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Problems, Intersections, and New  
Perspectives

*Edited by  
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# Commentary on Szmukler: Mental Illness, Dangerousness, and Involuntary Civil Commitment

*Ken Levy and Alex Cohen*

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## 1. Introduction

Dr. George Szmukler has written a very thought-provoking and enlightening chapter. After distinguishing among five different levels of “treatment pressures” – persuasion, interpersonal leverage, inducements/offers, threats, and compulsion (see p. 127) – Dr. Szmukler focuses mostly on the last of these. In both the United Kingdom and the United States, an individual cannot be compelled to receive “involuntary outpatient treatment” (IOT)<sup>1</sup> or be committed to a hospital unless she satisfies three criteria: (a) she is deemed by the authorities to constitute a danger to herself or others or (b) she is dangerous to others (c) because of a mental illness (see p. 130–31).<sup>2</sup> Most of Dr. Szmukler’s paper is concerned with (c). He argues, in line with the United Nations Convention on the Rights of Persons with Disabilities (see pp. 141–42), that it is both unnecessary and “unfairly discriminatory”; that the idea that compulsory treatment or commitment requires mental illness rests on the popular myth that there is a significant correlation between mental illness and dangerousness (see p. 132–34).

The solution that Dr. Szmukler proposes is to replace the mental-illness criterion with two tests: one to determine if an individual is suffering from an impairment of “decision-making capability” (DMC) and the other to determine if a given treatment is in the patient’s best interests (BI). As compared with current application of the mental-illness criterion, Dr. Szmukler argues, application of DMC and BI would help to minimize the risk of stigma and unfair discrimination and promote greater respect for patients’ decisions, preferences, values, and autonomy (see pp. 131, 134, 137–41).

Dr. Szmukler’s position regarding the mental-illness criterion advances a debate that has been raging in the literature for the last five decades concerning the tension

between individual rights and involuntary commitment for individuals with putative mental illness. We appreciate Dr. Szmukler's clear concern for patients and for their rights, reputations, and general well-being; we agree with his thesis that involuntary treatment is not always the optimal approach; and we are sympathetic to his proposal that we reconsider the conditions triggering involuntary civil commitment. We do, however, take issue with Dr. Szmukler's treatment of the dangerousness criterion. Dr. Szmukler does not really make clear what role it should play. He does suggest that non- or pre-criminal dangerousness "could be covered by the BI requirement" and suggests that if treatment either does not eliminate the danger of violence or is refused by an individual with impaired DMC, then "recourse to the criminal justice system would be necessary" (see p. 135). But this is all a little too quick; recourse to the criminal justice system is often unwarranted if the individual merely poses a danger to herself or others and has not (yet) committed any crime. What, then, should we do in these situations?

We will attempt to answer this question in section 3. (The preceding section, section 2, will explicate the different purposes of criminal punishment and of involuntary civil commitment.) In sections 4 and 5, we will discuss different approaches to the definition of mental illness and offer further reasons in support of Dr. Szmukler's skepticism about the mental-illness requirement. And in section 6, we will offer some final thoughts about the causal epistemology of mental illness. The reader should note that we are writing about involuntary commitment from an American perspective. So there will be some nuanced differences between our approach and that of Dr. Szmukler, who is writing from a more British perspective.

## **2. Constitutional Limits on Individual Freedom: Criminal Punishment and Involuntary Civil Commitment**

Involuntary civil commitment, which we consider to be a necessary evil, is a deprivation of liberty for the purpose of protecting either the patient from self-destructive behavior or society from the patient. Because Western societies greatly value individual liberty, there must be a rigorous test for imposing this deprivation. In order to determine whether a given individual poses a danger to herself or others, at least one qualified expert must apply this test, and both the content and application of this test must be consistent with the individual's constitutional rights—specifically, with the 5th Amendment ("No person shall be ... deprived of life, liberty, or property, without due process of law ... ") and the 14th Amendment ("[N]or shall any state deprive any person of life, liberty, or property, without due process of law ... ").<sup>3</sup>

This last point bears emphasis. Few would argue that arrest following probable cause or imprisonment following a criminal conviction is unconstitutional. Of course, she may argue that a particular arrest or conviction is constitutionally invalid. But arrest and imprisonment in and of themselves are perfectly consistent with the Constitution, despite the premium that the Constitution places on individual liberty. And the reason for this consistency is that constitutional rights are not absolute. There are several reasons. First, as George Washington stated in the cover letter transmitting the Constitution to the Congress: "Individuals entering into society must give up a share of liberty to

preserve the rest.”<sup>4</sup> In other words, individual liberty must be restricted to make society and social harmony possible. Second, the Constitution permits further restrictions of the right to liberty under certain circumstances. These circumstances include arrest, conviction, curfew, and military draft.

Whether the Constitution permits restrictions of the right to liberty under another circumstance—namely, the determination that a given individual poses a danger to herself or others—is less clear. The patient may have done nothing wrong, certainly nothing that warrants arrest or conviction. Yet involuntary civil commitment involves treating the patient in a manner that superficially resembles incarceration. Just like the criminal offender, the patient is “locked up” against her will. How, then, can we justify treating the patient like an offender? Isn’t this an obvious violation of her constitutional due process rights? In a word: no. The reasons justifying involuntarily committing an individual outweigh her constitutional right to liberty. To understand what these reasons are, we first need to understand the reasons why we imprison convicted offenders.

The first reason that we imprison offenders is “consequentialist”: to bring about good consequences. The main consequentialist goal of incarceration is to protect society from further crime. Incarceration contributes to this goal in three different ways. First, incarceration incapacitates; it protects society (at least society outside prison)<sup>5</sup> from the person who is incarcerated. Second, specific deterrence and rehabilitation: criminal punishment is designed to discourage the recipients of this punishment from committing further crimes if and when they return to society. Third, general deterrence: criminal punishment is designed to discourage all other similarly situated individuals from committing the same kinds of crime. Both kinds of deterrence, specific and general, presuppose that convicted criminals and most similarly situated individuals are rational (enough) actors who can weigh the risk of punishment for committing (further) crimes against the benefit of avoiding punishment, decide that the latter is more conducive to their well-being, and then act on this decision by choosing to comply with the law rather than violating it.

The second reason that we lock up offenders is “retributivist”: to give offenders what they deserve. This second reason intersects with the first (consequentialism) insofar as they both rest on the premise that the convicted offender was responsible for her criminal act. Retributivists assume that responsibility is necessary for (just) punishment because, without it, the person would not *deserve* punishment in the first place. Likewise, consequentialists generally assume that responsibility is necessary for punishment but for a different reason: (a) punishment cannot deter criminal activity unless the people whom the punishment is designed to deter can be motivated by the threat of punishment, and (b) this kind of motivation requires threshold levels of control and rationality, both of which are arguably sufficient for responsibility.

The third reason is “expressivist”: to communicate both to offenders and to the rest of society that the kind of behavior for which they are being punished is unacceptable. On this view, punishment is a kind of language that is used to communicate disapproval and impose stigma. One might argue that expressivism reduces to consequentialism because (a) communication is itself a consequence, and (b) it is desired as a means to further consequences (such as deterrence). But at least with regard to

(b), the expressivist may maintain that communication is intended not merely as a means to the end of deterrence but also as an end in itself. On this view, it is intrinsically, not just instrumentally, valuable for a community to speak its mind about criminal transgressions.

When it comes to cases of involuntary civil commitment that do not involve a crime being committed, the retributivist and expressivist justifications for criminal punishment simply do not apply. Once again, we involuntarily commit certain individuals for the very consequentialist reason of protecting either patients themselves or others from the patients. This is not specific deterrence because we assume that the patients suffer from serious cognitive, behavioral, and functional deficits and therefore cannot conduct, and then act upon, a rational risk/benefit analysis. Instead of hoping that we can influence them by incentivizing them to act rationally (through the threat of punishment), we need to directly control them. Nor does involuntary civil commitment involve general deterrence. We cannot hope to discourage similarly situated individuals from engaging in self-destructive or other-destructive behavior because similarly situated individuals are equally non-responsible and therefore equally immune to rational incentivization. Put very crudely, patients who are involuntarily committed are not “bad,” a term that connotes responsible wrongdoing, but “mad,” a term that connotes an inability to think or act rationally. As a result, we cannot appeal to their reason. Instead, we must resort to sheer brute force.

### 3. Should We Treat Homicide as a Public Health Threat?

Given the presumption of liberty that the Constitution guarantees to every citizen, there are three main reasons why this presumption will sometimes be overridden: arrest, criminal conviction, and involuntary civil commitment. For the remainder of this reply, we will concentrate on involuntary civil commitment. Involuntary civil commitment is authorized if and only if the individual either: (a) carries, or is reasonably expected to carry, a dangerous and infectious disease;<sup>6</sup> (b) is dangerous to herself; or (c) is dangerous to others because she is mentally ill.<sup>7</sup>

Consider (a).<sup>8</sup> Both the federal and state governments have the power to isolate and quarantine individuals whom they reasonably suspect carry a communicable disease.<sup>9</sup> The primary rationale for this power is to prevent the spread of the disease and thereby protect other members of society. The secondary rationale is to treat the individual herself.

Interestingly, while presenting a threat to the public is sufficient justification for involuntary commitment (isolation or quarantine) when the source of the threat is (suspected) infectious disease, presenting a threat to the public is *not* sufficient justification for involuntary commitment when the source of the threat is the person's disposition to homicide. In the latter situation, as we noted in the Introduction, two other conditions must also be satisfied: the person must be mentally ill, and the person's homicidal disposition must be attributable to this mental illness.<sup>10</sup>

Why are these two additional criteria required? Why aren't threats of homicide considered to be, and treated just like, public-health threats? Isn't, for example, a person's statement that he will kill others just as dangerous as a person's carrying of an

infectious disease? And if it is just as dangerous, why isn't a disposition to murder sufficient for civil commitment? Why must mental illness and a causal relationship also be satisfied?

There are three main reasons. First, the scale of the threat posed by homicide is far less than the scale of the threat posed by an infectious disease. While the most "successful" serial killers in history have killed hundreds of people, some diseases can easily kill thousands to millions. So as a matter of public policy, if the State wishes to minimize premature deaths, it should make sure to focus much more of its efforts on quarantining dangerous-disease carriers than it does on ferreting out and committing likely murderers. Indeed, as a public-policy priority, homicide prevention should lose out to suicide prevention as well. Despite what the media would lead us to believe, suicides happen to occur much more frequently than homicides.<sup>11</sup>

Second, the chance that a disease will spread if a host remains in the population is much higher than the chance that a given individual will act on her homicidal intentions or threats. If a person carries a highly infectious disease, the chance that she will spread this disease (if left free) is nearly 100 percent. If, however, a person is considered homicidal but not mentally ill, the chance that she will attempt to commit homicide is considered to be much lower—certainly not 100 percent.

Third, while isolation and quarantine are sometimes the only measures that society can implement to stop the spread of certain diseases, methods other than involuntary commitment such as anger management, restraining orders, threats of criminal punishment, and rational dissuasion can be used to "talk down" a would-be killer.

All of this is not meant to suggest that homicidal threats should not be taken seriously or that temporary detainment is not often appropriate to prevent these threats from being executed. It is only to say that the mere threat of homicide is not equivalent in scale, probabilities, or preventability to the dangers presented by communication of an infectious disease and therefore does not necessarily warrant the same kind of preventive response (i.e., involuntary commitment).

#### 4. Defining Mental Illness: Medical vs. Legal Perspectives

The American Psychiatric Association published the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) in 2013. The DSM-5 is rather unwieldy. It is approximately 1,000 pages long and lists over 300 kinds of mental disorders. These 300+ mental disorders are placed into 21 separate categories running the gamut of severity—from relatively minor disorders such as adjustment disorders to relatively severe disorders such as those involving dementia, psychosis, and neurodegenerative diseases.

DSM-5 offers one of the two major taxonomies of mental disorders. The other is the International Classification of Diseases (ICD-10), which is published by the World Health Organization. Because the DSM-5 and ICD-10 are so complicated, experts are needed to understand and apply them. As the DSM-5 states, "It requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges"<sup>12</sup> (see also Szmukler,

p. 141). Similarly, DSM-5 later states, "Use of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised."<sup>13</sup>

The DSM-5 defines *mental disorder* as follows:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual.<sup>14</sup>

At least two terms in this definition are necessarily vague: *significant* (twice) and *dysfunction* (twice). So are some exceptions to this definition: "[s]ocially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society" that are not the results of "a dysfunction in the individual."

Legal definitions of mental illness are quite different from the ones found in DSM-5 or ICD-10. While psychiatrists and psychologists must consider over 300 kinds of mental illnesses spanning the entire thousand-page DSM-5, law tends to focus only on that narrow part of the mental-illness spectrum that correlates with criminal activity or undermines consent. For example, Ohio's criminal code defines mental illness as a "substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgement, behavior, capacity to recognize reality or ability to meet the ordinary demands of life."<sup>15</sup> Importantly, the vast majority of mental illnesses in the DSM-5 fall short of this legal definition. Few of them either involve substantial impairment of judgment, of behavior, or of other domains of functioning or are associated with violent (or suicidal) behavior. Individuals diagnosed with, for example, a learning disability or an adjustment disorder are not necessarily likely to engage in dangerous behavior.

## 5. Why is Mental Illness Required for Involuntary Commitment?

Consider two scenarios. In "Suicidal Scenario," Suicidal Sam announces to his co-workers Connie and Clarence that he will hang himself after the close of business. When they laugh uncomfortably, he shows them a rope with a noose, tells them that he is quite serious, and asks them to make sure that he is cremated rather than buried. In "Homicidal Scenario," Homicidal Harry announces to the same co-workers, Connie and Clarence, that he is going to kill his superiors at a meeting the next morning. When they laugh uncomfortably, he shows them the loaded pistol that he legally purchased a week ago and the hole-riddled targets that he shot up at the local firing range. Both Suicidal Scenario and Homicidal Scenario are paradigmatic examples of danger to self and danger to others respectively.



The mere fact that Suicidal Sam threatened to commit suicide is not necessarily sufficient to warrant the conclusion that he suffers from mental illness. The notion that nobody “in her right mind” would prefer to die rather than to live is false. First, some individuals wish to die because they are terminally ill and suffering great physical pain. Their desire to die on their own terms and thereby minimize not only their own but also their family’s suffering is arguably quite rational. It is for this reason that the State may not force such individuals to receive life-saving medical treatment.<sup>16</sup> Second, some individuals who have just suffered great trauma—for example, losing a loved one, accidentally injuring or killing another person, or being accused or convicted of a serious crime—might be suicidal. Depending on the circumstances, their wanting to die in order to relieve themselves of great psychic pain (e.g., grief, guilt, or shame) may be rational enough that a diagnosis of mental illness would be inaccurate.<sup>17</sup>

For our purposes, however, assume that Suicidal Sam does not fit into either (rational) category. That is, he is suicidal not because he is terminally ill or because he just suffered great trauma but for a reason that society would consider irrational—that is, not strong enough to warrant a desire to die. (For example, Suicidal Sam is seriously distraught after his girlfriend broke up with him.) Suicidal Sam, then, probably qualifies as mentally ill. The question remains, however, why it matters whether or not Suicidal Sam is mentally ill. The fact that he is irrationally suicidal should be sufficient reason for conviction. Whether his suicidal impulses arise from mental illness or from something else—for example, nihilism or grief—should not matter. Suicide is suicide; it is such a tragic event that if the State has an opportunity to prevent it from occurring through involuntary commitment, it should be authorized to exercise this opportunity—again, whether or not the individual is mentally ill.<sup>18</sup>

Homicidal Harry’s situation is more difficult for the State.<sup>19</sup> He has a better chance of remaining free than does Suicidal Sam. Of course, the police may detain Homicidal Harry; ask him questions; and obtain a search warrant to search his person, office, home, and car. But if they cannot find any incriminating evidence—that is, evidence sufficient to warrant probable cause that Homicidal Harry has committed a crime—they cannot arrest him. The best that they can do is give him a stern warning, impose a restraining order on him (protecting his superiors), and then release him. This conclusion, however, assumes two things: (a) that Homicidal Harry’s purchase of a weapon, target practice, and stated intent of committing homicide do not, all together, qualify as attempted murder; and (b) that Homicidal Harry is not in one of the few jurisdictions that criminalize communications of intended violence against others even when the intended targets are not the recipients of these communications.<sup>20</sup>

Of course, the State may compel Homicidal Harry to undergo a psychological evaluation. And if the evaluation results in a determination that Homicidal Harry is mentally ill, then—given the danger that he poses to others—he may be involuntarily committed. But if the evaluation does not result in this determination, then—once again—the State’s hands are tied; they must release him. And in contrast to Suicidal Sam, whose irrational suicidal intent is generally considered to be presumptive, if not dispositive, evidence of mental illness (e.g., clinical depression), Homicidal Harry’s

homicidal intent will not necessarily lead to the same conclusion. This is a curious asymmetry that probably stems from the notion that while suicide is generally fundamentally irrational, homicidal behavior is (much) more “natural” and “normal.” As it turns out, this assumption may just be correct. There is a weaker correlation between mental illness and homicide than there is between mental illness and suicide.<sup>21</sup> The fact of the matter is that many more or less mentally stable people kill. Examples include domestic violence, bar fights, drug-turf battles, and drunk driving. Still, even if many “normal” people kill, certain kinds of abnormality heighten the probability of killing. The “risk of violence is three-fold among those with psychosis” and the predictors of violence include “acute psychiatric symptoms” (such as mania, depression, delusions, hallucinations, and violent fantasies), Antisocial Personality Disorder, and psychopathy (see Szmukler, pp. 133–34).<sup>22</sup>

One might very well argue that that the State *should* have the power to commit Homicidal Harry *whether or not* he is deemed mentally ill. The reason is that, even if he is not mentally ill, Homicidal Harry is very dangerous. He will likely kill at least one person *and* the person(s) he will kill presumably do(es) not wish to die.

We can think of four reasons why involuntarily committing Homicidal Harry requires him to be not merely dangerous but also mentally ill. First, the weakest reason: It might be thought that some sort of symmetry with the criminal justice system must be maintained. The idea is that if a criminal conviction roughly requires dangerousness (in the form of commission of a crime) and responsibility, then involuntary commitment requires dangerousness and *non*-responsibility. And non-responsibility just is, or is caused by, mental illness. But this hypothesis is problematic. Aside from the fact that not all crimes are necessarily dangerous (e.g., drug possession and perjury), it is not clear why there must be this symmetry with the criminal justice system in the first place. If a person makes clear that she poses a serious threat to others, then it should not matter whether this threatening disposition arises from mental illness or from some other cause. The threat is sufficient reason to commit her, and she should be released from commitment only after authorities determine that the threat has fully passed.

Second, mental illness is thought by some to increase the risk that Homicidal Harry will lose control or engage more readily in aggressive behavior. The problem with this hypothesis is that Homicidal Harry has already clearly exhibited homicidal intentions and (therefore) presents a serious enough risk that he will translate these intentions into action. So whether or not Homicidal Harry is mentally ill, the danger to others is quite real. Still, one might argue that if a person has demonstrated an inclination toward violence that is more ambiguous than Homicidal Harry’s, then we may not conclude that this person poses a threat to others unless she suffers from a mental illness (such as schizophrenia or psychosis) that increases the risk that this inclination will be realized. For *this* reason, mental illness is required for involuntary commitment. We believe that this argument is credible but leads to two undesirable consequences: (a) it rules out commitment of individuals who pose a clear and serious threat but are not mentally ill; and (b) by requiring mental illness, we perpetuate the myths that mental illness generally causes dangerousness and that dangerousness is generally caused by mental illness.

Third, it has been argued that if dangerousness alone were required, the State would too often be accused of labeling certain people as dangerous for ulterior reasons—not because they really are dangerous but because they are perceived as political opponents or threats whom the State wishes to silence and intimidate. By requiring mental illness as well, the State avoids this appearance of false pretext and creates the much more salutary impression that its sole reason for committing certain people is their own, and others', welfare.

Fourth, mental illness may be required in addition to dangerousness less from principle than from lack of resources. In a personal communication (dated August 31, 2014) to one of the authors, Ed Richards, Clarence W. Edwards Professor of Law and Director of the Program in Law, Science, and Public Health at LSU Law Center, put it this way:

After the deinstitutionalization movement, there are relatively few places to lock people up. There are lots of private beds for voluntary commitment (if you have insurance) but not even a lot of private beds for involuntary commitment. They do not want actually dangerous patients, and the state does not want to pay the costs of private facilities. ... Involuntary outpatient treatment has been the answer ... It is much less resource intensive. You do not need a facility.<sup>23</sup>

## 6. Conclusion: The Causal Epistemology Of Mental Illness

Unlike many complementary domains of medicine (e.g., virology), the causal mechanisms underlying mental illnesses are almost completely unknown. The little we know is that each of them is caused by a complicated interplay of genetic, neurobiological, and environmental factors. There are two reasons why we know so little.

First, there is no known genetic marker, neural signature, behavioral anomaly, or abnormal neuroanatomical structure that occurs in all, or often even most, patients with a specific mental illness. For example, only some individuals with schizophrenia suffer from gross impairments in reality testing. Moreover, symptoms of mental illness wax and wane over time. As a result, an individual diagnosed with schizophrenia may show impaired reality testing at one time, or in one context, but not another. Second, many of the symptoms associated with one particular mental illness are associated with other mental illnesses as well. For example, not only patients with schizophrenia but also patients with bipolar disorder and major depressive disorder suffer from gross impairments in reality testing.

Our etiological ignorance has fueled the development of new diagnostic approaches. Foremost among these is the Research Domain Criteria (RDoC) initiative that was undertaken by the National Institute of Mental Health, the world's largest funding agency for research in mental illness. The RDoC initiative is an attempt to (a) construct a "periodic table" of mental illness demarcating isolated domains of psychopathology; and (b) elucidate the genetic, biological, and environmental mechanisms that cause these domains to malfunction. While still in the initial stages, the RDoC initiative has already produced results. For example, measures of emotion

derived from automated acoustic analysis of natural speech are helping to predict episodes of anger and hostility and therefore will likely be useful in predicting individuals' risks of acting out.<sup>24</sup> Given its early successes and ambitious agenda, we are optimistic that RDoC will help us to discover other objective markers of mental illness; the biological processes underlying them; and new measures of, and treatments for, mental illness.

Still, it is important to realize that RDoC and related efforts are only in their infancy. In order for an RDoC approach to be applicable to civil commitment, the very definitions of consent, reality testing, suicidality, homicidality, and related constructs will need to be reduced to their most basic elements before they can be empirically evaluated and objective, reliable, and valid forensic measures of these elements can be developed. But all of this is much easier said than done. Reality testing and dangerousness to self or others are very difficult to deconstruct largely because the neural mechanisms that cause them are quite varied and differ both across individuals and within the same individuals across time. For example, impairments in reality testing can reflect dysfunctions in a range of basic cognitive, emotional, and/or impulse control systems, some or all of which may be present in a given individual at any given time. And even specific control systems are themselves difficult to measure. There is evidence, for example, that an important component of reality testing involves "insight." And while identifiable brain structures are associated with poor insight in schizophrenia,<sup>25</sup> insight itself is multidimensional in nature,<sup>26</sup> and different types of insight reflect different neurobiological mechanisms.<sup>27</sup>

## Notes

- 1 In the United States, the term is *Assisted Outpatient Treatment (AOT)*. See [www.treatment-advocacycenter.org/solution/assisted-outpatient-treatment-laws](http://www.treatment-advocacycenter.org/solution/assisted-outpatient-treatment-laws).
- 2 In some parts of the United States, danger to property, grave disability, and disorganized behavior also qualify.
- 3 We do not mean to limit the discussion to the United States or constitutional democracies. The UK, for example, is a parliamentary democracy, but it equally respects and protects the same due process rights. So by *constitutional rights*, we should be understood to mean due process rights generally.
- 4 Letter of the President of the Federal Convention, Dated September 17, 1787, to the "President of Congress, Transmitting the Constitution." See [http://avalon.law.yale.edu/18th\\_century/translet.asp#1](http://avalon.law.yale.edu/18th_century/translet.asp#1).
- 5 See generally Kevin Bennardo, "Incarceration's Incapacitative Shortcomings," *Santa Clara Law Review* 54.1: 1–18 (2014).
- 6 See *Varholy v. Sweat*, 153 Fla. 571, 576 (1943) ("The constitutional guarantees of life, liberty and property, of which a person cannot be deprived without due process of law, do not limit the exercise of the police power of the State to preserve the public health so long as that power is reasonably and fairly exercised and not abused. ... Not only must every reasonable presumption be indulged in favor of the validity of legislative action in this important field, but also in favor of the validity of the regulations and actions of the health authorities."); In the Matter of the Application of Mrs. A. Arata for a Writ of Habeas Corpus, 52 Cal.App. 380, 383 (1921) ("That the health authorities possess the power to place under quarantine restrictions persons whom they have reasonable cause to believe are afflicted with infectious or contagious diseases ... as a general right, may not be questioned. It is equally true that in the exercise of this unusual power, which infringes upon the right

of liberty of the individual, personal restraint can only be imposed where, under the facts as brought within the knowledge of the health authorities, reasonable ground exists to support the belief that the person is afflicted as claimed.”); Edward P. Richards and Katharine C. Rathbun, “Making State Public Health Laws Work for SARS Outbreaks,” *Emerging Infectious Diseases* 10.3: 356 (Feb. 2004) (“In the case of quarantine due to disease, a judge would determine whether the state has shown that the detained person deserves quarantine. The judge must defer to public health authorities on their choice of public health strategies.”) (footnote omitted).

- 7 See *Kansas v. Hendricks*, 521 U.S. 346, 347, 363, 372 (1997); *Heller v. Doe*, 509 U.S. 312, 314–15 (1993). In cases of civil commitment, it is necessary to demonstrate both a temporal and causal link between the mental illness and the dangerous behavior. If a person exhibits dangerous behavior but this danger is not related to her mental illness, then she does not qualify for commitment. For example, an individual diagnosed with schizophrenia—defined in part by gross impairments in judgment, reality testing, and functioning—may present as homicidal for reasons that do not pertain to her manifest diagnosis. Conversely, a soldier that has returned from combat and meets criteria for Post-Traumatic Stress Disorder—a disorder not typically associated with the level or type of impairment characteristic of legally defined mental illness—*would* be appropriate for commitment if she were displaying grossly disorganized and aggressive behavior secondary to flashbacks.
- 8 The Centers for Disease Control and Prevention website states: “Isolation is used to separate ill persons who have a communicable disease from those who are healthy. Isolation restricts the movement of ill persons to help stop the spread of certain diseases. For example, hospitals use isolation for patients with infectious tuberculosis. Quarantine is used to separate and restrict the movement of well persons who may have been exposed to a communicable disease to see if they become ill. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. Quarantine can also help limit the spread of communicable disease.” See [www.cdc.gov/quarantine/aboutlaws/regulationsquarantineisolation.html](http://www.cdc.gov/quarantine/aboutlaws/regulationsquarantineisolation.html).
- 9 See *ibid.* (“The federal government derives its authority for isolation and quarantine from the Commerce Clause of the U.S. Constitution. Under section 361 of the Public Health Service Act (42 U.S. Code § 264), the U.S. Secretary of Health and Human Services is authorized to take measures to prevent the entry and spread of communicable diseases from foreign countries into the United States and between states. The authority for carrying out these functions on a daily basis has been delegated to the Centers for Disease Control and Prevention (CDC). ... States have police power functions to protect the health, safety, and welfare of persons within their borders. To control the spread of disease within their borders, states have laws to enforce the use of isolation and quarantine. These laws can vary from state to state and can be specific or broad. In some states, local health authorities implement state law. In most states, breaking a quarantine order is a criminal misdemeanor. ... Centers for Disease Control and Prevention are charged with enforcement of federal laws authorizing isolation and quarantine.”). *But see* Edward P. Richards, “The Jurisprudence of Prevention: The Right of Societal Self-Defense Against Dangerous Individuals,” *Hastings Constitutional Law Quarterly* 16.3: 329, 337 n.38 (1989) (attributing the States’ constitutional power to quarantine not to “any power which the States assume to regulate commerce or to interfere with the regulations of Congress, but because police laws ... must of necessity have full and free operation, according to the exigency which requires their interference.”) (citing *Thurlow v. Massachusetts (The License Cases)*, 46 U.S. (5 How.) 504, 632 (1847)).
- 10 Just being mentally ill is also not sufficient for involuntary commitment. There are two reasons. First, if it were sufficient, then—given that over a quarter of the adult population suffer from a diagnosable mental illness in a given year (see [www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml](http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml))—the constitutional presumption of liberty would be rendered meaningless. Second, there is no point. The vast majority of

- mentally ill individuals are not threats to themselves or others. So the economic and non-economic costs of involuntarily committing them would far outweigh the benefits, if any.
- 11 The U.S. Center for Disease Control (CDC) reports that the overall suicide rate is twice the overall homicide rate and twice to three times the homicide rate for adults over 25 years old. See [www.cdc.gov/mmwr/preview/mmwrhtml/mm6128a8.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6128a8.htm). One explanation for this disparity might be that homicide is more difficult than suicide. While suicide involves killing a willing participant, homicide does not.
  - 12 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed, Washington DC: American Psychiatric Association, 2013, p. 19.
  - 13 *Ibid.*, p. 25.
  - 14 *Ibid.*, p. 20.
  - 15 Ohio's Revised Code (ORC) § 5122.01(A).
  - 16 See Ken Levy, "Gonzales v. Oregon and Physician-Assisted Suicide: Ethical and Policy Issues," *Tulsa Law Review* 42.3 (2007): 699, 701.
  - 17 See American Psychiatric Association, *DSM-5*, xlii (improving upon the *DSM-IV* by "differentiating bereavement and major depressive disorders").
  - 18 It is possible that the mental-illness requirement for civil commitment to prevent suicide is meant to distinguish between individuals who only seem suicidal and individuals who really are suicidal. This possibility rests on the assumption that mental illness dramatically raises the risk that an unhappy person will follow through on her (stated) intention to commit suicide, an assumption that is supported by the fact that suicide is highly comorbid with mental illness. See [www.afsp.org/understanding-suicide/key-research-findings](http://www.afsp.org/understanding-suicide/key-research-findings) ("[S]tudies have consistently found that the overwhelming majority of people who die by suicide—90% or more—had a mental disorder at the time of their deaths. Still, suicidal behavior is usually difficult to predict unless imminent risk factors are present."); <http://ajp.psychiatryonline.org/article.aspx?articleid=170454> ("In young men, completed suicide is linked to specific mental disorders, namely, major depression, borderline personality disorder, and substance abuse. Comorbidity involving any of these disorders is frequently associated with completed suicide."); [www.ncbi.nlm.nih.gov/pubmed/8678167?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_DiscoveryPanel.Pubmed\\_Discovery\\_RA&linkpos=1&log\\$=relatedarticles&logdbfrom=pubmed](http://www.ncbi.nlm.nih.gov/pubmed/8678167?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=1&log$=relatedarticles&logdbfrom=pubmed) ("[R]isk for suicide increases with age in individuals with major affective illness.").
  - 19 For a more extended discussion of the same issue, see Ken Levy, "Dangerous Psychopaths: Criminally Responsible But *Not* Morally Responsible, Subject to Criminal Punishment And to Preventive Detention," *San Diego Law Review* 48.4 (2011): 1299, 1382–92.
  - 20 See *ibid.* at 1384 n.187.
  - 21 See *supra* note 16. When we control for socio-economic status, gender, substance abuse, and other variables, we find that the contribution that mental illness makes to violent crimes is much smaller than the contribution that it makes to suicide. While a significant number of incarcerated individuals in the United States have mental illnesses, there is not necessarily a causal link. In many cases, their crimes are caused more by deinstitutionalization than mental illness *per se*. See [http://depts.washington.edu/mhreport/facts\\_violence.php](http://depts.washington.edu/mhreport/facts_violence.php).
  - 22 See also <http://www.forensicpsychiatry.ca/risk/assessment.htm>.
  - 23 Cf. [www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Outpatient-and-Civil-Commitment.aspx](http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Outpatient-and-Civil-Commitment.aspx). ("The Bazelon Center opposes outpatient commitment. There is no evidence that it improves public safety. ... When people are dangerous due to mental illnesses, they should be hospitalized. ... Outpatient commitment is not a quick-fix that can overcome the inadequacies of under-resourced and under-performing mental health systems.")
  - 24 See [www.ncbi.nlm.nih.gov/pubmed/23444120](http://www.ncbi.nlm.nih.gov/pubmed/23444120).
  - 25 See [www.ncbi.nlm.nih.gov/pubmed/22664168](http://www.ncbi.nlm.nih.gov/pubmed/22664168).
  - 26 See [www.ncbi.nlm.nih.gov/pubmed/23407202](http://www.ncbi.nlm.nih.gov/pubmed/23407202).
  - 27 See [www.ncbi.nlm.nih.gov/pubmed/17671876](http://www.ncbi.nlm.nih.gov/pubmed/17671876).

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