis. In short, the situation with respect to determining the "dangerousness" of mentally disordered persons is not basically different from that faced in evaluating criminal recidivism for offenders.

For example, if the individual has a long criminal record, a pattern of poor occupational functioning, very limited job skills, various behavioral and social problems such as alcohol and drug abuse, and if there is also likely to be an absence of family or other social supports to assist the individual upon his return to the community, then the probability of further criminal conduct would generally be rather high. And, the above factors will tend to be far more critical and determinative of outcome than the person's psychiatric diagnosis—other than accompanying personality disorders. Indeed, it appears that the conditional probabilities associated with serious criminal recidivism will have factors in common for convicted offenders and for many mentally disordered offenders. Predictions of future dangerous behavior can reasonably be made when there exists a long pattern of serious criminal behavior and associated factors (e.g., youthful age, alcohol problems, and absence of stabilizing and supportive resources) remain in effect. It remains to be determined whether variables such as psychiatric diagnoses (other than personality disorders) and a history of serious mental illness help by themselves to distinguish particular subgroups with respect to their future dangerousness. Based upon current knowledge, it might even be that, by focusing *primarily* on the person's mental condition and on vague and often very speculative psychodynamic factors, mental health professions may well tend to *decrease* their predictive accuracy (cf. the earlier discussion regarding some statistical rules in making predictive judgments).

(2) Who are likely to be the victims of the expected or feared "dangerous" behaviors?

Decisionmakers may wish to know whether the dangerous acts are more likely to occur against some *particular persons* (e.g., a spouse or girl friend, the individual's own children, or a neighbor with whom longstanding conflicts have occurred), and/or against some *broader group* of people (e.g., minor boys or girls in the case of a pedophile, adult women in the case of certain exhibitionists or rapists, etc.), and/or against a *more dispersed segment of the community* (e.g., the likely victims of "purse-snatchings" and other street robberies, potential victims of recidivistic drunken drivers, etc.). Here, again, the previous and longstanding pattern of behavior will typically provide relevant information. Even if there is a long pattern of previous assaultive behavior, but this behavior is very person- and situation-specific (e.g., involving a family member and after heavy drinking), preventive interventions may be feasible. Such person-specific criminal acts could possibly be prevented by means of explicit and closely monitored conditions of release that require a parolee to join AA, to receive other indicated treatment, and to stay away from some specific persons, settings, and situations which suggest markedly increased probabilities that some violent act will occur. While such conditions are often used in a variety of probation and parole situations, the absence of close monitoring and the lack of proper support and assistance to the individual tend greatly to reduce the potential value and effectiveness of such supervision.

(3) What is the severity of harm or injury likely to be inflicted IF the dangerous acts were to recur?

Relevant case law (e.g., *Millard* v. *Cross*, *Cross* v. *Harris*, and *State* v. *Krol*) has pointed out the need to carefully balance the severity of harm likely to be inflicted by an individual and the loss of liberty to be suffered as a result of confinement. In order to undertake such balancing, courts need to have some idea of the severity of harm or injury that particular persons (or the community more generally) are likely to suffer if the released person engaged in further dangerous behavior. Understandably, the decision to release, and the conditions to be set for such release, will depend upon the expected criminal behavior, e.g., whether such acts are likely to involve indecent exposure, forgery and issuing of checks, or burglary, as contrasted with assault with a dangerous weapon, armed robbery, or attempted homicide.

As repeatedly noted above, the past history and pattern of criminal or other dangerous behavior (mostly reflected by arrests, prosecutions, convictions, and penal incarcerations) will tend to provide the most relevant information. There is not very much

criminological evidence that would indicate a high degree of "specialization" by chronic offenders. However, some specialization is evident, for example, in the case of "flashers" (exhibitionists), "peepers" (voyeurs), "paper hangers" (check passers), child molesters, burglars, and certain so-called "white collar" criminals. More often, recidivistic offenders display a degree of versatility. For example, the PROMIS Research Project (1977a) in the District of Columbia analyzed data pertaining to all arrests between January 1, 1971 and August 31, 1975; information was available regarding rearrests, reprosecutions, and reconvictions involving 45,575 defendants. It was found that persons who are repeatedly arrested, prosecuted, and convicted accounted for a disproportionately large share of the "street crime." Moreover,

> A significant percentage of these repeat offenders switched between felonies and misdemeanors; for example, today's petty larceny defendant may have been involved in a past robbery case and might be the subject of a future homicide prosecution or simple assault arrest. (p. 13)

This same research project also found that defendants with previous violent crimes (i.e., homicide, assault, sexual assault, or robbery) had the highest proportion of rearrests for violent crimes. (See also Wolfgang et al. 1972.)

It appears that the extensiveness and seriousness of the person's criminal history (regardless of whether expressed in terms of arrests, prosecutions, or convictions), seem to be a rather good predictor of future criminality (PROMIS Research Project, 1977a).

(4) Is the feared dangerous behavior of a nature that could appreciably be decreased, modified, or even prevented by certain environmental changes?

The conceptualization of behavior as a product of person-environment interactions has certain clinical and other practical implications. For example, in the case of an elderly and somewhat senile person who is being considered for involuntary hospitalization because he forgets to turn off the gas jets on his stove after cooking, such lapses could endanger not only the man himself in the event of a fire or gas explosion, but also his neighbors in the apartment building. Thus, he could be considered as "dangerous to himself and others." However, it is obvious that the "dangerousness" does not lie *within* the person; rather, it results from certain characteristics of the person and their interactions with a particular environment. The "dangerous" situation in this particular case might readily be corrected by replacing the individual's gas stove with an electric one.

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The foregoing is, of course, a rather simple and even obvious illustration of the basic point. However, one might well wonder about the numbers of elderly persons who have been committed to mental hospitals because of similar or closely related circumstances (see, e.g., *Lake* v. *Cameron*;[25] Shah 1974). It would be fair to say that a large number of hospitalized mentally disabled persons, as well as incarcerated offenders, could very likely be handled in the community *if* our society were willing to provide the necessary resources to develop a wider range of less drastic alternatives for handling such persons and the problems that they present. It should be evident that the sociolegal decision to involuntarily confine a person considered to be "dangerous to himself or others" is *not* simply a reflection of the degree of danger posed by the person. It is also a reflection of the tolerance levels in the community for deviant behaviors, and of the lack of less restrictive alternatives available in the society. The latter relates very directly to the resources the society is willing to allocate to such social needs.

(5) **Are there certain treatment alternatives which relate more directly to the behaviors of specific concern, and which could more predictably reduce the likelihood of certain dangerous behaviors?**

It has been noted that very real questions arise whether mental hospitals are the appropriate social institutions for treatment of *dangerous behaviors*—as contrasted with the treatment of serious mental disorders. Questions also arise about how the treatments typically used for psychiatric disorders relate to specific and episodic dangerous behaviors.

During the last two decades, various behavioral approaches to treatment have been developed and many of these can more specifically be related to the particular behaviors and problems of concern. A rather immense and also impressive literature has accumulated on behavioral approaches to treatment (Bandura 1969; Browning and Stover 1971; Franks and Wilson 1976; Kanfer and Phillips 1970; Krasner and Ullmann 1965; Lazarus 1971; Schwitzgebel and Kolb 1974; Ullmann and Krasner 1965; Wolpe 1958, 1969). Thus, with respect to individuals who are easily aroused to anger and who then engage in assaultive behaviors, certain behavioral (desensitization) techniques could be utilized to reduce the intensity of the anger-arousing stimuli. In one relevant study (Rimm et al. 1971), research subjects who became angry while driving and who exhibited behaviors such as swearing, tailgating, or driving at excessive speeds, were gradually exposed to descriptions of driving situations that made them angry. Prior to and during these exposures the subjects engaged in deep muscle relaxation. Following such treatment the subjects reported less anger in response to these

driving scenes; these reports were confirmed by galvanic skin response measures, but not by heart rate measures. The most relevant assessment would relate, of course, to the subsequent driving behavior of these subjects and whether the angry behaviors and aggressive driving were actually decreased.

Various other treatment approaches have been discussed in the literature and they offer promise for future development and application to some of the behaviors discussed here (Meichenbaum and Cameron 1973; Novaco 1973; Bower and Bower 1976). For example, exhibitionists are subject to indeterminate confinement under provisions of various "sexual psychopath" and "sexually dangerous persons" laws. Assuming a societal interest in providing treatment, certain less drastic treatment approaches could be used in outpatient settings, rather than relying on indeterminate confinement. Maletzky (1974) used "covert sensitization" in treating 10 exhibitionists, and the results indicated a substantial reduction of exhibitionistic behavior and fantasy during a 12-month period.

Various biologically oriented approaches to treatment of certain criminal and dangerous behaviors (viz., aggressive and sexual crimes) have also been reported and offer some potentially useful applications (Shah and Roth 1974).

These treatment approaches have not been mentioned to suggest that they are the only useful methods, nor to imply that their effectiveness has clearly been demonstrated and that they are ready for wide application to the range of dangerous behaviors discussed in this chapter. Rather, such therapeutic approaches have been subjected to considerable empirical study and evaluation; they do appear in many instances to be quite promising; they can more specifically be related to certain behavioral problems; and, if their effectiveness can further be confirmed, they would offer less restrictive alternatives to involuntary confinement. As Schwitzgebel (1977) has recently noted,

> If treatment could become both brief and effective with minimal side-effects, the issue of the accuracy of predictions of dangerousness would not be as critical as it is today because false positive errors would not result in extensive deprivations of liberty. (p. 23)

Conclusion

This discussion has noted several decision points in the criminal justice and mental health systems where the issue of an individual's dangerousness and dispositional options is considered. Yet, despite

the extensive uses of the notion of dangerousness and the serious consequences that can follow such determinations, clear and precise definitions have long been overdue, and even now considerable clarification and further improvements are needed. The vagueness of a concept that is so critical for a variety of decisions can and does lead to numerous problems, since the notion can be pulled and stretched to fit various dispositional preferences. Similarly, the manner in which behavior is commonly conceptualized and various predictive assessments typically are made gives insufficient attention to the setting and situational variables that influence behavior. It was suggested that an interactionist perspective, which considers both individual and situational variables, offers many improvements over traditional personality trait, psychodynamic and situationism approaches.

Even though major decisions about people are based on assessments and predictions about their future dangerousness, it was indicated that there are immense technical difficulties inherent in predicting events with very low base rates. While such predictive tasks remain difficult, greater use of actuarial and statistical approaches could lead to several improvements. Even though predictive accuracy may only modestly be increased and false positives reduced to some degree, the major gain would relate to the markedly improved consistency and reliability of such assessments. Such improvements in consistency should enhance the equity and fairness of the decisions.

The manner in which therapeutic and social control objectives tend to become confused and confounded, to the detriment of the individual affected, was addressed at some length. For example, even though the societal value placed upon individual liberty leads to the use of rather demanding decision rules in the criminal process before conviction and incarceration can result, the values associated with coercive confinement undergo a major shift when the person is labeled as "mentally ill" and the purpose of the confinement is couched in the idiom of remediation and treatment. The application of the label "mentally ill" and the invocation of therapeutic objectives have for long had the effect of neutralizing the values and decision rules that would otherwise require us to let nine guilty men go free rather than risk the erroneous confinement of a single individual. Ironically, it is when our society proclaims therapeutic objectives and diverts "insane" and other mentally disordered persons from the punitive sanctions of the criminal justice system, that it manages also to exert more powerful social control. In recent years, however, courts have given major attention to these sources of inequity and unfairness and significant improvements have indeed been made.

The aforementioned discriminatory practices vis-a-vis the mentally ill tend to reinforce and to maintain longstanding social prejudices. For to the extent that policymakers, courts, and mental health professionals concentrate their concerns with "dangerous" behavior largely on the mentally ill, they help to perpetuate the myth that the mentally ill, as a group, are the most dangerous persons in our society. However, there is abundant empirical evidence to demonstrate that certain other groups (e.g., drunken drivers and recidivistic criminals) are clearly and convincingly more dangerous to the community. Thus, aside from the many legal and Constitutional concerns that are raised by such practices and are beginning to be addressed by courts and legal commentators (e.g., Note 1974), many questions are also raised about the fundamental unfairness of such discriminatory policies.

As Broderick (1971) has pointed out, if the basic object of a legal system in a society is to achieve the "idea of justice" for its members, its success at any given moment cannot be measured by the ideas it professes nor the constitutional or legal rules to which it pays lipservice. Rather, success must be measured in terms of the *actual achievement* of the guiding values and objectives. When societal institutions are found to be dysfunctional in reference to professed values and policy objectives, society must either modify the institutions or be forthright enough to abandon the professed values or strive diligently to bring the values closer to the reality which it wishes to preserve. Of course, when the policies themselves deviate from major societal values, appropriate changes in such policies must also be made—else the underlying goal values will tend to be depreciated and weakened.

Mental health professionals need, therefore, to consider very carefully the roles that they find themselves playing as agents of social control with respect to various categories of the mentally ill, rather than as caregivers and therapists. With better awareness of their own roles and with greater attention to ways in which empirical research findings can help to improve various clinical tasks, mental health professionals should join with lawyers, behavioral and social scientists, and other concerned citizens to make societal policies and practices with respect to the mentally ill more accountable and less hypocritical.

Footnotes

1. Section 730.50 of New York State's Criminal Procedure Law (Sept. 1971) mandates a determination of dangerousness for all indicted felony defendants found incompetent to stand trial.

2. Texas Code of Criminal Procedure, Art. 37.071, effective June 14, 1973. Section (b)(2) states, "Whether there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society" (p. 278).
3. The ongoing PROMIS research project in the District of Columbia sought to determine ways of predicting the likelihood of criminal recidivism. It was found that if a defendant had five or more arrests prior to the current arrest, the probability of subsequent arrest began to approach certainty. (PROMIS Research Project, 1977a, page 12.)
4. *McDonald* v. *United States*, 312 F.2d 847 (1962).
5. *Baxstrom* v. *Herold*, 383 U.S. 107 (1966).
6. *Bolton* v. *Harris*, 395 F.2d (1968).
7. *United States* v. *McNeil*, 434 F.2d 502 (1970).
8. *United States* v. *Ecker* II, 543 F.2d 178 (1976).
9. *State* v. *Carter*, 316 A.2d 449 (1974).
10. *State* v. *Krol*, 344 A.2d 289 (1975).
11. D.C. Code Sec. 21-501 to 21-591 (1967).
12. D.C. Code Sec. 24-301(e).
    Since such involuntary confinement stems from the commission of an act which is defined as a crime, we have here a police power concern, viz., to protect the community. Hence, it is interesting to note that both the indeterminate commitment following the *Bolton* hearing and also the criteria for release, refer to "dangerous to himself or others." Thus, despite the obvious police power concern involved, a wider net is used for confining the acquitee by also including the notion of "dangerous to himself."
13. D.C. Code, Sec. 24-301(e)-1.
14. *Bolton* v. *Harris*, op cit. FN 7, page 653.
15. *McDonald* v. *United States*, op cit. FN 5, page 851.
16. Judge Miller's dissenting opinion in *Hough* v. *United States*, 271 F.2d 458 (1959).
17. *Baxstrom* v. *Herold*, op cit. FN 6.
18. *Humphrey* v. *Cady*, 405 U.S. 504 (1972).
19. *Jackson* v. *Indiana*, 406 U.S. 715 (1972).
20. *Waite* v. *Jacobs*, 475 F.2d 392 (1973).
21. *Kent* v. *United States*, 383 U.S. 541, at 556 (1966).
22. *Millard* v. *Harris*, 406 F.2d 964 (1968).
23. *Cross* v. *Harris*, 418 F.2d 1095 (1969).
24. *State* v. *Krol*, op cit., FN 11.
25. *Lake* v. *Cameron*, 364 F.2d 657 (1966).

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