Dangerousness as a Criterion for Confinement

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Several years ago a science fiction writer created in his fiction a machine called a sanity meter, which automatically gauged a person's potential for dangerous conduct. The meter, which was installed in all public places, registered from zero to ten. A person scoring up to three was considered normal; a person scoring between four and seven, while within the tolerance limit, was advised to undergo therapy; and someone scoring between eight and ten was required to register with the authorities as highly dangerous and to bring his rating below seven within a specified probation period. Anyone failing this probationary requirement, and anyone passing the red line above ten, was required either to undergo immediate surgical alteration or to submit himself to the academy—a mysterious institution from which no one ever returned. The meter was not a diagnostic machine—it measured solely the intensity of the individual's potential for harm, not its underlying cause and not its amenability to treatment. Since the machine never erred, everyone in the society knew everyone else's danger rating and acted accordingly. Its widespread use finally succeeded in eliminating crime and all other social evils.

Although our society is not yet blessed with such a wonderful, error-free device, we do have people who claim to be able to gauge an individual's potential for harm. Indeed, the majority of persons currently confined in American institutions today are there, at least in part, on the basis of a prediction that they will commit harm at some future point in time. The dominant group numerically among these, and the group we are speaking about today, is the mentally ill committed to mental hospitals.

It's important to realize that not in every society, and not in every age, were the insane confined by the state in public institutions. The building of asylums on a wide scale did not begin in the United States until the middle of the nineteenth century and did not begin as a world-wide trend until the seventeenth century. Such confinement was originally designed to further vaguely articulated social goals. In the eighteenth and early nineteenth centuries, these laws were part of a larger tapestry which included the suppression of rogues, vagabonds, common beggars and other idle, disorderly and lewd persons. The legislative purpose behind this regulation seems fairly clear. It was to isolate those persons who, for whatever reason, were regarded as intolerably obnoxious to the community.

Originally, medical testimony had very little to offer in this regard. The people knew whom they regarded as obnoxious. By the middle of the nineteenth century, however, primarily as a result in the United States of the influence of Dr. Isaac Ray, madness was becoming widely regarded as a disease rather than simply a social phenomenon akin to vagrancy, and a disease that should be treated by physicians, with little or no interference

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by the courts. In 1838, Dr. Isaac Ray, in his classic *Treatise on Medical Jurisprudence of Insanity*, of course devoted most his attention, as most writers did during that period of time, to the insanity defense and to the financial affairs of the insane, but he did devote a chapter to interdiction and restraining, and yesterday you heard from one speaker, at least, some of what Isaac Ray said. I would like to mention to you some other matters to which he referred. His discussion of the issue of confinement of the insane was, for that period of time, very sophisticated both medically and legally, although Ray had no formal legal training. It also reflected, I think, a far greater sensitivity to the rights and liberties of the insane than one might have expected. Though written before the development of modern psychiatry, it still stands as one of the most balanced and thoughtful considerations of this complex issue.

Ray began his discussion of restraint on a note of warning. He said, "While restraint is often essential to the restoration or the comfort of the patient, and the safety of the community, it is, at the same time, libel to the most serious and shameful abuses. In this country it is true that public attention has scarcely been attracted to this subject but either human nature is very different here, from what it is in other countries, or we shall at some time or another have to deplore the abuses which they are now anxiously seeking to remedy unless admonished by the lessons that they set before us . . . we prevent them altogether by suitable and reasonable legislation."

Isaac Ray decided that confinement of the insane served three distinct purposes—a separation which is still functionally relevant today. First, their own restoration to health. Second, their comfort and well-being merely, regardless of expectation of their cure. Third, the security of the society. Writing during the height of what has come to be known as the "cult of curability," when it was thought that mental illness could be cured with a high degree of certainty, Ray expressed no reservations about the first object. He said when the restoration of the patient is the object sought for, as it always is in recent cases, no unnecessary restrictions should be imposed on this measure. The simple fact of the recency of the case should be sufficient, when properly attested, to warrant seclusion if it be deemed necessary for his care. Ray seemed at this point to be arguing for an exclusively medical prerogative to authorize the immediate confinement and treatment of the recently insane, at least for a short period of time. He saw no real potential for abuse in this category of patients, as long as doctors were making medical decisions about treatment.

The situation in which he thought that restraint was most in danger of being abused was within the large class of patients whose disorder was of too long standing to admit to any rational expectation of cure. In that situation, patients are generally confined because, in Ray's words, "They are destroying the peace of the family by constant ill temper or by overbearing, or furious deportment, or that they cannot receive in their own house the attention which the situation requires." These are the classic cases of custodial confinement, in which the doctor is asked to perform essentially a warehousing function. Ray used uncharacteristically strong language in discussing this object. He said that the idea of depriving a person of his liberty merely because other persons, who would benefit from such a step, say that he is mad, would be of so monstrous a nature that one finds it difficult to believe that it has ever actually been carried into practice. Perhaps in this country, he said, it never has. If so, however, it is not because it's been prevented by the salutory restraints of the law, which in many states is utterly silent respecting it.

Ray was wrong in assuming that custodial confinement for the convenience of the family had never been practiced in this country. My historical research into the origins of preventive confinement in this country indicate quite clearly that as far back as the seventeenth century, family convenience was a dominant reason for restraint and for the use of various other techniques, such as the New England "warning-out" laws, and other measures that were available for the treatment of the mentally ill. He was surely right in

predicting that the issue would soon become a serious one, and, of course, within thirty or forty years after he wrote, Mrs. Packard had written her book and we had seen a general change in attitudes with numerous writers focusing on the denial of due process. Where Ray was most seriously mistaken, in my view, was in not anticipating that uncritical acceptance of the first purpose of confinement—treatment—would inevitably lead to an increase of abuse of the second purpose—custody. It is far too easy to rationalize custodial care of an unpleasant relative by pretending that his custody is really treatment, and, once in the hospital, his failure to improve often results in a nondecision to leave the situation unchanged.

The third purpose of confinement cataloged by Ray was the security of society, which was promoted by preventive confinement of insane persons who were thought likely to engage in harmful conduct. He characterized such confinement as perpetual imprisonment and expressed his belief that it "should have been entrusted to the decision of a higher set of functionaries than a couple of justices of the peace" who, under colonial and post-revolutionary law, were entitled to confine the insane. He also raised an objection to the broad discretion vested in the justices. No plan of inquiry, he said, is laid down for them to pursue, or a single hint to guide them in their examination. Finally, he saw no need for the justices of the peace to have any more power over the dangerously mentally ill than they did over other dangerous people. Temporary confinement, he said, is all that the immediate security of society requires, and therefore the term of imprisonment for which the justices should have power to commit should be limited to a few weeks or months.

Ray saw confinement of the dangerously mentally ill as precisely what it was—preventive imprisonment—and he concluded that it should be surrounded with precisely the same safeguards as those required for ordinary imprisonment. It is too bad that early American history followed only part of Ray's advice, and not the other part. What happened is that the country accepted basically the medical model of confinement in which it was assumed that everybody to be confined was confined for treatment purposes, and few barriers were put in the way of psychiatric confinement.

Unfortunately, the present situation still reflects that approach. The criteria for confinement are so vague in most parts of the country that courts sit—when they sit at all—merely to review decisions made by psychiatrists. Indeed, the typical criteria are so meaningless as even to preclude effective judicial review. In one state, for example, the court is supposed to commit any person whom a doctor reasonably finds is "mentally ill and a fit subject for treatment in a hospital for mental illness," or "that he ought to be confined." Now, this kind of circularity is typical of the criteria, or lack thereof, in about half of our states. Even in those jurisdictions with legal-sounding criteria, such as this state, Massachusetts, and the District of Columbia, where the committed person must be mentally ill and likely to injure himself, or where there has to be a clear and present danger of injury, the operative phrases are still so vague that courts rarely upset psychiatric determinations.

Let me illustrate the distorting effect of this so-called medical model of confinement, by reference to two cases recently decided in the District of Columbia Court, over which Judge Bazelon presides. One involved a man named Bong Yol Yang, an American of Korean origin, who appeared at the White House gate, asking to see the President about people who were following him and revealing his subconscious thoughts. He also wondered whether his talent as an artist could be used by the government. The gate officer had him committed to a mental hospital, and Yang demanded a jury trial, at which a psychiatrist testified that he was mentally ill, a paranoid schizophrenic, and that although there was no evidence of his ever attacking anyone so far, there was always the possibility that, "If his frustrations become great enough, he may potentially attack someone." On the basis of this diagnosis and prediction the judge permitted the jury to commit Yang to a mental hospital until he was no longer dangerous to himself or others.

The other case, decided by Judge Bazelon, involved a man named Dallas Williams, who, at age thirty-nine, had spent most of his life in jail for seven convictions for assault with a deadly weapon and one conviction for manslaughter. Just before his scheduled release from jail, the government petitioned for his civil commitment; two psychiatrists testified that although "At the present time he shows no evidence of active mental illness, he is potentially dangerous to others and if released, is likely to repeat his pattern of criminal behavior and might commit homicide." The judge, in denying the government's petition for commitment and in granting the petition for his release, observed that the courts had no legal basis for ordering confinement on mere apprehension of future unlawful acts; they must wait until another crime is committed or the person is found insane. Within months of his release, Dallas Williams lived up to the prediction of the psychiatrists, which in this case was accurate, and shot two men to death in an unprovoked attack on a Washington street.

Now, are there any distinctions between the Williams and the Yang cases which justify the release of Williams and the confinement of Yang? There is no evidence that Yang was more dangerous, more amenable to treatment, less competent than Williams, but Yang was diagnosed as mentally ill and thus within the medical model, whereas Williams was not so diagnosed. Although there was nothing about Yang's mental illness which made him a more appropriate subject for voluntary confinement than Williams, the law attributed conclusive significance to the existence of mental illness. The outcomes in these cases, which I think make little sense when evaluated against any rational criteria for confinement, are I think typical under current civil commitment processes; and these contradictions are going to continue as long as the law continues to ask the disposative questions in medical rather than in legally functional terms. The medical model simply doesn't ask the proper questions, or it asks them in meaninglessly vague terms: Is the person mentally ill? Is he dangerous to himself? Is there a need for care and treatment? Is there a clear and present danger of injury? Nor is this the only way to ask the questions to which the civil commitment process is responsive. I think it will be instructive to restate the problems of civil commitment without employing any medical terms, and see whether the answers suggested are any different from those that are now given.

There are, in every society, people who may cause trouble if they're not confined. The trouble may be serious, such as homicide, or trivial, such as the making of offensive remarks, or somewhere in between, such as forging checks. The trouble may be directed at others, at the person himself, or at both. The person may be very likely to cause trouble, or fairly likely, or fairly unlikely. In some instances, this likelihood may be considerably reduced by a relatively short period of involuntary confinement; in others, a longer period may be required, with no assurance of reduced risk; while in still others, the likelihood can never be significantly reduced. Some people will have a fairly good insight into the risks they pose, and the costs entailed by an effort to reduce these risks, while other people will have poor insight into these factors. Now, when the issues are put this way, instead of in medical terms, I think there begins to emerge a series of meaningful questions, capable of traditional social and legal analysis. What sorts of anticipated harm warrant involuntary confinement? How likely must it be that the harm will occur? Must there be a significant component of harm to others, or is harm to self enough? If harm to self is enough, must the person also be incapable, because he lacks insight, of weighing the risks to himself against the cost of confinement? How long a period of involuntary confinement is justified to prevent what kinds of harm? Must the likelihood of the harm increase as severity decreases, or as the component of harm to others decreases?

These are complex questions, but this complexity is as it must be, because the business of balancing the liberty of an individual against the risks a free society must tolerate is the most complex business a society can undertake; and that is the business of the law. These are questions which need asking, and answering, before liberty is denied, but they

are obscured today because the issues are phrased in medical terms which frighten lawyers and citizens away. I haven't manufactured these questions. These are the very questions that are being implicitly answered every day by psychiatrists, but they are not being openly asked. Many psychiatrists do not even realize that they are, in fact, answering these difficult social policy questions. Let's consider briefly two of these questions and compare how they are being dealt with, or not dealt with, in the present system with how they might be handled under functional, social or legal criteria.

The initial and fundamental question that has to be asked about any system of confinement is which harms are sufficiently serious to justify our resort to this rather severe sanction. The question is asked and answered every day in the criminal law by the statutory definitions of crime. Thus, homicide is a harm which justifies the sanction of imprisonment—we all agree with that. Miscegenation, we all agree, does not. And adultery is a borderline case about which reasonable people may disagree. It is difficult to conceive of a criminal process which did not make some effort at articulating such distinctions. Imagine, for example, a penal code which simply made it imprisonable crime to cause injury to self or others, or to create a clear and present danger of injury to self or others, without further defining what injury means, or what kinds of injuries are contemplated. It is also difficult to conceive of a criminal process, at least in jurisdictions with an Anglo-American tradition, in which these distinctions were not drawn by the legislature or by the courts. It would seem beyond dispute that the question of which harms do and which do not justify incarceration is a legal, a political, a social question to be answered not by experts, but by the constitutionally authorized agents of the people. Again, try to imagine a penal code which authorized incarceration for anyone who performed an act regarded as injurious by a designated expert—say a psychiatrist or a penologist. None of us would tolerate that kind of allocation to the expert of such social policy judgments, yet this situation is precisely the one that prevails with civil commitment.

The statues authorize preventive incarceration of mentally ill persons who are likely to injure themselves. "Injure" is almost never further defined in statues or in the case law, and the critical decision whether a predicted pattern of behavior is sufficiently injurious to warrant incarceration is relegated to the unarticulated value judgments of the expert psychiatrist. Some psychiatrists are perfectly willing to provide their own personal opinions, often falsely disguised as expert opinions, about which harms are sufficiently serious. One psychiatrist recently told a meeting of the American Psychiatric Association that "you, the psychiatrists, have to define for yourself the word danger, then having decided that in your mind, look for it with every conceivable means." My own conversations with psychiatrists, and, I'm sure, your own as well, reveal wide differences of opinion as to what kinds of harm justify incarceration. As one would expect, some psychiatrists are political conservatives, others are liberals; some place greater premiums on safety, others on liberty. Their opinions about which harms justify confinement, and which do not, probably cover the range of opinions one would expect to encounter in any educated segment of the public, but they are opinions about matters which each of us is as qualified to judge as they are. Why then, is this most fundamental question almost never asked by the legislatures or the courts, often never explicitly asked by anybody, and when it is explicitly asked, it is by an unelected and unappointed expert operating outside the area of his expertise? I submit the reason is that the medical model has taken over in this country and we see the question as one of medical rather than of social policy.

Another important question which rarely gets asked in the civil commitment process is "How likely should the predicted event have to be to justify preventive incarceration?" Even if it is agreed, for example, that preventing serious physical assault would justify incarceration, an important question still remains: How likely should it be that the person will assault? If the likelihood is very high—say ninety per cent—then a strong case for confinement emerges. If the likelihood is very small—say five per cent—then it

would be very hard to justify confinement. Here, also, we get little guidance from any statutes; but someone is deciding what degree of likelihood should be required in every case. Today, it's the psychiatrist who makes that important decision. He's asked whether a given harm is likely, and he generally answers yes or no. He may, in his own mind, be defining *likely* to be anything—from virtual certainty to a probability slightly above chance—and his definition will be reflective not of any expertise but rather of his own social policy preference for safety versus liberty.

Not only do psychiatrists determine the degree of likelihood that should be required for incarceration, but they are also the ones who decide whether that degree of likelihood exists in any particular case. Now this, you may be thinking, is surely an appropriate role for the expert psychiatrist. But just how expert are psychiatrists in making the sorts of predictions upon which incarceration is presently based? Considering the heavy, indeed exclusive, reliance the law places on psychiatric and psychological predictions, one would anticipate numerous follow-up studies establishing their accuracy. Over the past several years, however, I have conducted a fairly thorough survey of the published literature on the prediction of anti-social conduct, and I have read and summarized several hundred articles, monographs and books, and surprisingly enough, I have been able to discover very few studies which follow up psychiatric predictions of anti-social conduct. Moreover, these few studies strongly suggest that psychiatrists are rather inaccurate predictors—inaccurate in an absolute sense, and even less accurate when compared with other professionals such as psychologists, social workers and correctional officials. Even more significantly for legal purposes, psychiatrists seem particularly prone to one type of error—errors of over-prediction. In other words, they tend to predict anti-social conduct in many instances where it does not, in fact, occur. Indeed, my research suggests that for every correct psychiatric prediction of violence, there are numerous erroneous predictions. That is, among every group of inmates presently confined on the basis of psychiatric predictions of violence, there are only a few who would, and many more who would not, actually engage in such conduct if released.

Let me review just briefly some of the recent studies that have been done by psychiatrists, and some done by people who are not psychiatrically trained, using psychiatric criteria or psychiatric conclusions. These studies are particularly significant for several reasons. First, they all deal with individuals who have previously engaged in the type of conduct which is being predicted. Further, each of the reports is based on large quantities of detailed information about the sample population and utilize the most sophisticated prediction techniques.

A 1973 study focused on the assessment of potential for assault with a view toward predicting the assault-proneness of an individual offender, with data collected prior to the current assaultive act. Over 4,000 young men, average age about nineteen, comprised the study population. After a fifteen-month follow-up period on parole, 2,500 individuals had a favorable parole outcome, while about 1600 had violated parole. For 1400 of these parole violators, the violation offense was known, enabling the researchers to develop a predictive index for violence-prone violators.

The data collected on each individual covered over a hundred variables, including demographic and psychiatric information, intellectual, vocational, social and personality assessments, assessment of psychopathology and parole follow-up data. These variables were combined, using very sophisticated statistical techniques, and the following results were achieved. Of the group of parole violators, a violence-prone sub-sample was isolated, who had scored the highest on the predictive test. The best the predictive device could do was to correctly identify twenty-eight individuals as violence-prone, while misclassifying two hundred and fifty-six. According to this prediction index, twenty-four persons were classified as non-violent, and turned out to be violent, or false negatives, while two hundred and thirty-two individuals were classified by the index as violent-prone, and turned out to be non-violent.

Another recent report details two large-scale studies in the prediction of violence, undertaken by the California Department of Corrections. The first study attempted to develop a violence prediction scale, and again the results were quite significant. Eighty-six per cent of those identified as potentially violent did not, in fact, commit a detected violent act while on parole, and since the study dealt with the isolated group that was most violent I think this is a very significant finding.

The final study that I'm going to mention sampled 4,000 California youth authority wards. This study is particularly important because of its scope and comprehensiveness. Extensive background information was given on each subject, including elaborate case histories, psychiatric evaluations, current measures of emotional functioning, prognostic judgments. The subjects were followed up for fifteen months and data on a hundred variables were retrospectively analyzed. The California researchers hoped to develop and classify a system for estimating assaultive potential with sufficient accuracy to be useful in corrective programs decision making. In the sample of four thousand, 250 (6%) had committed a violent offense, and 104 (2.5%) were involved in violent violations in the fifteen-month release follow-up period. The task of the California research group was to identify as many of the 104 violators as possible, while misclassifying as violent a minimum of the remaining class. Utilizing the best predictive variable, they yielded an extraordinary false positive rate of 95 per cent. The conclusion of the study was as follows: "There is no other form of simple classification available thus far that would enable the decision maker to improve on this level of efficiency."

Even after using a multi-varied approach to violence prediction, the group could do no better than a discouraging ratio of false positives to true positives of eight to one. Even with such a high ratio of false positives, the predictive device could spot only half of the violent acts. In other words, to prevent half of the violent acts, society would have had to confine eight times as many false positives as true positives. Thus, despite the use of these elaborate case studies, sophisticated measures of mental and emotional functioning, professional diagnosis, and a limitation to a group who had already committed at least one serious violent assault, the California group was forced to conclude as follows: "Simple classification procedures and multi-variable approaches failed to yield an operationally practical prediction instrument of violent conduct that would warrant implementation in actual practice." Concern about violence, they say, "will inevitably lead to the development of special treatment programs but the vast majority of persons placed in such programs must be false positives, persons who would not commit the act which the program is designed to prevent. Confidence in the ability to predict violence serves to legitimate intrusive types of social control." They conclude, "Our demonstration of the futility of such predictions should have consequences as great for the protection of individual liberty as a demonstration of the utility of violence prediction would have for the protection of society."

What, then, have been the effects of virtually turning over the civil commitment process to the experts? We have accepted a legal policy, never approved by any authorized decision maker, which permits significant over-prediction. In effect, we have accepted a rule which says that it's better to confine ten persons who would not assault, than to let free even one who would, an exact reversal of the legal doctrine of Blackstone enunciated almost two hundred years ago. We have defined danger to include all sorts of minor social disruptions. We have equated harm to self with harm to others, without recognizing the debatable nature of that equation.

It may be true that if we were to substitute functional legal criteria for the medical model, we would still accept many of the answers we accept today. Perhaps our society is willing to tolerate significant over-prediction; our penchant for law and order certainly suggests that. Perhaps we do want incarceration to prevent minor social harms. Perhaps we do want to protect people from themselves as much as from others. But we will never learn the answers to these questions unless they are exposed and openly debated, and

such open debate is discouraged, indeed made impossible, when the questions are disguised in medical jargon against which the lawyer and the citizen feel helpless.

The lesson of this experience is that no legal rule should ever be phrased in medical terms, that no legal decision should ever be turned over to psychiatry, that there is no such thing as a legal problem which cannot and should not be phrased in terms familiar to lawyers and, indeed, to laymen. Make no mistake about it, civil commitment of the mentally ill is a legal problem. Whenever compulsion is used, whenever freedom is denied—whether by the state, the church, the union, the university, or the psychiatrist—the issue becomes a legal one, and lawyers must be quick to immerse themselves in it.

The words of Brandeis ring as true today as they did in 1927, and they are as applicable to the psychiatrist as they were to the wire-tapper whom he was describing when he said, "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers," and he concluded that "the greatest dangers to liberties lurk in insidious encroachment by men of zeal, well-meaning, but without understanding."