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Risky Business versus Overt Acts: What Relevance Do Actuarial, Probabilistic Risk Assessments Have for Judicial Decisions on Involuntary Psychiatric Hospitalization

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RISKY BUSINESS VERSUS OVERT ACTS: WHAT RELEVANCE DO "ACTUARIAL," PROBABILISTIC RISK ASSESSMENTS HAVE FOR JUDICIAL DECISIONS ON INVOLUNTARY PSYCHIATRIC HOSPITALIZATION?

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I. INTRODUCTION

All jurisdictions[1] in the United States have statutory provisions for forcing persons with serious mental illnesses to undergo psychiatric hospitalization. Although statutory wording and criteria vary from state to state, U.S. laws governing "traditional" mental health commitments[2] typically permit judicial authorities to order confine-

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1 *See* Heller v. Doe, 509 U.S. 312, 327 n.2 (1993) (listing statutes); *see also infra* Part IV-B.

2 This Article focuses on "traditional" mental health commitments, that is, involuntary hospi-

ment of individuals who have serious or "substantial" mental disorders that cause "gross" impairments in their functioning, but only if "clear and convincing" evidence[3] shows that those individuals pose risks of harm to themselves or others.[4]

During civil commitment hearings, a portion of the evidence supporting involuntary hospitalization sometimes comes from nonprofessional fact witnesses—family members or acquaintances of the respondent, or law enforcement officers—who testify about aspects

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talization of persons traditionally viewed as needing treatment for severe mental illness. Such persons typically have psychoses (severe disturbances of thinking) or affective disorders that grossly compromise their ability to perform everyday living tasks. Examples of such conditions include schizophrenia and bipolar disorder. Our use of "traditional" to describe mental health commitments follows John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 395, 433–34 (2006). Professor Monahan, a psychologist, uses the term "traditional" to express the view held by most mental health professionals that mental health commitments differ importantly from the indefinite confinement of sex offenders allowed by more than twenty U.S. jurisdictions following completion of a prison term. In upholding sex offender commitments as a constitutional use of state power, the U.S. Supreme Court did not recognize this distinction. *See* Kansas v. Hendricks, 521 U.S. 346, 357–58 (1997) (Kansas sex offender commitment statute was "plainly of a kind with" mental health commitment laws because it "require[d] a finding of . . . dangerousness" caused by "a 'mental abnormality' or 'personality disorder' that makes it difficult, if not impossible, for the person to control his dangerous behavior").

We also note that this Article focuses on criteria for inpatient hospitalization. Forty-four U.S. jurisdictions permit courts to order "outpatient commitment" under statutes that require individuals to obtain psychiatric treatment while they live in the community. Marvin S. Swartz et al., *Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program*, 61 PSYCHIATRIC SERVICES 976, 976 (2010). Often, the statutory requirements permitting outpatient commitment are less stringent than those governing involuntary hospitalization. *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.60(9)(c) (McKinney 2006) (criteria for assisted outpatient treatment require having a mental illness, likelihood of not being safe or participating in voluntary treatment, likelihood of relapse, previous noncompliance with treatment, two hospitalizations in last thirty-six months, and violence or threats in the past four years); MICH. COMP. LAWS § 330.1401(d) (West 2010) (listing criteria for assisted outpatient treatment that differ from criteria for involuntary hospitalization).

3 To satisfy due process, the minimum burden of proof applicable to a civil commitment case is "'clear and convincing' evidence." Addington v. Texas, 441 U.S. 418, 431, 433 (1979) ("[T]he precise burden [must be] equal to or greater than the 'clear and convincing' standard . . . .").

4 *See* Ohio's definition as an example: "'Mental illness' means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life." OHIO REV. CODE ANN. § 5122.01(A) (LexisNexis 2008).

of the respondent's behavior that concerned them and that led to initiation of the civil commitment process.[5] In most cases, however, the crucial evidence bearing on legal satisfaction of commitment criteria comes from mental health professionals,[6] for only their expert opinion can establish whether the respondent has a mental disorder, the connection between the disorder and the respondent's troublesome behavior, and the relationship between the disorder and the respondent's risk to others or himself.[7]

When twenty-first century healthcare professionals think or talk about "risk," they typically refer to (or, at least, implicitly mean) a *probability* that some *future* event will occur. In common medical usage, "risk" and "probability" have connotations related to group statistics and beliefs about individuals' health outcomes. To take a familiar example, when physicians say that cigarette smoking raises the risk of death from cancer or coronary artery disease, they refer to studies of large groups of smokers and non-smokers showing that the proportion of smokers who die from these conditions is larger than the proportion of non-smokers.[8] Physicians also use large-group trends, patient-specific factors, and clinical intuition to make risk and probability statements in individual cases. Thus, a physician might tell a patient that smoking heightens his chance of dying from cancer or heart disease.[9] In both the group and individual cases, health pro-

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5 *See, e.g., In re* Katz, 638 A.2d 684, 686–87 (D.C. Cir. 1994) (discussing testimony of officers).

6 *Addington*, 441 U.S. at 429 ("Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists.") (emphasis in original).

7 Almost all states' commitment statutes specify that hospitalization may occur only because of dangerousness that stems from mental illness. *See, e.g.*, ALASKA STAT. § 47.30.735(c) (2010) (commitment requires clear and convincing evidence that respondent is mentally ill and as a result is likely to come to harm).

8 The voluminous data supporting these judgments appear in U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION, THE HEALTH CONSEQUENCES OF SMOKING, http://www.cdc.gov/tobacco/data_statistics/sgr/2004/complete_report/index.htm (last visited March 20, 2011).

9 Under the frequency interpretation of probability, such single-case situations must be considered to lie within some sort of collective "long sequence of observations." RICHARD VON MISES, PROBABILITY, STATISTICS, AND TRUTH 15 (Hilda Geiringer trans., 2nd rev. ed. 1957). Under a "subjective" view, however, the interpretation of single cases is much more straightforward, and refers to an individual's rational betting decisions. For an introduction,

fessionals' discussions of risks concern *outcomes* that have *not yet* happened but *may* do so.

Mental health professionals apply similar probabilistic conceptions when thinking about the types of risks of harm that are relevant to civil commitment. Over the past two decades, for example, several teams of psychologists have developed "actuarial risk assessment instruments" (ARAIs)[10] to aid in quantifying the level of risk—that is, the probability—that an evaluee will engage in certain kinds of violent behavior during specified future periods of time. These instruments get the name "actuarial" because they implement a judgment process similar to methods used by insurance companies to assess probabilities of certain events (e.g., deaths) and to make decisions about premiums (e.g., for life insurance).[11] In both cases, an actuarial judgment of risk is based on the presence or absence of a limited number of pre-specified factors with known, empirically established relationships to an outcome. Although the scope and implementation styles of ARAIs vary, they generally direct mental health professionals to gather information about a specific set of "risk factors"—informational items known to affect the likelihood of violence.[12] The evaluator then assigns numerical values to these factors according to some preset formula to produce an estimate of risk—a numerical probability—that the evaluee will act violently during a specified

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see RICHARD JEFFREY, SUBJECTIVE PROBABILITY: THE REAL THING 1-28 (2002). In this article, we assume that it makes sense to think of probabilities as applying to individual cases (respondents). For additional discussion of philosophical limits of these positions, *see* Alan Hájek, *Interpretations of Probability*, STAN. ENCYCLOPEDIA OF PHIL. (Dec. 31, 2009), http://plato.stanford.edu/entries/probability-interpret/ (last visited Nov. 21, 2010).

10 This abbreviation comes from Stephen D. Hart et al., *Precision of Actuarial Risk Assessment Instruments: Evaluating the 'Margins of Error' of Group v. Individual Predictions of Violence*, 190 BRIT. J. PSYCHIATRY s60, s60 (2007).

11 Robyn M. Dawes et al., *Clinical Versus Actuarial Judgment*, 243 SCI. 1668, 1668 (1989). We further discuss this judgment method *infra* Section III-C.

12 "A risk factor is a measurable *characterization* of each *subject* in a specified *population* that precedes the *outcome* of interest and which can be used to divide the population into two groups (the high-risk and the low-risk groups that comprise the total population)." Helena C. Kraemer et al., *Coming to Terms with the Terms of Risk*, 54 ARCHIVES GEN. PSYCHIATRY 337, 338 (1997) (emphasis in original). Note that this definition does not imply that the risk factor *causes* the outcome of interest. Epidemiologists term something a *causal* risk factor if it is a "variable risk factor that can be shown to be manipulable and, when manipulated, can be shown to change the risk of the outcome." *Id.* at 340.

span of time.[13]

Thus framed, the assessment problem that ARAIs address reflects the increasing influence of financial thinking on what we mean when, in ordinary parlance, we speak of risk. We often think about assessing risk—making judgments about the probability of an outcome and the magnitude of its consequences—for purposes of deciding how to manage, avert, or insure ourselves against it, a conceptualization that reflects a decidedly economic perspective on risk.[14] As operationalized in finance, risk relates to variation in actual investment returns around an expected return.[15] More generally, we now tend to perceive and speak of risk as "exposure to a proposition of which one is uncertain" but for which the outcome has practical importance to us, especially if the outcome involves physical or financial harm.[16]

This notion of "risk" as something future and probabilistic differs subtly but importantly from an older and more traditional usage of "risk" often encountered in criminal law. In discussing the law on criminal negligence, for example, a Texas court notes, "Criminal negligence involves inattentive risk creation. The key to criminal negligence is the failure of the actor to perceive the risk created by his conduct. Before a charge on criminally negligent homicide is required, the record must contain evidence showing an unawareness of the risk."[17] Here, the idea that risk is "created" speaks to something physically present as a result of behavior, rather than to a possibility or probability. Similarly, the Model Penal Code states, "A person acts recklessly . . . when he consciously disregards a substantial and unjustifiable risk that . . . exists or will result from his conduct. The risk must be of such a nature and degree that . . . its disregard involves a gross deviation from the standard of conduct [of] a law-abiding per-

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13 *See id.* at 338-39.

14 Such is the motivation for what has become known as "modern portfolio theory." Harry M. Markowitz, *Foundations of Portfolio Theory*, 46 J. FIN. 469, 469 (1991).

15 ASWATH DAMODARAN, STRATEGIC RISK TAKING: A FRAMEWORK FOR RISK MANAGEMENT 6 (Upper Saddle River: Wharton School Publishing 2008).

16 Glyn A. Holton, *Defining Risk*, 60 FIN. ANALYSTS J. 19, 22 (2004).

17 Jackson v. State, 248 S.W.3d 369, 371-72 (Tex. App. 2007) (citations omitted).

son . . . ."[18] Note again that the "risk" is something either *present* in the circumstances that the actor should perceive and respond to, or *inherent* in the actor's *current* behavior. That is, risk is a feature of the situation that the actor can create or fail to heed.

A similar risk-as-present connotation informs "assumption of risk" doctrine in tort law. In a leading case on this topic, the California Supreme Court observes that, although persons generally are obligated to exercise "due care to avoid injury to others," in some situations, such as sporting events:

> conditions or conduct that otherwise might be viewed as dangerous often are an integral part of the sport itself. Thus, although moguls on a ski run pose a risk of harm to skiers . . . the challenge and risks posed by the moguls are part of the sport of skiing, and a ski resort has no duty to eliminate them . . . . [Similarly, i]n some situations, . . . the careless conduct of others is treated as an 'inherent risk' of a sport, thus barring recovery by the plaintiff. . . . [Courts should not] hold a sports participant liable to a coparticipant for ordinary careless conduct committed during the sport . . . [because] in the heat of an active sporting event . . . , a participant's normal energetic conduct often includes accidentally careless behavior.[19]

Here, danger and risk are "integral" or "inherent" in an activity, and the risk of encountering harm is created for or applied to oneself—that is, "assumed"—through one's presence or participation. As in the criminal contexts just discussed, the risk is presented by (and present in) current circumstances or activities.

What about "risk" for purposes of civil commitment? In the 1970s and 1980s, the "present risk" concept seemed to dominate the development of mental health commitment law. During an era of statutory revision and legal decisions that some commentators have termed the "criminalization" of civil commitment,[20] several jurisdictions required that the respondent have committed an "overt act"—actual harm, attempted harm, or threatened harm in some form—as a

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18 MODEL PENAL CODE § 2.02(2)(c) (1962).

19 Knight v. Jewett, 834 P.2d 696, 708, 710 (Cal. 1992).

20 Paul S. Appelbaum, *Civil Commitment: Is the Pendulum Changing Direction?*, 33 HOSP. & COMMUNITY PSYCHIATRY 703, 703 (1982); S. Jan Brakel, *Competency to Stand Trial: Rationalism, "Contextualism" and Other Modest Theories*, 21 BEHAV. SCI. & L. 285, 294 (2003).

condition of involuntary hospitalization.[21] Just as in criminal and tort law, proof of some threatened or actual injury is required, no matter how serious a respondent's illness or how concerning the possibility of future harm might seem.

In the last few years, however, scholars from both legal and mental health backgrounds have suggested a contrasting view: properly grounded evidence for—and hence, legal determinations of—risk for civil commitment should reflect the probabilistic information generated by scientifically developed ARAIs:

- Psychologists Joel Dvoskin and Kirk Heilbrun advise their colleagues that if courts seek "the best available prediction of violence risk, . . . one should rely on an applicable actuarial tool."[22]
- Attorney Susan Stefan has argued forcefully that risk assessment instruments should function as a check against overuse of hospitalization.[23]
- In a series of articles, Professor John Monahan[24] has described, advocated, and explored the implementation of civil commitment decision-making schemes based on scientifically estimated probabilities of future violence.
- In discussing the relevance of ARAIs in "clinical practice," psychiatrist Alec Buchanan assumes that such an instrument might "be used in civil commitment determinations" if "its predictive validity" were "established . . . in relation to the kind of behavior occurring sufficiently close to the point of discharge that, had it been foreseen, would have justified continued hospitalization."[25]

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21 *See infra* Part IV-B for still-existing statutory examples.

22 Joel A. Dvoskin & Kirk Heilbrun, *Risk Assessment and Release Decision-Making: Toward Resolving the Great Debate*, 29 J. AM. ACAD. PSYCHIATRY & L. 6, 9 (2001).

23 SUSAN STEFAN, EMERGENCY DEPARTMENT TREATMENT OF THE PSYCHIATRIC PATIENT: POLICY ISSUES AND LEGAL REQUIREMENTS 73 (Oxford Univ. Press 2006).

24 For more than three decades, Professor Monahan has been regarded as "the leading thinker" on violence prediction. Barefoot v. Estelle, 463 U.S. 880, 899 n.7 (1983) (quoting State's expert and citing JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 47–49 (1981) [*hereinafter* MONAHAN, CLINICAL PREDICTION]). Among the many other decisions that cite his work are Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 344 n.10 (Cal. 1976) and Heller v. Doe, 509 U.S. 312, 323 (1993).

25 Alec Buchanan, *Risk of Violence by Psychiatric Patients: Beyond the "Actuarial Versus Clinical" Assessment Debate*, 59 PSYCHIATRIC SERVICES 184, 188 (2008).

- Psychologists Nicholas Scurich and Richard John have explored ways that "framings" of information based from ARAIs might affect decisions about civil commitment—a study in which the authors assume "that the way the probability is framed will be consequential for involuntarily civil commitment decisions."[26]

Writers cited in the preceding paragraphs assume that civil commitment decision-makers will accept and embrace scientifically supported statements of risk-as-probability. But if faced with such information, should courts actually respond this way? More specifically, would it be legally appropriate for a court to order the involuntary hospitalization of a respondent who had committed no overt act of violence solely because an ARAI established an elevated probability of violence? In this Article, we suggest this answer: "In some jurisdictions, maybe; in most jurisdictions, probably not." To our knowledge, just a few written decisions mention the use of an ARAI in "traditional" mental health commitment cases, and no decision has expressly relied on or endorsed ARAI-based information as the determinative factor in favor of commitment.[27] As this Article shall show, only a minority of states have statutory language that appears broad enough to let ARAI-based evidence be the chief justification for ordering involuntary psychiatric hospitalization.

We proceed as follows. In Part II, we provide a short review of the development of civil commitment case law and statutory provisions therein, particularly the "overt act" requirement. In Part III, we explain the development and status of ARAIs potentially relevant to civil commitment. Our Article's chief contribution comes in Part IV, in which we examine U.S. commitment statutes and related case law as it might bear upon use of ARAIs to justify involuntary hospitalization. In Part V, we summarize the implications of these findings for future use of ARAI-based probabilities as supportive evidence in favor of involuntary psychiatric hospitalization.

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26 Nicholas Scurich & Richard S. John, *The Effect of Framing Actuarial Risk Probabilities on Involuntary Civil Commitment Decisions*, L. & HUM. BEHAV. 3 DOI 10.1007/s10979-010-9218-4 (published online Feb. 10, 2010). In a related article, these authors assume that commitment decisions would be based on risk that exceeds a particular probabilistic threshold. Nicholas Scurich & Richard John, *The Normative Threshold for Psychiatric Civil Commitment*, 50 JURIMETRICS J. 425, 425 (2010).

27 We discuss these *infra* Section IV-A.

II. DEVELOPMENT OF MODERN CIVIL COMMITMENT STATUTES

A. Mental Health Commitment Before the 1960s

In 1961, the American Bar Association published an analysis of then-existing state statutes governing involuntary hospitalization.[28] In the late 1950s, just seven states required some sort of dangerousness (to self, others, or property) as justification for involuntary hospitalization.[29] In twenty-two states, simply needing care or treatment was sufficient grounds, and seven other states permitted commitment if it seemed necessary for the patient's welfare or the welfare of others.[30] Massachusetts permitted commitment of persons deemed "likely" to violate "the established laws, ordinances, conventions, or morals of the community."[31] Seventeen states had *no* specific statutory criteria for commitment, apparently leaving the choice of rationale entirely to legal decision-makers.[32]

Moreover, the legal mechanisms that led to mental health commitments gave respondents few procedural protections. In twelve states, a commitment decision could take place without a judge's order (though a court might later review the decision).[33] Instead, administrative tribunals of varying composition—sometimes made up of just two physicians, sometimes including physicians and other officers—made decisions about involuntary hospitalization that a court might later review.[34] Fewer than half the states required that persons receive notice of the hearing on their involuntary hospitalization.[35] Just seventeen states made legal representation available to individu-

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28 FRANK T. LINDMAN & DONALD M. MCINTYRE, THE MENTALLY DISABLED AND THE LAW, REPORT OF THE AMERICAN BAR FOUNDATION 4 (1961).

29 *Id.* at 44–51 (tables).

30 *Id.* at 49–51.

31 MASS. GEN. LAWS ANN. ch. 123, § 1 (1957).

32 LINDMAN & MCINTYRE, *supra* note 28, at 49–51 (tables showing no specified criteria for CO, DE, KY, MD, MI, MS, NE, NJ, NY, NC, ND, SD, UT, VT, VA, WV, and WY).

33 *Id.* (tables showing no specific criteria for CO, DE, MD, MS, NE, NC, ND, SD, VT, VA, WV, and WY).

34 *Id.* at 63–65 (tables).

35 *Id.* at 49–51, 56–59, 63–65 (tables).

als facing commitment proceedings (with only fifteen states specifying arrangements for attorney compensation).[36] The standard of proof by which courts needed to evaluate evidence was largely unspecified.

B. Changes in Commitment Statutes

At the time, civil commitment often meant confinement for several months or years at state mental hospitals where, with few exceptions, patients typically received "care" that was at best custodial and at worst abominable.[37] Revelations about conditions in state hospitals, concerns about costs of housing patients, and the advent of effective psychotropic medications, led, in the 1960s, to a changing public perception of mental illness and its treatment.[38] In response, state leg-

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36 *Id.* The U.S. Supreme Court had not yet established a constitutional guarantee of appointed counsel for indigent felony defendants, let alone persons charged with lesser criminal offenses that might lead to confinement. *See* Argersinger v. Hamlin, 407 U.S. 25, 37 (1972) ("[A]bsent a knowing and intelligent waiver, no person may be imprisoned for any offense, whether classified as petty, misdemeanor, or felony, unless he was represented by counsel at his trial."); Gideon v. Wainwright, 372 U.S. 335, 344–45 (1963).

37 In a 1958 presidential address to the American Psychiatric Association, Dr. Harry Solomon told his colleagues that these institutions were "antiquated, outmoded, and rapidly becoming obsolete.... [T]hey are bankrupt beyond remedy. I believe, therefore, that our large mental hospitals should be liquidated as rapidly as can be done...." Harry C. Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, Presidential Address, 115 AM. J. PSYCHIATRY 1, 7 (July 1958).

In 1961, Albert Deutsch gave a U.S. Senate committee this stark description of state hospital patients' living conditions:

> Some physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed and treated than many of the patients on their wards. I saw hundreds of sick people shackled, strapped, straitjacketed, and bound to their beds. I saw mental patients forced to eat meals with their hands because there were not enough spoons and other tableware to go around.... I found evidence of physical brutality, but that paled into insignificance when compared with the excruciating suffering stemming from prolonged, enforced idleness, herdlike crowding, lack of privacy, depersonalization, and the overall atmosphere of neglect.

Constitutional Rights of the Mentally Ill, HEARINGS BEFORE THE SENATE SUBCOMMITTEE ON CONSTITUTIONAL RIGHTS OF THE COMMITTEE OF THE JUDICIARY, 87th Congress, 2nd Session at 40–41 (1961).

38 David A. Rochefort, *Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963*, 9 J. HEALTH POL. POL'Y & L. 2, 4–6, 20 (1984).

islatures rewrote commitment laws to encourage community treatment rather than institutionalization.[39] The most significant of these laws, California's Lanterman-Petris-Short Act (LPS), expressly aimed "to end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons."[40] LPS ultimately "shaped a generation of commitment statutes across the country"[41] that reflected an emerging social consensus: institutionalized mental patients—along with other previously marginalized groups—should enjoy the full benefits of U.S. civil rights protections.

Passage of these statutes coincided with several court decisions[42] that elaborated the substantive and procedural due process rights of individuals subject to civil commitment. For present purposes, the most significant of these cases is *Lessard v. Schmidt*,[43] a 1972 Wisconsin federal district court decision that sparked a nationwide transformation in civil commitment statutes. The case centered on the autumn 1971 hospitalization of Alberta Lessard following *ex parte* proceedings of which she never received notice.[44] With the help of Milwaukee Legal Services, Miss Lessard brought a federal class action suit seeking to prevent enforcement of Wisconsin's involuntary

39 *See, e.g.*, Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE § 5001 (West 2010).

40 *Id.* at §5001(a).

41 Paul S. Appelbaum, *Ambivalence Codified: California's New Outpatient Commitment Statute*, 54 PSYCHIATRIC SERVICES 26, 26 (2003).

42 *See, e.g.*, Lake v. Cameron, 364 F.2d 657, 661 (D.C. Cir. 1966) (requiring trial court to consider whether "other alternative courses of treatment" or interventions less restrictive than hospitalization might suffice); O'Connor v. Donaldson, 422 U.S. 563, 576 (1975) ("a State cannot constitutionally confine without more [justification] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."); Wyatt v. Stickney, 325 F.Supp 781 (M.D. Ala. 1971), 334 F.Supp. 1341 (M.D. Ala. 1971), 344 F.Supp. 373 (M.D. Ala. 1972), *aff'd sub. nom.*; Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (finding a right to treatment and imposing rules for its implementation); Addington v. Texas, 441 U.S. 418, 432–433 (1979) (Constitution requires "clear and convincing" proof of elements of commitment); Vitek v. Jones, 445 U.S. 480, 494 (1980) (State may not classify a convict as mentally ill and "subject him to involuntary psychiatric treatment without affording him additional due process protections"); Jackson v. Indiana, 406 U.S. 715, 738 (1972) (duration of commitment must bear a reasonable relationship to the purpose of commitment).

43 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974), *on reh'g*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

44 *Id.* at 1081.

commitment statute.[45]

Noting that civil commitment entailed consequences[46] at least as significant as those that followed criminal conviction, the *Lessard* court ruled that to commit someone, the state must prove beyond a reasonable doubt that the person was mentally ill and "that if the person is not confined he will do immediate harm to himself or others."[47] Civil commitment might be justified only if an individual had committed "a recent overt act, attempt or threat to do substantial harm to oneself or another."[48] Even then, someone who had tried to kill himself should not be committed unless he still posed an "immediate danger at the time of the hearing of doing further harm to [him]self."[49] In addition to requiring "proof beyond a reasonable doubt" of criteria for commitment, *Lessard* held that persons facing potential involuntary hospitalization were entitled to several other constitutional protections afforded to accused criminals.[50] Although *Lessard* was binding only in Wisconsin, it became the impetus for several other courts and many state legislatures to revise commitment laws such that an "overt act" would be required to demonstrate dangerousness.[51]

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45 *Id.* at 1082.

46 At the time, these included loss of the ability to make contracts, restrictions on professional licenses, loss of the right to vote and marry, and even a prohibition against driving. "In some respects," said the *Lessard* court, "the civil deprivations which follow civil commitment are more serious than the deprivations which accompany a criminal conviction." *Id.* at 1088-89.

47 *Id.* at 1093, 1095.

48 *Id.* at 1093.

49 *Id.* at 1093 n.24.

50 These conditions included prompt notice of the allegations justifying the detention; a probable cause hearing within 48 hours of detention; a full hearing on commitment within two weeks; representation by counsel; a hearsay prohibition; a privilege against "self-incrimination" (i.e., a warning that statements made to evaluators could be used to support commitment); and requiring that those seeking hospitalization consider other, less restrictive alternatives. *Id.* at 1103.

51 Reed Groethe, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 (1977); *see also* Douglas S. Stransky, Comment: Civil Commitment and the Right to Refuse Treatment: Resolving Disputes from a Due Process Perspective, 50 U. Miami L. Rev. 413, 419 (1996).

C. Current requirements of commitment criteria

Although some statutes have undergone modification over the last two decades, public safety is still the dominant rationale for mental health commitments. What is often termed "dangerousness" in statutes and court decisions remains the primary emphasis in commitment proceedings, coupled with a showing that a "substantial mental disorder" is the cause of the dangerousness.

1. Mental Disorder

Most (if not all) major legal decisions dealing with civil commitment treat having a mental disorder as a requirement so fundamental and obvious that it is left unstated.[52] Civil commitment statutes define mental disorder in a wide variety of ways,[53] but in most states, the definition does not refer to recognized psychiatric diagnoses or use medical terminology. For example, Michigan law specifies that commitment requires "a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life."[54] Diagnostic

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[52] David W. Burgett, *Substantive Due Process Limits on the Duration of Civil Commitment for the Treatment of Mental Illness*, 16 HARV. C.R.-C.L. L. REV. 205, 223 n.84 (1981). In a 1972 decision that sets limits on pre-trial commitment for restoration of adjudicative competence, the U.S. Supreme Court accepts as a given that states "have traditionally exercised broad power to commit persons found to be mentally ill." Jackson v. Indiana, 406 U.S. 715, 736 (1972).

[53] Some jurisdictions' definitions of mental illness are circular. For example, New York law defines "mental illness" as "an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation," N.Y. MENTAL HYG. LAW § 1.03(20) (2006), and that needing care and treatment "means that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate," N.Y. MENTAL HYG. LAW § 9.01 (20) (2006).

[54] MICH. COMP. LAWS ANN. §330.1400(g) (West 2010). For examples of very similar statutory definitions, *see* ALA. CODE § 22-52-1.1(1) (LexisNexis 2006 & Supp. 2010), ARIZ. REV. STAT. ANN. § 36-501(22), (West 2009) IDAHO CODE ANN. §66-317(12) (2007), 104 MASS. CODE REGS. § 27.05(1)(2006), MINN. STAT. ANN. § 253B.02(13)(a) (West Supp. 2011), N.J. STAT. ANN. § 30:4-27.2(r), OHIO REV. CODE ANN. § 5122.01(A) (LexisNexis 2008), OKLA. STAT. ANN. tit. 43A, §1-103(3) (West 2001), S.D. CODIFIED LAWS § 27A-1-1(18) (West 2004), VT. STAT. ANN. 18 § 7101(14) (LexisNexis 2000), and WIS. STAT. §51.001 (13)(b) (West 2008). Nevada takes a different approach, defining mental illness for purpose of commitment as "a clinically significant disorder" listed in official diagnostic manuals that "[s]eriously limits" a person's capacity "to function in the primary aspects of daily living." NEV. REV. STAT. ANN. § 433.164

terminology is used, however, in several states' laws to designate conditions that *dis*qualify persons from being eligible for involuntary psychiatric hospitalization.[55] For example, many jurisdictions' statutory language explicitly precludes substance abuse disorders from being the sole grounds for involuntary psychiatric hospitalization.[56]

How, then, is the presence of the requisite disorder to be proven? Notwithstanding the skeptical opinions of psychiatric expertise often voiced in legal opinions,[57] many jurisdictions require a mental health professional's opinion testimony in commitment proceedings—a requirement that obviates questions as to whether such experts' evidence meets criteria for admissibility.[58] Virtually all states require an

(LexisNexis 2009).

55 *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-501(26) (LexisNexis 2009) Arizona's civil commitment statute specifically excludes "drug abuse, alcoholism or mental retardation," and "personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including [illegal] sexual behaviors" unless these are also accompanied by "a substantial disorder of the person's emotional processes, thought, cognition or memory." *Id.*

56 *See, e.g., id.*; KAN. STAT. ANN. §59-2946(f)(1) (2005); WASH. REV. CODE ANN. §71.05.040 (West 2008).

However, several states permit judicial commitment of an individual with substance use disorders and no other major mental illness if the individual poses a substantial risk of physical harm to himself or others. In some states, statutes concerning civil commitment of mentally ill persons include, in their definition of mental illness or mental disorder, persons who have alcohol and/or drug use disorders. *See, e.g.*, IND. CODE § 12-7-2-130 (LexisNexis 2006) ("Mental illness . . . includes . . . alcoholism, and addiction to narcotics or dangerous drugs."); ME. REV. STAT. 34-B §3801(5) (2010) ("'Mentally ill person' includes persons suffering from the effects of the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol."); WIS. STAT. ANN. §§ 51.15(1)(a), 51.01(8) (West 2008) (allowing detention of "drug dependent" persons). In other states, laws concerning alcohol and drug abuse commitments are separate from the statutes pertaining to commitment of mentally ill persons. *See, e.g.*, COL. REV. STAT. §§ 27-81-102(1), 27-81-112 (LexisNexis 2010) (permitting commitment if a "person is an alcoholic and . . . has threatened or attempted to inflict or inflicted physical harm on himself or on another"); FLA. STAT. ANN. § 397.675 (West 2006) ("A person meets the criteria for involuntary admission if the person is substance abuse impaired . . ." and satisfies other conditions); S.C. CODE ANN. § 44-52-10 (West 2002) (permitting involuntary commitment of "chemically dependent" persons who have been violent, have physical problems, or have repeatedly had substance-related legal problems).

57 *See, e.g.*, Addington v. Texas, 441 U.S. 418, 429 (1979) (citing "the lack of certainty and the fallibility of psychiatric diagnosis" and doubting "whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous").

58 For a discussion of this topic, see Robert F. Schopp & Michael R. Quattrocchi, *Predicting the present: Expert testimony and civil commitment* 13 BEHAV. SCI. & L. 159 (1995) (examining civil commitment testimony in light of the then-recent *Daubert* decision).

examination by a physician or psychologist as the basis for a petition for commitment,[59] giving professional expertise a key role in initiating the civil commitment process. Some states' statutes require that mental health professionals testify about one or more matters that are at issue in making the commitment decision.[60] In other states (*e.g.*, California), case law implies that mental health testimony is required to establish the legal basis for commitment.[61] This only makes sense: though commitment decisions hinge in part on what the Supreme Court terms "factual issues," such as the respondent's behavior, finding out whether a respondent is mentally ill and needs hospitalization requires that facts "be interpreted by expert psychiatrists and psychologists."[62]

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59 Alexander W. Scherr, *Daubert & Danger: The "Fit" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 38 (2003).

60 *See, e.g.*, 405 ILL. COMP. STAT. 5 § 3-807 (2010) ("No respondent may be found subject to involuntary admission on an inpatient or outpatient basis unless at least one psychiatrist, clinical social worker, or clinical psychologist who has examined him testifies in person at the hearing."); R.I. GEN. LAWS §40.1-5-8(f) (LexisNexis 2006) ("A person with respect to whom a court hearing has been ordered under this section shall have and be informed of a right to employ a mental health professional of his or her choice to assist him or her in connection with the hearing and to testify on his or her behalf."); ME. REV. STAT. ANN. 34-B §3864-5-F (2010) ("In each case, the applicant shall submit to the court, at the time of the hearing, testimony, including expert psychiatric testimony, indicating the individual treatment plan to be followed by the psychiatric hospital staff."); OHIO REV. CODE ANN. §5122.14 (LexisNexis 2008) ("the court may appoint a psychiatrist . . . to examine the respondent, and at the first hearing . . . such psychiatrist, or licensed clinical psychologist and licensed physician, shall report to the court his findings as to the mental condition of respondent, and his need for custody, care, or treatment in a mental hospital."); WIS. STAT. ANN. §51.20(9)(a)(5) (West 2008) ("The examiners shall personally observe and examine the subject individual at any suitable place and satisfy themselves, if reasonably possible, as to the individual's mental condition, and shall make independent reports to the court . . . [a] written report shall be made of all such examinations and filed with the court. The report and testimony . . . shall be based on beliefs to a reasonable degree of medical certainty . . . in regard to the existence of the conditions [required for involuntary commitment], and the appropriateness of various treatment modalities or facilities.").

61 *See, e.g.*, People v. Bennett, 182 Cal. Rptr. 473, 497-98 (Cal. Ct. App. 1982); People v. Devers, No. A095661, 2002 WL 724931, at *3 (Cal. Ct. App. Apr. 25, 2002).

62 Addington v. Texas, 441 U.S. 418, 429 (1979).

2. *"Risk" or "Dangerousness"*

a. Meaning of Dangerousness

Historically, the putative "dangerousness" of mentally ill persons has been the core social and legal rationale for involuntary psychiatric hospitalization,[63] with mental incompetence or unrecognized need for treatment being ancillary factors in just a few states' commitment laws.[64] Several decades ago, forensic psychiatrist Melvin Goldzband identified the types of concerns animating authors of involuntary hospitalization statutes in this definition of dangerousness: "the quality of an individual or a situation leading to the potential or actuation of harm to an individual, community or social order. It is inherent in this definition that dangerousness is not *necessarily* destructive . . . ."[65]

People often use the words "dangerous" or "dangerousness" to refer to (and sometimes, to conflate) factors on which judgments about dangerousness are based, the types of dangerous events being predicted, and the probability of those events.[66] For these reasons, recent social science scholarship has focused on "risk assessment" and "risk communication" rather than the once-common but infelicitous "prediction of dangerousness," a topic to which we shall return

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63 John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 512–13 (1992) (giving historical examples).

64 *See infra* Part IV-B.

65 Melvin G. Goldzband, *Dangerousness*, 1 BULL. AM. ACAD. PSYCHIATRY & L. 238, 238 (1973).

66 *See* John Monahan & Henry J. Steadman, *Toward a Rejuvenation of Risk Assessment Research*, *in* VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 1, 2 (John Monahan & Henry J. Steadman eds., 1994). As several writers have noted, "dangerousness," "dangerous," and "danger" are words that, in ordinary usage, designate various things: actual manifestations of aggressive behavior (including threats, acts that have harmful potential, and/or acts that actually result in harm); an especially large probability of causing harm; or *any* probability (great or small) of acting violently. For additional discussion, see Douglas Mossman, *Understanding Risk Assessment Instruments*, *in* THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF FORENSIC PSYCHIATRY 563, 563-64 (R.I. Simon & L.H. Gold, 2nd ed., 2010) 563, 563–564 (2010) [*hereinafter* Mossman, *Understanding*]; Saleem A. Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOLOGIST 224, 224–25 (1978); Douglas Mossman, *Dangerousness Decisions: An Essay on the Mathematics of Clinical Violence Predictions and Involuntary Hospitalization*, 2 U. CHI. L. SCH. ROUNDTABLE 95, 101 (1995).

shortly.[67]

In many jurisdictions, statutes eliminate at least some of the ambiguity in "danger" and "dangerousness" by directing courts and evaluators to focus primarily on a respondent's recent actions (including utterances). In Pennsylvania, for example, "clear and present danger to others" is limited to severely mentally ill persons for whom clear and convincing evidence establishes:

> that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. . . . [A] clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.[68]

This language strongly suggests that some *actual behavior* (which may be a threat—a form of verbal behavior) is a necessary condition for ordering involuntary hospitalization.[69] As we shall see shortly,[70] it appears that in most U.S. jurisdictions, a respondent is eligible for commitment only if he has a serious mental illness, did something threatening or harmful because of the illness, and still has the mental problems that led to the threatening or actually harmful behavior. Under such requirements, commitment decisions do not depend on probabilistic assessments about *future* behavior, but on the respondent's *past* deeds (including statements) that arose from mental conditions that continue to be *present*.

b. Types of Dangerousness

(i) To Self or Others

All states permit civil commitment of persons whose mental illness has rendered them physically dangerous to themselves,[71] either

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67 *See infra* Part III.

68 50 PA. STAT. ANN. § 7301(b)(1) (West 1976).

69 As we note below, statutes in many jurisdictions further specify that the behavior must have occurred "recently," e.g., within the last month. *See infra* Part II(c)(2)(b)(iii).

70 *See infra* Part IV-B (citing statutory requirements of most U.S. jurisdictions).

71 *See infra* Part IV-B; *see also* Robert A. Brooks, *Psychiatrists' Opinions About Involuntary Civil*

through suicidal behavior (that is, threats of or attempts to take one's own life) or acts that are physically harmful but not life-threatening (*e.g.*, self-mutilation). Almost all states also permit commitment because of what often is termed "grave disability," a phrase referring to the condition of persons who do not express wishes or try to harm themselves, but who so neglect their basic needs[72] as to put their lives in peril.[73] Finally, all states permit civil commitment of persons for whom clear and convincing evidence shows they are physically dangerous to others.[74]

Commitment: Results of a National Survey, 35 J. AM. ACAD. PSYCHIATRY L. 219, 219 (2007) (citing C.D. Stromberg, A.A. Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983)).

72 Examples of such physical neglect include not eating, not dressing properly or seeking adequate shelter in cold weather, and not attending to one's life-threatening medical conditions. In most states (e.g., Ohio, *see* OHIO REV. CODE § 5122.01(B)(1)-(3) (LexisNexis 2008)), commitment laws distinguish between intentionally self-harming behavior and self-neglect separately. Some statutes, however, subsume suicidal behavior and grave disability under a unitary danger-to-self rubric. *See, e.g.*, 50 PA. STAT. ANN. § 7301(b)(2)(i) (West 1976) (danger to self provable by showing that the respondent "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 . . . .").

In four states where commitment statutes do not mention grave disability explicitly, courts have interpreted phrases referring to "danger to self" as allowing commitment for being "gravely disabled." Robert A. Brooks, *Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey*, 35 J. AM. ACAD. PSYCHIATRY L. 219, 221 (2007); *see* Ruff v. Cent. State Hosp., 385 S.E.2d 734, 735-36 (Ga. Ct. App. 1989); *In re* Albright, 836 P.2d 1, 4-5 (Kan. Ct. App. 1992); State v. Christofferson, 615 P.2d 1152, 1153 (Or. Ct. App.1980); G.H. v. State, 96 S.W.3d 629, 633 (Tex. Ct. App. 2002).

An interesting exception is Arizona's civil commitment statute, which specifically *excludes* involuntary hospitalization based on "behavior that establishes only the condition of gravely disabled." ARIZ. REV. STAT. ANN. § 36-501(6)(b) (Supp. 2010).

73 Kansas permits commitment of a mentally ill person who "is substantially unable . . . to provide for any of the person's basic needs, such as food, clothing, shelter, health or safety, causing a substantial deterioration of the person's ability to function on the person's own." KAN. STAT. ANN. § 59-2946(f)(3) (2005). Wisconsin permits civil commitment if a mentally ill person "[e]vidences behavior manifested by recent acts or omissions" and thereby creates "a substantial probability . . . that death, serious physical injury, serious physical debilitation, or serious physical disease will imminently ensue" without prompt psychiatric treatment. WIS. STAT. ANN. §51.20(1)(a)(2)(d) (West 2008).

74 Many states require that respondents have displayed *behavioral evidence* of violence towards others in the form of credible threats, attempts to harm others, or actually harmful deeds. *See infra* Part IV-B.

(ii) Other Types of Risk

O'Connor v. Donaldson prohibits states from using need for treatment as the sole justification for involuntary hospitalization[75], and some states have incorporated the language of this constitutional judgment in their statutes.[76] In some jurisdictions, however, need for treatment combined with some other form of severe mental compromise permits a court to order civil commitment.[77] A few states explicitly include risk of property damage among their criteria for civil commitment.[78] At least three states—Minnesota, South Dakota, and Wisconsin—have statutes that authorize civil commitment of women who abuse alcohol during pregnancy;[79] here, the rationale for deten-

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75 *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1975) ("[A] State cannot constitutionally confine without more [justification] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").

76 *See, e.g.*, WIS. STAT. § 51.20(1)(a)(2)(d) (West 2008) (stating that "no substantial probability of harm" justifying civil commitment "exists if reasonable provision for the individual's treatment and protection is available in the community"); FLA. STAT. ANN. §394.467(2)(a) (West 2006) (permitting commitment of someone who "is manifestly incapable of surviving alone or with the help of willing and responsible family or friends").

77 For example, Ohio allows involuntary hospitalization of a person with grossly compromised judgment, behavior, reality-testing, or capacity to manage basic tasks of living who "[w]ould benefit from treatment in a hospital for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person." OHIO REV. CODE ANN. § 5122.01(B)(4) (LexisNexis 2008). South Carolina allows for commitment of a "person [who] is mentally ill, needs involuntary treatment and because of his condition lacks sufficient insight or capacity to make responsible decisions with respect to his treatment." S.C. CODE ANN. § 44-17-580(1)(2002).

78 *See, e.g.*, ALASKA STAT. § 47.30.915(10)(A)-(B)(2010) (permitting involuntary hospitalization of a mentally ill person whose "recent behavior" has included "causing, attempting, or threatening harm," and who "is likely in the near future to cause . . . substantial property damage to another person"); WASH. REV. CODE ANN. § 71.05.020(23)(a)(iii)(West 2008) (allowing civil commitment upon showing "a substantial risk that . . . physical harm will be inflicted by a [mentally ill] person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others").

79 WISC. STAT. ANN. § 48.193(1)(c)(West 2008) (permitting commitment of an expectant mother if her "habitual lack of self-control in the use of alcohol beverages . . . exhibited to a severe degree [creates] a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered"); *see also* MINN. STAT. ANN. § 253B.02 Subd. 2 (West 2007); S.D. CODIFIED LAWS § 34-20A-70(3)(2004).

tion and hospitalization is to reduce potential harm to the fetus.[80] Finally, about one-third of U.S. states permit commitment of individuals who are at risk for relapse of their mental illness or mental deterioration.[81]

(iii) Evidence of Risk

Earlier, we noted that *Lessard v. Schmidt* required that the respondent must have made an actual threat or must have committed some actual behavior—more simply, an "overt act"—as the basis for inferring dangerousness.[82] Shortly after *Lessard* was issued, eight states altered their commitment statutes to require an overt act to justify commitment, and several state and federal courts held that the U.S. constitution required an "overt act" as proof of dangerousness.[83] In several jurisdictions, however, decisions have specifically *rejected* an overt act requirement,[84] and as Part IV-B shall show, statutes in a

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80 Excessive alcohol consumption during pregnancy is incontrovertibly associated with adverse health consequences for the fetus. Fetal alcohol exposure may be the most common nonhereditary cause of mental retardation, and can lead to a variety of other physical and neurodevelopmental disorders. *See generally* Kenneth R. Warren & Laurie L. Foudin, *Alcohol-Related Birth Defects: The Past, Present, and Future*, 25 ALCOHOL RES. & HEALTH 153, 155 (2001).

81 *See, e.g.*, WASH. REV. CODE ANN. § 71.05.020(17)(b)(West 2008) (permitting commitment of someone whose mental illness is causing a "severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control"); WIS. STAT. ANN. § 51.20(1)(a)2.e (West 2008) (person may be civilly committed when recent behavior indicates that "he or she will, if left untreated, . . . suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions"); ALA. CODE § 22-52-10.4(a)(ii)-(iii) (1975) (permitting commitment only if respondent both "poses a real and present threat of substantial harm to self and/or others" and "will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently . . . .").

82 *See supra* Part II-B.

83 Reed Groethe, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 n.1 (1977) (citing statutes).

84 *See, e.g.*, People v. Sansone, 309 N.E.2d 733, 739 (Ill. App. Ct. 1974); United States *ex rel.* Mathew v. Nelson, 461 F. Supp. 707, 707 (N.D. Ill. 1978), Matter of Monroe, 270 S.E.2d 537, 541 (N.C. Ct. App. 1980); Project Release v. Prevost, 722 F.2d 960, 961 (2d Cir. 1983); People v. Stevens, 761 P.2d 768, 773 (Colo. 1988). In Washington state, courts have required overt acts to prove risk of physical harm, (*In re* Harris, 654 P.2d 109, 113 (Wash. 1982)), but not grave disability, (*In re* LaBelle, 728 P.2d 138, 144 (Wash. 1986)).

minority of states appear to allow other evidence as potential proof of dangerousness.

The *Lessard* decision also required the overt act be "recent," and some other "overt act" jurisdictions impose similar conditions.[85] In a few states, statutes specify a period within which the behavior must have occurred to count in favor of commitment.[86] Those court decisions that discuss recentness requirements have not set clear rules specifying the time within which an act remains "recent" enough for purposes of commitment.[87] Instead, courts have ruled that actions need only be "material and relevant to the [respondent's] present condition"[88] or have "occurred close enough in time to the . . . hearing to have probative value on the ultimate question before the court . . . ."[89]

Although proving that a respondent has a mental disorder would appear to require the expertise of a mental health professional, testimony relevant to risk and danger—particularly whether the respondent committed any overt acts of violence—might well come from nonprofessionals who, for example, actually saw pre-detention behavior that raised concern about the respondent's dangerousness.[90] Several states have case law establishing the potential sufficiency of

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85 Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972); *see, e.g., In re* Gatson, 593 P.2d 423, 424–25 (Kan. Ct. App. 1979) (overt act jurisdiction).

86 *See, e.g.*, 50 PA. STAT. ANN. § 7301(b) (West 2010) (in Pennsylvania, "determination of present danger" relates to behavior within the previous 30 days); *see also*, NEV. REV. STAT. ANN. § 433A.115(2) (LexisNexis 2009) (Nevada requires "determination of present danger" to be based on behavior within the previous 30 days); H.B. 3076, 61st Leg., 2010 Reg. Sess. (Wash. 2010) ("recent" means "a period of time not exceeding three years prior to the current hearing.").

87 Alexander Scherr, *Daubert & Danger: The "Fit" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 46–47 (2003).

88 *In re* D.D., 920 P. 2d 973, 975 (Mont. 1996).

89 Davis v. North Carolina Dep't of Human Res., 465 S.E.2d 2, 8 (N.C. Ct. App. 1995). Vermont, which does not have a recency requirement, nonetheless applies the principle that "[o]vert acts occurring shortly before the hearing may be given more weight than remote acts . . . ." *In re* L.R., 497 A.2d 753, 756 (Vt. 1985).

90 *See, e.g.*, Hill v. State, 358 So. 2d 190, 207 (Fla. Dist. Ct. App. 1978); People v. Hockenberry, No. A095277, No. A095277 2002 WL 1000075, at *3–4 (Cal. Ct. App. May 16, 2002); People v. Sword, 34 Cal. Rptr. 2d 810, 818 (Cal. Ct. App. 1994).

lay testimony alone to prove dangerousness.[91] But do mental health professionals have anything to offer courts beyond observations of actual violent behavior of the sort that nonprofessionals might equally well provide?

III. DEVELOPMENT AND CURRENT STATUS OF RISK ASSESSMENT

A. Actuarial Judgment

Writing in 2003, Professor Scherr noted that despite profound doubt among mental health professionals as to the value of psychiatric predictions,[92] "no appellate court has ever ordered exclusion of expert psychiatric testimony about danger in a civil commitment case."[93] This is striking, because until the early 1990s, mental health professionals believed that they could not distinguish persons who would become violent from those who would not, especially when such assessments concerned conduct several months or years in the future.[94] Moreover, mental health professionals believed that their predictions of violence usually were *wrong*.[95]

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91 *See Hill*, 358 So. 2d at 207; *Hockenberry*, 2002 WL 1000075 at *3–4; *Sword*, 34 Cal. Rptr. at 818.

92 *See, e.g.*, Barefoot v. Estelle, 697 F.2d 593, 596 (5th Cir. 1983) ("[The testifying psychiatrists] disagreed over the degree of certainty with which future conduct could be predicted, but this only shows a difference of opinion among professionals-no rarity to the courts or to citizens who serve as jurors."); Estelle v. Smith, 451 U.S. 454, 472 (1981) ("[S]ome in the psychiatric community are of the view that clinical predictions as to whether a person would or would not commit violent acts in the future are 'fundamentally of very low reliability' and that psychiatrists possess no special qualifications for making such forecasts.").

93 Scherr, *supra* note 87, at 26–27 (citing Brief for Amicus Curiae American Psychiatric Association at 8; Estelle v. Smith, 451 U.S. 454 (1981)); *see also* JOHN PARRY, CRIMINAL MENTAL HEALTH AND DISABILITY LAW, EVIDENCE AND TESTIMONY 367 (2009) (noting that "[c]ourts rarely, if ever, exclude [dangerousness] testimony based on legitimate questions about its relevance or reliability.").

94 Douglas Mossman, *Assessing Predictions of Violence: Being Accurate about Accuracy*, 62 J. CONSULTING & CLINCAL PSYCHOL. 783, 783 (1994) [hereinafter Mossman, *Being Accurate about Accuracy*].

95 A principal source for this belief was MONAHAN, CLINICAL PREDICTION, *supra*, note 24. This highly influential monograph famously claimed that "psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a several-year period among institutionalized populations that had both committed violence in the past (and thus had high base rates for it) and who were diagnosed as mentally ill." *Id.* Mo-

This conclusion should have seemed perplexing, in no small part because it runs counter to our everyday experience of having *some* idea of what others will do, especially in the near future.[96] Indeed, by the late 1980s, mental health professionals had published research suggesting they could gauge dangerousness reasonably well over the next few days.[97]

B. Quantifying Assessment Accuracy

In the mid-1990s, mental health professionals introduced a new method of quantifying prediction accuracy, which recognized that assessing violence risk involved more than making a binary, "he-will-or-he-won't" judgment about an individual's future behavior.[98] Rather, judgments about the likelihood of future violence fall on a lesser-to-greater continuum with potentially adjustable thresholds—levels of risk—at which clinicians make particular decisions (for example, to hospitalize). This means that the accuracy of risk assessment techniques should be described using *receiver operating characteristic* (ROC) analysis.[99] Since the introduction of ROC analysis as the

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nahan's earlier work suggesting that clinical predictions were not accurate was cited in Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 344 n.10 (Cal. 1976). MONAHAN, CLINICAL PREDICTION was cited in Barefoot v. Estelle, 463 U.S. 880, 899 n.7 (1983), and in countless scientific publications used by mental health professionals.

96 John Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy* 141 AM. J. PSYCHIATRY 10, 11 (1984) (discussing evidence supporting potentially "valid short-term assessments of dangerousness").

97 Dale E. McNiel & Renée L. Binder, *Predictive Validity of Judgments of Dangerousness in Emergency Civil Commitment*, 144 AM. J. PSYCHIATRY 197, 197 (1987) ("emergency commitment situation permits judgments of dangerousness with a relatively high degree of short-term predictive validity"); Renée L. Binder & Dale E. McNiel, *Effects of Diagnosis and Context on Dangerousness*, 145 AM. J. PSYCHIATRY 728, 729 (1988) (factors in assessing risk of inpatient violence); *see also* Dale E. McNiel & Renée L. Binder, *Clinical Assessment of the Risk of Violence Among Psychiatric Inpatients*, 148 AM. J. PSYCHIATRY 1317, 1320 (1991) (findings in this and previous publications support clinical assessments of short-term violence risk).

98 Douglas Mossman, *Further Comments on Portraying the Accuracy of Violence Predictions*, 18 LAW & HUM. BEHAV. 587, 587 (1994) [hereinafter Mossman, *Further Comments*].

99 William Gardner et al., *Clinical Versus Actuarial Predictions of Violence in Patients with Mental Illness*, 64 J. CONSULTING & CLINICAL PSYCHOL. 602, 602–609 (1996); Marnie E. Rice & Grant T. Harris, *Violent Recidivism: Assessing Predictive Validity*, 63 J. CONSULTING & CLINICAL PSYCHOL. 737, 737 (1995); Mossman, *Being Accurate about Accuracy*, *supra* note 94, at 783; Mossman, *Further Comments*, *supra* note 98, at 587.

method for quantifying assessment accuracy, clinicians have completely revised their views about whether violence is "predictable" and about whether they can accurately assess someone's dangerousness. In the 21st century, ROC analysis has become the standard way to describe the accuracy of violence risk assessments.[100]

Originally developed in the 1950s to evaluate radar applications,[101] ROC methods assume that the ratio of correct detections of a target (here, violent individuals) to "false alarms" (nonviolent persons) reflects the intrinsic discrimination capacity of the detection method and the threshold at which the "receiver" (here, a mental health clinician) operates.[102] ROC analysis teases out the intrinsic discrimination capacity of a detection method from the particular threshold or operating point used to make a yes-no decision.[103] ROC analyses often feature a ROC graph, which plots the true positive rate (TPR, or the "hit rate") as a function of the false positive rate (FPR, or the "false alarm rate"), and depicts how the TPR increases as the FPR increases.[104] ROC graphs thus display the performance of a detection method across the entire range of possible decision thresholds, which lets users quickly grasp the trade-offs between true positive results (for example, correct identification of persons who will become violent) and true negative results (correct identification of persons who will not).[105] Unless the detection method is perfect, one can increase detection of actually violent persons only by *de*creasing the identifica-

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100 *See* Linda Drazga Maxfield, *Measuring Recidivism Under the Federal Sentencing Guidelines*, 17 FED. SENT'G REP. 166, 169 (February 2005) (quantifying accuracy of prediction model for criminal recidivism using ROC analysis); ROC graphs are used to describe prediction or detection accuracy in a host of circumstances. *Id.* at 168; *see also* Lewis O. Harvey, Jr. et al., *Application of Signal Detection Theory to Weather Forecasting Behavior*, 120 MONTHLY WEATHER REV. 863, 865-66 (1992).

101 *See* W. W. Peterson et al., *The Theory of Signal Detectability*, 4 TRANSACTIONS IRE PROF'L GRP. ON INFO. THEORY 171, 183 (1954).

102 Douglas Mossman & Eugene Somoza, *ROC Curves, Test Accuracy, and the Description of Diagnostic Tests*, 3 J. NEUROPSYCHIATRY CLIN. NEUROSCIENCE 330, 330-32 (1991).

103 *Id.* at 330-31.

104 *Id.* at 330.

105 *See id.* Though ROC graphs usually plot TPR as a function of FPR—rather than the true negative rate (TNR)—one can easily interconvert FPR and TNR using the relationship TNR = 1 - FPR. *See* Mossman, *Further Comments*, *supra* note 98, at 589.

tion of nonviolent subjects.

The area under the ROC curve (AUC) provides an intuitively useful, single-number summary of a detection system's overall accuracy. Where predicting violence is concerned, AUC equals the probability that an assessment method will identify a randomly selected violent individual as more likely to be violent than a randomly selected nonviolent person.[106] A perfect assessment method would have an AUC of 1.0 (implying a 100% probability of correctly sorting violent and nonviolent persons); an assessment method that is no better than a coin toss (i.e., that gives no information) would have an AUC of 0.5.[107] A recent meta-analysis[108] shows that commonly used ARAIs have AUCS of approximately 0.7-0.8.[109]

ROC methods have led scholars and researchers to conclusions about psychiatrists' and psychologists' ability to assess dangerousness that differ sharply from what mental health professionals believed in the 1970s and 1980s. Huge numbers of publications now confirm that mental health professionals can meaningfully rank potential for future violence over periods of hours, days, months, or

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106 *See generally,* James A. Hanley & Barbara J. McNeil, *The Meaning and Use of the Area under a Receiver Operating Characteristic (ROC) Curve,* 143 RADIOLOGY 26, 30 (1982) (explaining AUC).

107 *Id.* at 31.

108 Meta-analysis refers to a statistical method of summarizing, integrating, and interpreting the results of several research studies. *See* MARK W. LIPSEY & DAVID B. WILSON, PRACTICAL META-ANALYSIS 1-11 (2001) (noting that "meta-analysis is now widely accepted as a method of summarizing the results of empirical studies within the behavioral, social, and health sciences.").

109 Grant T. Harris & Marnie E. Rice, *Actuarial Assessment of Risk among Sex Offenders,* 989 ANNALS N.Y. ACAD. SCI. 198, 207 (2003) ("The use of actuarial methods for the prediction of violent recidivism among sex offenders routinely achieves ROC areas in the range from 0.74 to 0.79."). Actuarial methods have produced similar findings for violence in other contexts. *See, e.g.,* Kevin S. Douglas et al., *Assessing Risk for Violence Among Psychiatric Patients: The HCR-20 Violence Risk Assessment Scheme and the Psychopathy Checklist: Screening Version,* 67 J. CONSULTING & CLINICAL PSYCHOL. 917 (1999) [hereinafter Douglas et al., *Assessing Risk for Violence*]; KEVIN S. DOUGLAS ET AL., HCR-20 VIOLENCE RISK ASSESSMENT SCHEME: OVERVIEW AND ANNOTATED BIBLIOGRAPHY, at 8-14, (2008), *available at* http://kdouglas.files.wordpress.com/2006/04/annotate10-24nov2008.pdf (last visited December 12, 2010) (tables listing ROC areas found in several studies); Min Yang et al., *The Efficacy of Violence Prediction: A Meta-Analytic Comparison of Nine Risk Assessment Tools,* 136 PSYCHOL. BULL. 740, 755 (2010) (ROC areas for VRAG and HCR-20 are about 0.7).

years.[110]

C. "Actuarial" Methods Supplant "Clinical" Judgment

Recent publications on violence prediction contrast two broad types of assessment methods: those that reflect purely "clinical judgment," and those that rely on mechanical, statistical, or (most commonly, in current mental health parlance) "actuarial" methods. In risk assessments based on clinical judgment alone, mental health professionals use information from interviews and history-taking that is similar to the kinds of information they obtain when doing outpatient medicine or psychotherapy. Among the information gathered might be the evaluee's present mental status and life history. Other sources of information—family, friends, and court records—might also be consulted, along with available test results and whatever else is available and seems relevant. Once gathered, professionals combine the information mentally ("in their heads"), using their background and experience to make inferences about likelihood of violence.[111]

110 The change began with a reanalysis of published data. *See* Mossman, *Being Accurate about Accuracy*, *supra* note 94, at 787 (Table 3 shows that, contrary to what had previously been thought, clinical predictions of violence typically have clearly-above-chance accuracy). Closely following this were studies of newly gathered data evaluated with ROC methods. *See e.g.*, Gardner et al., *supra* note 99; Rice & Harris, *supra* note 99; Douglas et al., *Assessing Risk for Violence*, *supra* note 109. Over the next few years, several reports confirmed mental health professionals' abilities to sort individuals into groups with higher and lower probabilities of acting violently. Alec Buchanan & Morven Leese, *Detention of People with Dangerous Severe Personality Disorders: A Systematic Review*, 358 LANCET 1955, 1958 (2001); John Monahan, *The Scientific Status of Research on Clinical and Actuarial Predictions of Violence*, *in* MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 300 (D. L. Faigman et al. eds.,) 90 (2002); Douglas Mossman, *Assessing the Risk of Violence - Are "Accurate" Predictions Useful?* 28 J. AMER. ACAD. PSYCHIATRY & L. 272 (2000); Marnie E. Rice et al., *The Appraisal of Violence Risk*, 15 CURRENT OPINION IN PSYCHIATRY 589 (2002). Evidence on mental health professionals' ability to rank individuals' dangerousness continues to accumulate. *See*, e.g., R. Karl Hanson & Kelly E. Morton-Bourgon, *The Accuracy of Recidivism Risk Assessments for Sexual Offenders: A Meta-analysis*, PUB. SAFETY CAN. (January 2007), accessed December 12, 2010 from http://www.publicsafety.gc.ca/res/cor/rep/cprmindex-eng.aspx (meta-analysis summarizing accuracy for detection methods for sex offender recidivism); Alec Buchanan, *Risk of Violence by Psychiatric Patients: Beyond the "Actuarial Versus Clinical" Assessment Debate*, 59 PSYCHIATRIC SERVICES 184, 184-85 (2008) (describing studies since 2000; AUCs of 0.61 to 0.82); Yang et al., *supra* note 109, at 740.

111 Dawes et al., *supra* note 11, at 1668; William M. Grove & Paul E. Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y & L. 293, 293 (1996);

By contrast, actuarial methods feature algorithms, formulae, or some other explicit, mechanical combination of information for classification purposes.[112] A probability assessment is derived from empirically established relationships between risk factors and outcome of interest.[113] To conduct actuarial risk assessments of violence risk, mental health professionals would look for information about prespecified items concerning their evaluees; then, they plug this information into a formula or other predetermined scoring system.[114] The result would be a numerical value or category that summarizes the evaluee's violence risk.[115]

When it comes to complex phenomena like human aggression, one might think that unfettered clinical judgment—which lets professionals use all relevant aspects of their accumulated knowledge and wisdom—would provide better predictions than could simple formulae. Just the opposite is usually the case, however. Empirically based, statistical prediction algorithms probably provide more accurate assessments of dangerousness than does the unaided clinical judgment of mental health professionals.[116] In support of this position are numerous studies of various prediction tasks comparing actuarial techniques with predictions by unaided clinicians,[117] which show that the former were more accurate than the latter. The reason is that predicting is not a pattern-recognition task (e.g., recognizing faces), at which

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William M. Grove et al., *Clinical Versus Mechanical Prediction: A Meta-Analysis*, 12 PSYCHOLOGICAL ASSESSMENT 19 (2000).

112 *See* Grove & Meehl, *supra* note 111, at 293.

113 This classic description appears in PAUL MEEHL, CLINICAL VERSUS STATISTICAL PREDICTION 3 (1954).

114 *See e.g., infra* Section III-D.

115 *See e.g., infra* Section III-D.

116 *See* Eric S. Janus & Robert A. Prentky, *Forensic Use of Actuarial Risk Assessment with Sex Offenders: Accuracy, Admissibility and Accountability*, 40 AM. CRIM. L. REV. 1443, 1455–58 (2003) (summarizing studies); John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 408–27 (2006) (summarizing common, valid actuarial predictive factors).

117 *See e.g.*, Janus & Prentky, *supra* note 116; Monahan *supra* note 116. The emphasis in this paragraph is on "unaided" or "unfettered" clinical judgment, that is, judgment based solely on the evaluator's mental combination of the data. Contrasted with this the assessment of dangerousness using "structured clinical judgment" (or "structured professional judgment"), discussed further below.

human brains do well, but an extended calculation task that is straightforward yet hard to do mentally (e.g., totaling a grocery store bill).[118] People, including clinicians, are overconfident in their own predictive capabilities, and human beings' ability to consistently use and manipulate arithmetic information is limited.[119]

Actuarial predictions may have other advantages over clinical judgment that are morally and perhaps legally relevant. Properly implemented actuarial judgment is systematic and consistent from case to case, and it uses only variables or factors that have a demonstrable relationship to violence. Actuarial judgments are explicit, replicable, and transparent; they start with particular types of data and use explicit, pre-specified approaches to combine and make inferences, so that the results of actuarial judgments are "open to inspection, questioning, and when necessary, critique."[120]

Recent psychological research on violence focuses on identifying risk factors that are statistically associated with violence and on developing instruments that use these factors to evaluate potential for violence.[121] The intent is that clinicians will use these scales to implement either an actuarial judgment about likelihood of future violence or a "structured professional judgment" of risk.[122] In structured professional judgment, a clinician uses ARAI-based information as an

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118 Dawes et al., *supra* note 11, at 1671–72.

119 Michael A. Bishop & J. D. Trout, *50 Years of Successful Predictive Modeling Should Be Enough: Lessons for the Philosophy of Science*, 69 PHIL. SCI. s197, s200–02 (2002); William M. Grove et al., *Clinical Versus Mechanical Prediction: A Meta-Analysis*, 12 PSYCHOL. ASSESSMENT 19, 25 (2000); Grove & Meehl, *supra* note 111, at 316 (1996) ("The human brain is a relatively inefficient device for noticing, selecting, categorizing, recording, retaining, retrieving, and manipulating information for inferential purposes.").

120 Mossman, *Understanding*, *supra* note 66, at 577. Professor Slobogin recognized this in the 1980s. *See* Christopher Slobogin, *Dangerousness and Expertise*, 133 U. PA. L. REV. 97, 122–23. He later comments, "Arguably, actuarial prediction promotes greater fairness than clinical prediction because it explicitly recognizes the variables relied upon, whereas clinical prediction allows the conscious or unconscious submergence of untidy evaluative factors." *Id.* at 151 n.188.

121 Dozens of such instruments are now available. *See generally* HANDBOOK OF VIOLENCE RISK ASSESSMENT (Randy K. Otto & Kevin S. Douglas eds., 2010) (describing dozens of instruments).

122 *See, e.g.*, Kevin S. Douglas et al., *Evaluation of a Model of Violence Risk Assessment Among Forensic Psychiatric Patients*, 54 PSYCHIATRIC SERV. 1372, 1372 (2003).

anchor for assessing risk; then—in contrast to a purely actuarial approach—the clinician reaches an ultimate risk judgment that incorporates other information with known relevance to risk that is not included in the ARAI.[123] Whether they are used only as actuarial measures or as a step in structuring judgment, ARAIs include features of an individual's personal background, criminal history, other past behavior patterns, current mental condition, and future circumstances.[124] Numerous published studies show that ARAIs do a respectable job of ranking individuals' relative likelihoods of acting violently.[125]

D. ARAIs Potentially Relevant to Civil Commitment

1. *Absence of Established Instruments*

Although examiners who conduct many types of forensic assessments may avail themselves of instruments designed for specific evaluation tasks,[126] no instrument has received formal promulgation as an aid to judging the need for commitment.[127] As we noted in Part

123 *Id.* at 1372–73 (contrasting actuarial and structured professional judgment).

124 *Id.* at 1374 (see Table 1).

125 As of late 2010, the most recent such study was Yang et al., *supra* note 109, at 741. Whether structured clinical judgment is superior or inferior to purely actuarial judgment is controversial, but the majority of authors in this area endorse structured clinical judgment. For a short, informative discussion, see Anthony Maden, *Violence Risk Assessment: The Question Is Not Whether But How*, 29 PSYCHIATRIC BULL. 121, 121 (2005) ("[E]vidence on this question, from both forensic and general psychiatry, is unequivocal; the best assessment of violence risk in an individual patient is provided by structured clinical judgment."). For a more extensive discussion, see Michael A. Norko & Madelon V. Baranoski, *The Prediction of Violence; Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTION 73, 73, 80 (2008) (noting that "[a]ctuarial predictions of future violence based on static nonpsychiatric characteristics achieve greater statistical accuracy than purely clinical methods" but cautioning about the persisting, "substantial limitations of the science").

126 For example, several forensic assessment instruments (FAIs) can be used in evaluations of adjudicative competence. *See* Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 J. AM. ACAD. PSYCHIATRY L. S3, S39–S43(2007) (describing the Georgia Court Competency Test and MacArthur criminal adjudication instrument, among others). FAI results are not dispositive of psycholegal matters, but using FAIs aids in systematic assessment and lets evaluators compare an individual's results to results from a normative population. RONALD ROESCH ET AL., FORENSIC PSYCHOL. & L. 51–52 (2009) (stating that FAIs "assist the evaluator in coming to an opinion").

127 Several factors may explain this absence: (1) differences in legal standards across U.S. juris-

I, several authors have suggested that forensic assessment tools might be appropriate for civil commitment assessments.[128] Here, we describe three already-existing measures that are potential sources of evidence in civil commitment hearings.

2. *Classification of Violence Risk™ (COVR™)*[129]

The creators of the COVR™ hoped their commercial software would help practitioners apply major findings from the MacArthur studies[130] to assess risk of community violence in psychiatric patients. The software uses a "classification tree method" to guide an evaluator through a short review of patient records and a 10-minute interview that emphasizes useful risk factors in the original MacArthur subject population.[131] The output of the COVR™ is a percentage-and-

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dictions, which makes it hard to develop an instrument that can be used nation-wide; (2) the chief assessment task in civil commitment evaluations concerns diagnosis and proper treatment of mental illness, which is a general clinical skill rather than a specialized type of assessment; (3) testimony from treating clinicians concerning the respondent's mental condition usually suffices for the decisions a trial court makes in civil commitment hearings; (4) most civil commitment hearings are short and perfunctory, which means that clinicians have little incentive to develop more rigorous evaluation methods; (5) in most jurisdictions (as Part IV-B shows), the trial court looks to the respondent's current condition and past "overt acts"—not features of the respondent that contribute to probabilities of future acts, which is what psychological tests and FAIs typically measure.

128 *See supra* notes 22-26 and accompanying text.

129 John Monahan et al., *An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders*, 56 PSYCHIATRIC SERVICES 810, 815 (2005). The MacArthur studies on violence risk assessment originally examined the predictive impact of more than 100 potential risk factors for violence. They did this by following approximately 1,100 former psychiatric inpatients in the community for several months after their discharges from the hospital. Investigators gathered information about whether the patients acted violently by interviewing patients themselves, interviewing relatives or other "collateral" sources, and examining arrest records and records of subsequent hospitalizations. The project's methods are described in detail in JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE 145-62 (2001).

130 "The MacArthur Violence Risk Assessment Study had two core goals: to do the best science' on violence risk assessment possible, and to produce an actuarial violence risk assessment 'tool' that clinicians in today's world of managed mental health services could actually use." THE MACARTHUR VIOLENCE RISK ASSESSMENT STUDY, http://www.macarthur.virginia.edu/risk.html (last visited Feb. 7, 2011).

131 In contrast to traditional regression methods (which apply the same question pattern, risk factors, factor weights, and decision algorithms to all individuals), the classification tree directs gathering and prioritizing of information based on the evaluee's previous answers.

confidence-interval estimate for the probability of violence over the next several months.[132] Note that this is a longer follow-up period than is often the focus of civil commitment hearings, which in most jurisdictions are not concerned with violent behavior that might occur several months in the future. Over time, however, future research on the COVR™ may clarify its potential utility in civil commitment cases.

3. *HCR-20*

As its name suggests, the HCR-20[133] is a three-part, twenty-item FAI focusing on an evaluee's personal history (ten items), current clinical status (five items), and risk management (five items). Each item has research-based support concerning its association with future violence.[134] Unlike the COVR™, the HCR-20 generates no numerical probability of violence. Rather, the HCR-20 should function as "an *aide-mémoire*," helping evaluators to gather data about well-known risk factors.[135] Having begun with the HCR-20 items, evalua-

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This approach allows consideration of many potential combinations and weightings of risk factors. John Monahan et al., *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. PSYCHIATRY 312, 312 (2000).

132 These estimates and their implied accuracy may be unrealistic because the authors tested bootstrap samples from the full study population on just the classification tree developed from the full study population. The proper cross-validation approach would have involved drawing bootstrap samples from the full population, constructing classification trees for each bootstrap sample, then testing the classification accuracy of these multiple trees in the full population. The authors' approach yielded an AUC of 0.81 for the COVR™, which probably is overly optimistic, and risk percentages probably are extreme (the percentages for high-risk groups are too high; the percentages for low-risk groups are too low). Results from a follow-up study yielded findings that indicated over-optimism. *See* John Monahan et al., *An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders*, 56 PSYCHIATRIC SERVS., 810, 814-15 (2005) (attributing this to "the shrinkage that can be expected whenever an actuarial instrument moves from construction to validation samples"). A recent study showed the COVR™ had some utility (AUC = 0.73) in assessing risk of future violence among forensic patients in the United Kingdom. Robert J. Snowden et al., *Assessing Risk of Future Violence Among Forensic Psychiatric Inpatients with the Classification of Violence Risk (COVR)*, 60 PSYCHIATRIC SERVS. 1522, 1524 (2009).

133 C.D. WEBSTER ET AL., HCR-20: ASSESSING THE RISK FOR VIOLENCE (VERSION 2) (1997).

134 Laura S. Guy & Catherine M. Wilson, *Empirical Support for the HCR-20: A Critical Analysis of the Violence Literature*, KEVIN S. DOUGLAS, http://kdouglas.files.wordpress.com/2006/04/hcr-20-report-2007.pdf, at 2 (last visited October 31, 2010).

135 WEBSTER ET AL., *supra* note 133, at 5.

tors then consider other factors—such as availability of potential victims, treatment factors, or recent threats—to make their ultimate judgment ("low," "medium," or "high") about an evaluee's potential for violence.

One of the first tests of the HCR-20[136] used information about involuntary psychiatric inpatients followed for two years (on average) after hospitalization. The HCR-20 did well at identifying the former patients who had violent incidents after discharge (AUC = 0.76) and at identifying those who committed violent crimes (AUC = 0.80).[137] Subsequent studies from other countries and clinical contexts have consistently found that the HCR-20 assigns higher scores to violent individuals than nonviolent individuals.[138]

Using the full HCR-20 often requires more than two hours for clinical data gathering, including detailed background information for scoring "psychopathy" (one of the historical items). The items that make up the clinical subscale[139] can often be assessed quickly, however, and these have some value in detecting potential for violence in the hospital.[140] Good information about potential for institutional violence often comes directly from clinical symptoms,[141] which are always directly assessed in a standard psychiatric evaluation for civil commitment.

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136 Kevin S. Douglas et al., *Assessing Risk for Violence Among Psychiatric Patients: The HCR-20 Risk Assessment Scheme and the Psychopathy Checklist: Screening Version*, 67 J. CONSULTING & CLINICAL PSYCHOL. 917, 919–20 (1999).

137 *Id.* at 924.

138 KEVIN S. DOUGLAS ET AL., HCR-20 VIOLENCE RISK ASSESSMENT SCHEME: OVERVIEW AND ANNOTATED BIBLIOGRAPHY, at 8–9 (November 24, 2008), *available at* http://kdouglas.files.wordpress.com/2006/04/annotate10-24nov2008.pdf, (showing numerous studies yielded AUCs values of 0.7–0.8).

139 These are insight, attitudes toward treatment, presence of symptoms, impulsiveness, and treatment response. *See* C.D. WEBSTER ET AL., *supra* note 133, at 49–60.

140 Dale E. McNiel et al., *Utility of Decision Support Tools for Assessing Acute Risk of Violence*, 71 J. CONSULTING CLINICAL PSYCHOL. 945, 951 (2003).

141 Barbara E. McDermott et al., *The Accuracy of Risk Assessment Instruments in the Prediction of Impulsive Versus Predatory Aggression*, 26 BEHAV. SCI. & L. 759, 775 (2008).

4. *Brøset Violence Checklist (BVC)*

Developed to help staff members assess risk of violence by psychiatric inpatients during the initial phase of hospitalization,[142] the Brøset Violence Checklist[143] requires clinicians to indicate whether six outwardly observable traits or behaviors[144] are present or absent. The more items scored "present," the higher the patient's level of violence risk.[145] An initial evaluation of the BVC showed that each item was individually correlated with inpatient violence; inter-rater reliability was good, and the AUC was 0.82±0.04.[146] Another study showed that a low score could correctly identify almost all nonviolent patients,[147] and a third study involving elderly patients produced a very high AUC of 0.940±0.015.[148]

E. Comments

The previously summarized information about three ARAIs suggests that actuarial methods provide relevant information about future violence. Yet ARAIs have evidentiary and scientific limitations that make their use in civil commitment hearings less than automatic. As we have just seen, the predictive capabilities of HCR-20 and COVR have been evaluated chiefly in patients who underwent treatment and were discharged to the community, and the BVC is used for and has been tested only in inpatients. The concern in civil com-

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142 This focus on violence soon after psychiatric admission may make the BVC especially relevant to persons subject to potential commitment.

143 *See generally,* Roger Almvik & Phil Woods, *Predicting Inpatient Violence Using the Brøset Violence Checklist (BVC)*, 4 INT'L J. PSYCHIATRIC NURSING RES. 498 (1999).

144 *Viz.*, being confused, irritable, boisterous, physically threatening, verbally threatening, and attacking objects. *See* Roger Almvik et al., *The Brøset Violence Checklist (BVC): Sensitivity, Specificity and Inter-rater Reliability*, 12 J. INTERPERSONAL VIOLENCE 1284, 1286 (2000). Note that the last three BVC risk items are overt acts that, by themselves, might justify civil commitment.

145 *Id.*

146 *Id.* at 1289–91.

147 A. Björkdahl et al., *Nurses' Short-term Prediction of Violence in Acute Psychiatric Intensive Care*, 113 ACTA PSYCHIATRICA SCANDINAVICA 224, 227 (2006).

148 R. Almvik et al., *Assessing Risk for Imminent Violence in the Elderly: the Brøset Violence Checklist*, 22 INT'L. J. GERIATRIC PSYCHIATRY 862, 865 (2007).

mitment hearings, however, is what risk an untreated respondent would pose if he were immediately released from custody.

A more important limitation stems from the fact that probabilistic quantifications of future risk are useful only if one can state the probability threshold that should trigger a decision. Yet evidence from studies on this matter suggests that no one—judges, mental health professionals, and other populations—agrees on what probability of future violence justifies involuntary hospitalization.[149] In a study conducted by Silver and Monahan, some judges said a 1 percent risk of violence sufficed, while others would require that the risk of violence be at least 3 out of 4.[150] Two studies that examined attitudes of students[151] and mental health professionals[152] on balancing false positive and false negative errors[153] found that subjects' views differed by five orders of magnitude.

A final limitation is that the available instruments assess only the risk of violence toward other persons.[154] Yet other types of risk—*viz.*, for suicide and grave disability—appear in all jurisdictions' civil commitment statutes.[155]

Though these scientific problems pose major problems in deciding how to apply findings from ARAIs to civil commitment decisions, they are not the only barriers to ARAI use. As we have sug-

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149 *See generally* John Monahan & Eric Silver, *Judicial Decision Thresholds for Violence Risk Management*, 2 INT'L J. FORENSIC MENTAL HEALTH 1 (2003).

150 *Id.* at 4. For Professor Monahan's different interpretation of these results, see John Monahan, *The MacArthur Studies of Violence Risk*, 12 CRIM. BEHAV. & MENTAL HEALTH, S67, S71 (2002) (focusing on the average result but ignoring the divergence of opinions).

151 Douglas Mossman & Kathleen J. Hart, *How Bad Is Civil Commitment? A Study of Attitudes Toward Violence and Involuntary Hospitalization*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 181, 182-90 (1993).

152 Douglas Mossman, *Critique of Pure Risk Assessment or, Kant Meets* Tarasoff, 75 U. CIN. L. REV. 523, 574-76 (2006).

153 *Id.* at 574. In this context, a "false positive" is a prediction (or decision based upon a belief) that an actually nonviolent person will be violent, and a "false negative" is a prediction (or a decision based upon a belief) that an actually violent person will not be violent. *Id.* One of the earliest uses of such terminology in this context is Henry J. Steadman, *The Right Not to Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC Q. 84, 85-86 (1980).

154 *See, e.g.*, Monahan, *supra* note 150, at S70.

155 *See, e.g., infra* p.55 (Arkansas statute).

gested above, the actual behavioral requirements of many involuntary hospitalization statutes may render probabilities of future behavior irrelevant. Part IV examines this matter more closely.

IV. WOULD ARAI-BASED EVIDENCE SUFFICE?

Hearings pursuant to statutes permitting post-imprisonment commitment of "sexually violent predators" (SVPs) have generated hundreds of published decisions that mention actuarial risk assessment instruments.[156] Although SVP statutes apply only to individuals who have been found guilty of past criminal acts, these statutes expressly direct courts to decide whether the respondent is "likely to engage in acts of sexual violence if not confined in a secure facility for long-term control, care, and treatment."[157] Such language makes probabilities of future actions the explicit focus of a court's concern, and ARAI-based information may represent the best "science" that mental health experts can offer to courts charged with making SVP commitment decisions.[158]

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156 A January 4, 2011 search of the LEXIS "Federal and State Cases, Combined" Database yielded 1,076 cases that cite one or more of the Static-99, RRASOR, or MnSOST-R, three instruments often used in sex offender hearings. *See, e.g.*, GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 314 (3d ed. 2007) (discussing these instruments).

157 N.H. REV. STAT. ANN. § 135-E:2(XII)(b) (LexisNexis Supp. 2010); FLA. STAT. ANN. § 394.912(10)(b) (West 2002) (exhibiting same language as New Hampshire statute); N.J. STAT. ANN. § 30:4-27.26(b) (West 2010) (exhibiting same language as New Hampshire statute); *see* CAL. WELF. & INST. CODE § 6600(a)(1) (West 2010) ("likely that he or she will engage in sexually violent criminal behavior").

158 Janus & Prentky, *supra* note 116, at 1449. Certain features of such instruments—particularly their numerical estimates of risk—are controversial among mental health professionals. *See, e.g.*, Terence W. Campbell & Gregory DeClue, *Maximizing Predictive Accuracy in Sexually Violent Predator Evaluations*, 2 OPEN ACCESS J. FORENSIC PSYCHOL. 148, 148-49 (2010), available at http://web.me.com/gregdeclue/Site/Volume_2__2010_files/Campbell2%202010.pdf (making recommendations about developing numerical estimates); Scott I. Vrieze & William M. Grove, *Predicting Sex Offender Recidivism. I. Correcting for Item Overselection and Accuracy Overestimation in Scale Development. II. Sampling Error-Induced Attenuation of Predictive Validity Over Base Rate Information*, 32 LAW & HUM. BEHAV. 266, 266 (2008) ("the user of an instrument similar in performance to the MnSOST-R cannot expect to achieve [a better] correct fraction . . . [estimate than what one would learn from] . . . the population recidivism rate alone"). As a result, some *Frye* jurisdictions have rejected testimony based on ARAIs. *See, e.g.*, Collier v. State, 857 So.2d 943, 946 ("Clearly, the State failed to establish SVR-20's

If criminal courts consider ARAI-based testimony to gauge risk in SVP commitments, might courts hearing traditional mental health commitment cases now be willing to do so, too? Our search for an answer took two forms.

A. Searching Decisions

We first searched the LEXIS "Federal & State Cases, Combined" database to see whether any court had expressly ruled that ARAI-based findings might, on their own, justify an order for involuntary psychiatric hospitalization.[159] We also searched the same database using a strategy that sought non-SVP commitment cases that mentioned actuarial methods.[160] As of November 16, 2010, this search returned 104 published decisions. Few of these concerned civil commitments of persons not previously involved in related criminal proceedings,[161]

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general acceptance in the relevant scientific community by a preponderance of the evidence."); People v. Taylor, 782 N.E.2d 920, 931 (Ill. App. Ct. 2002) ("Lacking a threshold showing of any indicia of validity, these instruments should not be presented to the jury as 'science.'"), abrogated by In re Commitment of Simons, 821 N.E.2d 1184 (Ill. 2004), and appeal denied, judgment vacated, 824 N.E.2d 277 (Ill. 2005), and vacated, 830 N.E.2d 855 (Ill. Ct. App. 2005). Interestingly, some *Frye* jurisdictions have held that the use of actuarial assessments in sexually violent predator commitment proceedings is not novel scientific evidence subject to the *Frye* test. *See, e.g., In re* Detention of Thorell, 72 P.3d 708, 725 (Wash. 2003); State *ex rel.* Romley v. Fields, 35 P.3d 82, 89 (Ariz. Ct. App. 2001); *In re* Detention of Erbe, 800 N.E.2d 137, 149 (Ill. Ct. App. 2003).

159 We initially searched "CLASSIFICATION OF VIOLENCE RISK" OR "COVR" OR "HCR-20" OR ((BR! OR BROSET) PRE/1 "VIOLENCE CHECKLIST"), which returned 40 cases mentioning the HCR-20. Most of these concerned parole or SVP commitment decisions. To exclude these, we modified the strategy to ("CLASSIFICATION OF VIOLENCE RISK" OR "COVR" OR "HCR-20" OR ((BR! OR BROSET) PRE/1 "VIOLENCE CHECKLIST")) AND NOT (PAROLE OR "SEXUALLY VIOLENT" OR "SEXUALLY DANGEROUS" OR "SEXUAL PREDATOR"). As of November 16, 2010, this strategy yielded four cases, of which two—*Makas* and *Ecker*, discussed below—concerned civil commitment.

160 The Boolean language for this search strategy was ((INVOLUNT! PRE/2 HOSPITA!) OR "CIVIL COMMITMENT" OR (INVOLUNT! PRE/2 COMMIT!) OR "MENTAL HEALTH COMMITMENT" OR (PSYCH! COMMITMENT)) AND (ACTUARIAL OR "RISK ASSESSMENT") AND NOT ("STATIC-99" OR "SEXUALLY VIOLENT" OR SVP OR "SEX OFFENDER").

161 That is, many of the appellants were former criminal defendants who had been found incompetent to stand trial and unrestorable (IST-U) or not guilty by reason of insanity (NGRI) concerning their criminal charges and who were then committed to hospitals for further care. Though the involuntary hospitalizations of such individuals technically are "civil" matters, committing courts know about the individual's previous actions, and judgments about their dangerousness reflect this knowledge. *See, e.g.*, Jones v. United States, 463 U.S.

and none addressed our question directly, but seven decisions provided indications about potential use of ARAIs for judging appropriateness of civil commitment. The following paragraphs summarize these cases, which provide indications of courts' views concerning ARAIs in civil commitment decisions.

1. *Griffin v. Twin Valley Psychiatric Systems*

The two Ohio cases of *Griffin v. Twin Valley Psychiatric Systems* are a Court of Claims decision and subsequent appeal by survivors of a former inpatient's shooting rampage and family members of persons whom the former inpatient killed.[162] On May 11, 1995, Jerry Hessler's mother initiated commitment proceedings via an affidavit.[163] That evening, the county sheriff picked up Hessler and brought him to Central Ohio Psychiatric Hospital (COPH), where Hessler was temporarily detained pending a hearing.[164] On May 17, the county probate court ruled that Hessler should remain at COPH under a commitment order, and he stayed there until his discharge on July 20,

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354, 364 (1983) ("The fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness."); Gwen A. Levitt et al., *Civil Commitment Outcomes of Incompetent Defendants*, 38 J. AM. ACAD. PSYCHIATRY & L. 349, 349 (2010) (empirical study showing that in commitment hearings, IST-U persons are treated differently from persons not previously charged with crimes). Also, commitment of IST-U and NGRI often takes place pursuant to special legislation and remains the supervision of the original criminal court. *See e.g.*, OHIO REV. CODE ANN. §§ 2945.39, 2945.401 (LexisNexis 2010) (section from state's criminal procedure volume provides that individuals found IST-U or NGRI may remain under criminal court jurisdiction subject to proceedings different from those governing ordinary civil commitment); State v. Williams, 930 N.E.2d 770, 772 (Ohio 2010) (upholding constitutionality of sections 2945.39 and 2945.401).

162 Griffin v. Twin Valley Psychiatric Sys., 771 N.E.2d 945, 947 (Ohio Ct. Cl. 2002); Griffin v. Twin Valley Psychiatric Sys., No. 02AP-744, 2003 WL 22999355, at *4 (Ohio Ct. App. Dec. 23, 2003).

163 771 N.E.2d at 947. In her filings, Hessler's mother said her son had recently assaulted her and damaged her home, possessed multiple firearms, threatened his brother with a handgun, and stalked and threatened to kill a former girlfriend and her husband. *Id.*

164 *Id.* at 947–48. COPH was subsequently renamed Twin Valley Psychiatric System. *Id.* Located at 2200 West Broad Street in Columbus, Ohio, the hospital is one of Ohio's public sector regional psychiatric facilities. Its current name is Twin Valley Behavioral Healthcare. *See Twin Valley Behavioral Healthcare*, OHIO DEP'T OF MENTAL HEALTH, http://www.mh.state.oh.us/what-we-do/provide/hospital-services/regional-psychiatric-hospitals/twin-valley.shtml (last visited November 15, 2010).

1995.[165] On November 19, 1995, Hessler killed four people and wounded and terrified others.[166] The police promptly apprehended him, and he received a death sentence at his subsequent murder trial.[167] The plaintiffs in *Griffin* alleged that COPH had negligently treated and discharged Hessler, but following a bench trial, the Court of Claims found in favor of the defendant hospital.[168]

The plaintiffs' appeal faulted the trial court for concluding that COPH had adequately evaluated Hessler before discharging him.[169] The trial court had found that COPH personnel had "assessed [Hessler's] risk of violence according to standards of care applicable then, which did not rely on any formal risk assessment checklist but depended upon clinical interviews with knowledge of his violent history."[170] But a plaintiffs' expert had testified that COPH "should have performed a structured risk assessment."[171] Experts for the defendants countered that the hospital had considered known risk factors thoroughly and that instruments for structured risk assessment did not exist when Hessler was hospitalized.[172] The appeals court found that the trial court appropriately concluded that COPH had assessed Hessler's risk of violence in accordance with the 1995 standards of care.[173]

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165 *Griffin*, 771 N.E.2d at 948–49.

166 *Id.* at 958.

167 *See* State v. Hessler, 734 N.E.2d 1237, 1258 (Ohio 2000). Hessler died in prison in January 2003. Alayna DeMartini, *Killer Dies in Death Row Cell; Murderer of Four Suffers Heart Attack*, COLUMBUS DISPATCH (OHIO), January 15, 2003, at C1.

168 *Griffin*, 771 N.E.2d at 958–59.

169 Griffin v. Twin Valley Psychiatric Sys., No. 02AP-744, 2003 WL 22999355, at *11 (Ohio Ct. App. Dec. 23, 2003).

170 *Griffin*, 771 N.E.2d at 952.

171 *Griffin*, No. 02AP-744 at *12.

172 *Id.* at *12–*13.

173 *Id.* at *13.

2. *Matter of Bolles*[174]

Before hospitalization, Alicia Lee Bolles used a three-inch paring knife to stab a recreation center employee—"an overt [dangerous] act causing serious physical harm to another"[175] that the trial and appellate courts felt satisfied Minnesota's requirements for demonstrating dangerousness.[176] In her appeal, however, Bolles contended that she was no longer dangerous by the time her hearing occurred.[177] However, a psychologist at her hearing had testified that Bolles's history of failing to take her medication, the stabbing, "and other actuarial factors" made her dangerous; this testimony, said the appeals court, was a sufficient basis for the trial court's conclusion that Bolles remained "substantially likely to engage in future acts capable of inflicting serious harm on another."[178]

3. *Monaco v. Hogan*[179]

In this section 1983 class action lawsuit, the plaintiffs sought declaratory and injunctive relief against New York State mental health clinicians and officials, challenging allegedly lengthy confinement of individuals found incompetent to stand trial and the procedures used in involuntary hospitalization of mentally ill persons.[180] The defendants moved for summary judgment on several of the plaintiffs' causes of action, which the court ultimately granted after finding that the "deliberate indifference" standard had not been met.[181]

Among other accusations, the plaintiffs had alleged that psychiatrists said mentally ill persons were dangerous merely because the persons needed treatment; the psychiatrists had not used "guide-

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174 *In re* Civil Commitment of Bolles, No. A07-552, 2007 Minn. App. Unpub. LEXIS 791 (Minn. Ct. App. Aug. 7, 2007).

175 *Id.* at *2–*3.

176 *Id.* at *1.

177 *Id.* at *3.

178 *Id.* *8–*9.

179 Monaco v. Hogan, 576 F. Supp. 2d 335 (E.D.N.Y. 2008).

180 *Id.* at 336–37.

181 *Id.* at 338, 351.

lines" or "significant criteria related to the likelihood of causing harm when examining allegedly mentally ill individuals for civil commitment purposes . . . ."[182] Of particular interest here is the court's acceptance of the position articulated by testifying experts for both parties, who agreed that actuarial or structured professional judgment—but not unaided clinical judgment—were the proper methods for assessing risk.[183] Evidence introduced by the plaintiffs showed that clinicians had used clinical judgment—a presumptively inferior method—in making decisions related to present dangerousness.[184] Yet the court noted that "[d]ue process does not require a guarantee that a physician's assessment of the likelihood of serious harm be correct," provided that the physician applies "criteria that are not substantially below the standards generally accepted in the medical community."[185] The court stated that plaintiffs had submitted sufficient evidence that, if accepted by a fact-finder, might permit the conclusions that psychiatrists' practice fell below generally accepted medical standards,[186] but the psychiatrists' actions did not "shock the conscience."[187] Moreover, given other, conflicting obligations faced by psychiatrists who make civil commitment judgments,[188] the psychiatrists' conduct clearly had not constituted "deliberate indifference" to their patients, and no psychiatrist had used a declaration of dangerousness as a pretext to commit anyone whom the psychiatrist did not really think was dangerous.[189]

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182 *Monaco*, 576 F. Supp. 2d at 342 n.14.

183 *Id.* at 344.

184 *Id.* at 348.

185 *Id.* at 347 (citing Rodriguez v. City of New York, 72 F.3d 1051, 1061, 1063 (2d Cir. 1995)).

186 *Id.* at 349.

187 The court cited several cases that established this as the standard for evaluating alleged due process violations in civil commitment matters. *Monaco*, 576 F. Supp. 2d at 350, (citing Benn v. Univ. Health Sys., Inc., 371 F.3d 165, 174 (3d Cir. 2004); Norris v. Engles, 494 F.3d 634, 638 (8th Cir. 2007); James v. Grand Lake Mental Health Ctr., Inc., 161 F.3d 17 (10th Cir. 1998); Abascal v. Hilton, 2008 WL 268366 at *18 (N.D.N.Y. Jan. 30, 2008); Disability Advocates, Inc. v. McMahon, 279 F. Supp. 2d 158, 167 (N.D.N.Y. 2003)).

188 *Monaco*, 576 F. Supp. 2d at 350–51 (citing Olivier v. Robert L. Yeager Mental Health Ctr., 398 F.3d 183, 189 (2d Cir. 2005) and Lombardi v. Whitman, 485 F.3d 73, 82 (2007)).

189 *Id.* at 351.

4. *United States v. Wabol*[190]

In late 2006, a federal district court found Mr. Wabol not guilty only by reason of insanity (NGRI) on charges of making threatening interstate telephone calls and committed him to the Federal Medical Center in Butner, North Carolina pursuant to 18 U.S.C. § 4243(e).[191] Wabol sought unconditional release from his post-NGRI commitment on grounds that he no longer had a mental illness and posed no risk of harming anyone.[192] In denying Wabol's request, the court cited, *inter alia*,[193] a June 2008 report prepared by Butner clinicians that examined "twenty-three well-recognized risk and protective factors that have been shown to correlate positively and negatively with future violent behaviors."[194]

However, the court's decision focuses not on a score or probability derived from these factors, but on the *presence* of these factors and what these factors' *established past effects* on Wabol's behavior implied about the factors' likely future impact.[195] The court cited persistence of Wabol's delusions about "an elaborate conspiracy" against him, his comments throughout his hearing, his previous violence and criminal activity, his ability to resume abusing alcohol and drugs if released, his lack of any plans for where he could live, and evidence suggesting that he would stop taking his medication (which would allow his illness to gain renewed intensity).[196] If released, said the

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190 United States v. Wabol, No. 3:04-Cr-62-TS, 2009 U.S. Dist. LEXIS 11957 (N.D. Ind. Feb. 13, 2009).

191 *Id.* at *2–*6 (summarizing case history).

192 *Id.* at *1. Following Foucha v. Louisiana, 504 U.S. 71, 77 (1992), individuals found NGRI may be confined only if they are both longer mentally ill and pose a danger to themselves or others. Under 18 U.S.C. § 4243(f)(2006), a federal insanity acquittee who seeks release from a hospital must show that leaving confinement would not "create a substantial risk of bodily injury to another person or serious damage to property of another. . . ."

193 The court also noted persistence of many signs and symptoms of mental illness. *Wabol*, 2009 U.S. Dist. LEXIS 11957, at *9–*10.

194 A previous decision, United States v. Wabol, No. 3:04-CR-62-TS, 2006 U.S. Dist. LEXIS 92610 at *8, *10 (N.D. Ind. Dec. 21, 2006), expressly mentions the "HRC-20 [sic]."

195 *Wabol*, 2009 U.S. Dist. LEXIS 11957 at *11.

196 *Wabol*, 2006 U.S. Dist. LEXIS 92610 at *12–*19. Here, the court quoted a testifying expert's statement that this was "probably the best single predictor of future violence, with risk increasing with each prior episode." *Id.* at *14.

court, Wabol "would experience a drastic change from the highly controlled and supervised environment to complete independence," experience recurrence of the same delusions that led to the acts for which he was found NGRI, and be able to act on those delusional beliefs.[197] Wabol, therefore, still had "a present mental disease or defect," and when not medicated, "he acts on the delusions and is unable to appreciate the wrongfulness of his conduct."[198]

5. *Matter of Timothy Makas v. Mid-Hudson Forensic Psychiatric Center*[199]

Although *Makas* addressed the continued commitment of an insanity acquittee (rather than someone who never was charged criminally for acts related to his hospitalization),[200] we examine this case because New York state specifies that an appellate court's review of an insanity acquittee's commitment must be "a *de novo* evidentiary proceeding, *with the findings a snapshot of the acquittee's condition at that moment.*"[201] The court found that Makas, though mentally ill and in need of treatment, was no longer dangerous.[202] In reaching this conclusion, the court noted that Makas had done nothing violent for twelve years and (referring to an expert's testimony) had low scores on the HCR-20 and the Hare Psychopathy Checklist-Revised.[203]

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197 *Id.* at *16-*17.

198 *Id.* at *21.

199 Makas v. Mid-Hudson Forensic Psychiatric Ctr., 905 N.Y.S.2d 477 (N.Y. Sup. Ct. 2010).

200 *Id.* (discussing distinctive features of insanity acquittees' commitments).

201 *Id.* at 478-79 (quoting *In re* Norman D., 818 N.E.2d 642 (N.Y. 2004)).

202 *Id.* at 480.

203 *Id. See generally* Robert D. Hare, *Psychopathy: A Clinical and Forensic Overview*, 29 PSYCHIATRIC CLINICS N. AM. 709 (2006) (discussing psychopathy and its relationship to criminal offending); Robert D. Hare, *Psychological Instruments in the Assessment of Psychopathy*, *in* THE INTERNATIONAL HANDBOOK ON PSYCHOPATHIC DISORDERS AND THE LAW 41 (A. R. FELTHOUS & H. SAß eds., 2007) (discussing Hare's checklist).

6. *Ecker v. Worcester State Hospital*[204]

John Ecker had spent twenty years in federal facilities after being found incompetent to stand trial on a charge of possessing a firearm when, in September 2009, he was transferred to Worcester State Hospital (WSH) in Massachusetts.[205] Ecker refused to sign in voluntarily, so WSH clinicians initiated civil commitment proceedings.[206] District court judge Loconto ordered Ecker's commitment, which Ecker appealed.[207]

According to the appellate court's account of the district court hearing, testifying clinicians had described Ecker's paranoia and delusional fixations on women and multiple calls to WSH staff members.[208] These symptoms appeared to satisfy the requirement of a current mental disorder under Massachusetts law.[209] Moreover, his persisting delusions and ongoing attentions to a case worker showed that he still "posed a threat," as did Ecker's "history and risk of violent behavior" documented by historical risk factors on the HCR-20.[210] Taken together, these findings convinced Judge Loconto that Ecker still represented "a likelihood of serious harm to the public."[211] Ecker had not engaged in any recent incident of harmful behavior, but as the appeals court noted, Massachusetts law has "'no requirement that a 'likelihood of serious harm' be established by evidence of a recent overt act. Nor does the statutory definition of 'likelihood of serious

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204 Ecker v. Worcester State Hosp., No. 10-0494, 2010 Mass. Super. LEXIS 222 (Mass. Super. Ct. June 30, 2010).

205 *Id.* at *1-*2.

206 *Id.* at *2.

207 *Id.* at *2-*3, *17.

208 *Id.* at *8-*11. At the hearing, psychiatrist Debra A. Pinals testified that Ecker's behavior reflected an erotomanic delusional system in which Ecker interpreted irrelevant events as "signs" that a woman really liked him. *Id.* at *10-*11 & n.8.; *see generally* STALKING: PSYCHIATRIC PERSPECTIVES AND PRACTICAL APPROACHES 28-36 (Debra A. Pinals ed., 2007) (discussing erotomania in the context of persistent contacting or "stalking").

209 *Ecker*, 2010 Mass. Super. LEXIS 222 at *17-*18.

210 *Id.* at *11, *12 & n.9.

211 *Id.* at *12.

harm,' . . . require a recent overt act.'"[212] The appeals court, therefore, found no reason to overturn the district court's judgment.[213]

B. Searching Statutes

We also conducted LEXIS searches of each state's commitment laws. We located the portions of each state's code dealing with (traditional) mental health commitments; then, we examined statutory language to see whether the plain meaning suggested (or clearly stated) that overt behavior was a requirement for commitment. For several states, LEXIS provided case annotations for commitment statutes. We examined these citations to find any cases that interpreted sections of the commitment law dealing with evidence requirements related to any overt behavior. When annotated cases did not adequately clarify matters for a particular state, we searched that state's LEXIS "State Cases, Combined" database to find cases containing phrases from the commitment statute that referred or were in close proximity to phrases dealing with behavioral requirements.[214] We also checked to see whether incompetence to make treatment decisions about psychiatric care was a requirement for commitment.

The results of our statutory searches appear in Table 1. Column 1 contains the two-letter symbol for each U.S. state and the District of Columbia. Columns 2–4 of each row contain a citation for the state's statute, the specific type of risk addressed by the statutory phrase, and the statute's language concerning what evidence proves that risk. Column 5 uses "Y" and "N" ("yes" or "no") to indicate whether incompetence to make treatment decisions is a criterion for commitment based on the specific type of risk that the statutory section addresses. Columns 6–9 use "Y" and "N" to indicate whether behavior

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212 *Id.* at *19 (citing Commonwealth v. Rosenberg, 573 N.E.2d 949 (Mass. 1991)). Though Massachusetts law requires some behavioral evidence, MASS. GEN. LAWS ANN. Ch. 123, §1 (West 2003), *Rosenberg* permits commitment based on "any activity"—not just recent activity. *Rosenberg*, 573 N.E.2d at 959.

213 *Ecker*, 2010 Mass. Super. LEXIS 222, at *20.

214 Because the commitment statutes vary in their wording, the exact search strategy for each state differed. For states with statutes that contain the phrase "overt act," we used this to look for instances where courts might have interpreted the phrase and confirmed or disconfirmed the need for actual behavior.

is required to prove the risk. Finally, Column 10 contains those cases we located that clarified whether actual behavior was required to prove the risk exists.

Before summarizing our findings, we acknowledge that for the many statutes about which we found no state case law addressing the "overt act" issue, we had to infer how courts might interpret statutory language. Some states' statutes seem to provide clear indications about this. For example, Florida's statute requires that risk of harm to self or others be "evidenced by recent behavior causing, attempting, or threatening such harm."[215] In Georgia, proving risk to self or others requires "recent overt acts or recent expressed threats of violence which present a probability of physical injury . . . ."[216]

In many cases, however, matters were less certain, particularly where statutes addressed risk of deterioration or grave disability. For example, in Idaho, proof of risk for deterioration requires a showing, based on the respondent's "psychiatric history, clinical observation or other clinical evidence, [that] if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate . . . ."[217] Because the statute refers to someone who will "continue to" experience deterioration, we concluded that the statute implies that some deterioration has occurred—something that one could know only from observing the respondent's speech or actions. By contrast, proving grave disability in Idaho involves demonstrating the respondent's "inability to provide for any of his own basic personal needs," or his lack of insight into needing treatment, failure to comply with treatment, and clinical evidence that without treatment, he would continue to deteriorate and fail to provide for himself.[218] We interpreted this statute as *not* requiring actual behavior because a mental health professional's clinical knowledge of how a severe illness affects persons in general, or of how a previous episode of illness had affected a particular respondent, might suffice to justify civil commitment, even if the respondent

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215 FLA. STAT. ANN. § 394.467(1)(a)2b (West 2009).

216 GA. CODE ANN. § 37-3-1(9.1) (1995).

217 IDAHO CODE ANN. § 66-317(11)(c) (2010).

218 IDAHO CODE ANN. § 66-317(13) (2010).

in question had not yet let anything self-damaging occur.

[this section resumes after Table 1]

Table 1.—Overt behavioral requirements in civil commitment statutes

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
AL	ALA. CODE § 22-52-10.4(a) (2006).	harm to self	(i) Mental illness causes "a real and present threat of substantial harm to self"; (ii) if not treated, will "continue to suffer mental distress and . . . experience deterioration"; (iii) cannot "make a rational and informed [treatment] decision"	Y		N			Garrett v. State, 707 So. 2d 273 (1997).
AL	ALA. CODE § 22-52-10.4(a) (2006).	harm to others	(i) Mental illness causes "a real and present threat of substantial harm to . . . others"; (ii) if not treated, will "continue to suffer mental distress and . . . experience deterioration"; (iii) cannot "make a rational and informed [treatment] decision"	Y	N				
AK	ALASKA STAT.§ 47.30.735(c) (2010).	gravely disabled	Because of mental illness, respondent is likely to be gravely disabled	N			N		
AK	ALASKA STAT. § 47.30.735(c) (2010).	harm to others	Because of mental illness, respondent is likely to cause harm to others	N	N				
AK	ALASKA STAT. § 47.30.735(c) (2010).	harm to self	Because of mental illness, respondent is likely to cause harm to respondent	N		N			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
AZ	ARIZ. REV. STAT. ANN. § 36-501(6) (2009 & Supp. 2010).	danger to self	(a) "[B]ehavior that . . . (i) constitutes a danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof . . . (ii) without hospitalization will result in serious physical harm or serious illness to the person." This definition "[d]oes not include behavior that establishes only the condition of gravely disabled."	N		Y			
AZ	ARIZ. REV. STAT. ANN. § 36-501(5) (2009 & Supp. 2010).	danger to others	"[J]udgment of a person who has a mental disorder is so impaired that [he] is unable to understand [his] need for treatment and as a result of [his] mental disorder [his] continued behavior can reasonably be expected . . . to result in serious physical harm"	Y	N				A finding of "danger to others" need not be predicated on recent dangerous conduct. *In re* Pima County Mental Health No. MH 1717-1-85, 149 Ariz. 594, 721 P.2d 142 (Ct. App. 1986).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
AZ	ARIZ. REV. STAT. ANN. § 36-501(33) (2009 & Supp. 2010).	persistently or acutely disabled	"[S]evere mental disorder that meets all these criteria: (a) if not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality, (b) substantially impairs the person's capacity to make an informed decision regarding treatment, and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and . . . the alternatives . . . after the advantages, disadvantages and alternatives are explained, (c) has a reasonable prospect of being treatable. . ."	Y				N	*In re* Appeal of Mental Health Case No. MH 94-00592, 897 P.2d 742, 747 (Ariz. Ct. App. 1995) (holding "the court may not require evidence of current behavior which may manifest the patient's persistent or acute disability, so long as petitioner provides other clear and convincing evidence of the disability.").
AZ	ARIZ. REV. STAT. ANN. § 36-501(16) (2009 & Supp. 2010).	gravely disabled	"[A] condition evidenced by behavior in which a person . . . is likely to come to serious physical harm or serious illness because [he] is unable to provide for [his] own basic physical needs"	N			Y		
AR	ARK. CODE ANN. § 20-47-207(c)(1) (A)–(B) (Supp. 2009).	danger to self	The person has inflicted, or threatened serious bodily self-injury or has attempted suicide, and there is a reasonable probability that the conduct will be recur without admission;	N		Y			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
AR	ARK. CODE ANN. § 20-47-207(C)(1) (C) (Supp. 2009).	grave disability	"[R]ecent behavior or behavior history demonstrates [the person] so lacks the capacity to care for his own . . . welfare that there is a reasonable probability of death, serious bodily injury, or serious physical or mental debilitation if admission is not ordered"	N			Y		
AR	ARK. CODE ANN. § 20-47-207(C)(1) (D) (Supp. 2009).	deterioration	"(i) The person's understanding of the need for treatment is impaired to the point that [he] is unlikely to participate in treatment voluntarily; (ii) The person needs mental health treatment . . . to prevent a relapse or harmful deterioration . . . ; and (iii) in the last 48 months, the person's noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least twice, or has been a factor in the individual's committing one or more acts, attempts, or threats of serious violent behavior."	Y				Y	
AR	ARK. CODE ANN. § 20-47-207(c)(2) (Supp. 2009).	danger to others	"[T]he person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another, and there is a reasonable probability that the conduct will occur if admission is not ordered."	N	Y				Ford v. U.S., No. 4:08CV00176 JLH, 2010 WL 936693, at *9 (E.D. Ark. Mar. 15, 2010)

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
CA	CAL. WELF. & INST. CODE § 5300 (West 2010).	danger to others	"At the expiration of the 14-day period of intensive treatment, a person may be confined for further treatment . . . for an additional period, not to exceed 180 days if . . . [t]he person has attempted, inflicted or made a serious threat of substantial physical harm upon the person of another [and] . . . presents a demonstrated danger of inflicting substantial physical harm upon others"	N	Y				*In re* Gonzales, 491 P.2d 809,810 (Cal. 1971). (case pre-dates changes to the statute.)
CA	CAL. WELF. & INST. CODE § 5150 (West 2010).	danger to himself or herself	"When any person, as a result of mental disorder, is a danger to others, or to himself or herself . . . upon probable cause . . . be taken . . . into custody"	N		N			People v. Jason K., 116 Cal. Rptr. 3d 443, 448 (Cal. Ct. App. 2010), *review denied* (Jan. 26, 2011), reh'd denied (Oct. 26, 2010).
CA	CAL. WELF. & INST. CODE § 5008(h) (West 2010).	gravely disabled	"unable to provide for his or her basic personal needs for food, clothing, or shelter"	N			N		Estate of Chambers, 139 Cal. Rptr. 357–60 (Cal. Ct. App. 1977)
CO	COLO. REV. STAT. § 27-10-105 (1)(a)(I) (2010).	danger to others	"When any person appears to have a mental illness . . . appears to be in imminent danger to others or himself . . . [or] gravely disabled, then . . . the 'intervening professional' . . . may take the person into custody"	N	Y				People v. Taylor, 618 P.2d 1127, 1137 (Colo. 1990). ("[d]anger-ousness to others may be shown by evidence of injurious acts, attempts, or threats.")
CO	COLO. REV. STAT. § 27-10-105 (1)(a)(I) (2010).	danger to self	"When any person appears to have a mental illness . . . appears to be in imminent danger to others or himself . . . [or] gravely disabled, then . . . the 'intervening professional' . . . may take the person into	N		Y			People v. Taylor, 618 P.2d 1127, 1137 (Colo. 1990). ("Danger-ousness to oneself may be shown by . . . evidence,

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
			custody"						where the individual's injurious behavior is directed toward himself.")
C O	COLO. REV. STAT. § 27-65-102(9) (2010).	gravely disabled	(a)(I) [D]anger of serious physical harm due to his or her inability or failure to provide himself with food, clothing, shelter, and medical care; or (II) lacks judgment in managing resources and conducting social relations to the extent that his health or safety is significantly endangered and lacks the capacity to understand this. (b) if notice is given that [family] support is to be terminated and the individual (I) has a major mood or thought disorder; (II) has been certified or gotten inpatient treatment at least twice in the last 36; and (III) is deteriorating toward danger to self or others or grave disability with symptoms and behavior similar to those associated with previous treatment; and (IV) Is not receiving treatment essential for health or safety.	Y			N		
C T	CONN. GEN. STAT. ANN. § 17a-495(a) (West Supp. 2010).	dangerous to himself	"[S]ubstantial risk that physical harm will be inflicted by an individual upon his or her own person"	N		N			
C T	CONN. GEN. STAT. ANN. § 17a-495(a) (West Supp. 2010).	danger to others	"[S]ubstantial risk that physical harm will be inflicted by an individual . . . upon another person"	N	N				

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
CT	CONN. GEN. STAT. ANN. § 17a-495(a) (West Supp. 2010).	gravely disabled	"[I]n danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities"	Y			Y		
DE	DEL. CODE ANN. tit. 16 § 5001(6) (2010).	harm to self	"[B]oth (i) renders such person unable to make responsible decisions with respect to the person's hospitalization, and (ii) poses a real and present threat, based upon manifest indications, that such person is likely to commit or suffer serious harm to that person's own self or others or to property if not given immediate hospital care and treatment."	Y		Y			
DE	DEL. CODE ANN. tit. 16 § 5001(6) (2010).	harm to others	"[B]oth (i) renders such person unable to make responsible decisions with respect to the person's hospitalization, and (ii) poses a real and present threat, based upon manifest indications, that such person is likely to commit or suffer serious harm to that person's own self or others or to property if not given immediate hospital care and treatment."	Y	Y				
DE	DEL. CODE ANN. tit. 16 § 5001(6) (2010).	harm to property	"[B]oth (i) renders such person unable to make responsible decisions with	Y				Y	

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
			respect to the person's hospitalization, and (ii) poses a real and present threat, based upon manifest indications, that such person is likely to commit or suffer serious harm to that person's own self or others or to property if not given immediate hospital care and treatment."						
DC	D.C. CODE § 21-545(b)(2) (LexisNexis 2008).	harm to others	"[I]s likely to injure himself or others if not committed"	N	N				*In re* Artis, 615 A.2d 1148,1153 (D.C. 1992).
DC	D.C. CODE § 21-545(b)(2) (LexisNexis 2008).	harm to self	"[I]s likely to injure himself or others if not committed"	N		N			
FL	FLA. STAT. ANN. § 394.467(1)(a) (2)(a) (West 2006).	harm to well-being	"[Cannot survive] alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself"	Y			Y		
FL	FLA. STAT. ANN. § 394.467(1)(a) (2)(b) (West 2006).	serious bodily harm to self	"[R]ecent behavior causing, attempting, or threatening such harm"	Y		Y			
FL	FLA. STAT. ANN. § 394.467(1)(a) (2)(b) (West 2006).	serious bodily harm to another	"[R]ecent behavior causing, attempting, or threatening such harm"	Y	Y				
GA	GA. CODE ANN. § 37-3-1(9.1)(A)(i) (Supp. 2011).	harm to self	"[R]ecent overt acts or recent expressed threats of violence which present a probability of physical injury to that person"	N		Y			
GA	GA. CODE ANN. § 37-3-1(9.1)(A)(i) (Supp. 2011).	harm to others	"[R]ecent overt acts or recent expressed threats of violence which present a probability of physical injury to other persons"	N	Y				
GA	GA. CODE ANN. § 37-3-1(9.1)(A)(ii) (Supp. 2011).	unable to care for self	"[S]o unable to care for . . . own physical health and safety as to create an imminently life-endangering crisis"	N			N		Ruff v. Cent. State Hosp., 385 S.E.2d 734, 735-36 (Ga. Ct. App. 1989).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
H I	HAW. REV. STAT. ANN. § 334-1 (LexisNexis Supp. 2009).	dangerous to self	"[P]erson recently has threatened or attempted suicide or serious bodily harm; or the person recently has behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded"	N		Y			
H I	HAW. REV. STAT. ANN. § 334-1 (LexisNexis Supp. 2009).	dangerous to others	"[L]ikely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat"	N	Y				
H I	HAW. REV. STAT. ANN. § 334-1 (LexisNexis Supp. 2009).	gravely disabled	"(1) . . . [U]nable to provide for . . . basic personal needs for food, clothing, or shelter; (2) . . . unable to make or communicate rational or responsible decisions concerning . . . personal welfare; and (3) lacks the capacity to understand [this]."	Y			Y		
H I	HAW. REV. STAT. ANN. § 334-1 (LexisNexis Supp. 2009).	obviously ill	"[C]urrent behavior and previous history of mental illness, if known, indicate a disabling mental illness[;] the person is incapable of understanding [the] . . . serious and highly probable risks to health and safety involved in refusing treatment, the advantages of . . . treatment, or of understanding the advantages of treatment and the	Y				Y	

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
			alternatives to the treatment offered, after [these] have been explained"						
I D	IDAHO CODE ANN. § 66-317(11)(a) (Supp. 2010).	physical harm to self	"[E]videnced by threats[,] attempts to commit suicide[,] or inflict physical harm on [self]"	N		Y			
I D	IDAHO CODE ANN. § 66-317(11)(b) (Supp. 2010).	physical harm to another	"[E]videnced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm"	N	Y				
I D	IDAHO CODE ANN. § 66-317(11)(c) (Supp. 2010).	deterioration	"[L]acks insight into . . . need for treatment and [cannot or will not] comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive . . . treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point [he will soon] inflict physical harm on himself or another person"	Y				Y	

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
ID	IDAHO CODE ANN. § 66-317(13) (Supp. 2010).	gravely disabled	"(a) In danger of serious physical harm [from] inability to provide for any . . . basic personal needs [(nourishment, clothing, medical care, shelter or safety)]; or (b) Lacking insight into his need for treatment and [cannot or will not] comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not [get] treatment, there is a substantial risk [of deteriorating and being] in danger of serious physical harm due to [failure to provide] for . . . basic personal needs"	Y			N		
IL	405 ILL. COMP. STAT. ANN. 5/1-119(1) (LexisNexis Supp. 2006).	harm to others	"[C]ourt may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness"	N	N				*See In re* Lillie M., 875 N.E..2d 157, 161 (Ill. App. Ct. 2007) ("The court may look to evidence of a person's illness."). *But see In re* Torski C., 918 N.E.2d 1218, 1232 (Ill. App. Ct. 2009), appeal dismissed as moot (Sept. 15, 2010), appeal allowed, 930 N.E.2d 409 (Mar. 24, 2010) ("'dangerous conduct,' as set forth in section 1-104.5 and referenced in section 1-119(3) . . . does not

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
									provide a sufficient standard to justify the involuntary hospitalizati on of a mentally ill individual.").
IL	405 ILL. COMP. STAT. ANN. 5/1-119(1) (LexisNexis Supp. 2010).	harm to self	"[C]ourt may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness."	N		N			*In re* Mazzara, 478 N.E.2d 567, 569 (Ill. App. Ct. 1985).
IL	405 ILL. COMP. STAT. ANN. 5/1-119(2) (LexisNexis Supp. 2010).	serious harm	"[C]ourt may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness."	N			N		
IL	405 ILL. COMP. STAT. ANN. 5/1-119(3) (LexisNexis Supp. 2010).	deterioration	"[U]nable to understand . . . need for treatment and . . . if not treated, is [likely] to suffer . . . mental . . . or emotional deterioration . . . to the point [of engaging] in dangerous conduct"	Y				N	
IN	IND. CODE ANN. § 12-7-2-53 (LexisNexis 2006).	harm to others	"[T]he behavior used as an index of a person's dangerousness would not occur but for that person's mental illness"	N	Y				*In re* Commitment of Gerke, 696 N.E.2d 416, 418 (Ind. App. 1998).
IN	IND. CODE ANN. § 12-7-2-53 (LexisNexis 2006).	harm to self	See case citation	N		Y			*In re* Commitment of Gerke, 696 N.E.2d 416, 418 (Ind. App. 1998).
IN	IND. CODE ANN. § 12-7-2-53 (LexisNexis 2006).	gravely disabled	See case citation	N			Y		*In re* Commitment of Gerke, 696 N.E.2d 416, 418 (Ind. App. 1998).
IA	IOWA CODE ANN. § 229.1(17)(a) (West Supp. 2010).	physically injure self	See case citation	Y		Y			*In re* Mohr, 383 N.W.2d 539, 542 (Iowa 1986)

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
									(" recent overt act, attempt or threat").
IA	IOWA CODE ANN. § 229.1(17)(a) (West Supp. 2010).	physically injure others	See case citation	Y	Y				*In re* Mohr, 383 N.W.2d 539, 542 (Iowa 1986) (" recent overt act, attempt or threat").
IA	IOWA CODE ANN. § 229.1(17)(b) (West Supp. 2010).	emotional injury to others	See case citation	Y				Y	In Interest of J.P., 574 N.W.2d 340, 344 (Iowa 1998) ("recent overt act, attempt or threat").
IA	IOWA CODE ANN. § 229.1(17)(c) (West Supp. 2010).	physical injury or debilitation	See case citation	Y			Y		In Interest of J.P., 574 N.W.2d 340, 344 (Iowa 1998) ("recent overt act, attempt or threat").
KS	KAN. STAT. ANN. § 59-2946(f)(3)(a) (2005).	harm to self	Behavior threatening, attempting or causing such injury, abuse or damage	Y		Y			
KS	KAN. STAT. ANN. § 59-2946(f)(3)(a) (2005).	harm to others	Behavior threatening, attempting or causing such injury, abuse or damage	Y	Y				
KS	KAN. STAT. ANN. § 59-2946(f)(3)(a) (2005).	harm to property		Y				Y	
KS	KAN. STAT. ANN. § 59-2946(f)(3)(b) (2005).	deterioration	"[A] substantial deterioration of the person's ability to function"; present statute, however, does not expressly require a showing of present danger or a recent overt act.	Y			N		*In re* Albright, 836 P.2d 1, 5 (Kan. Ct. App. 1992)
KY	KY. REV. STAT. ANN. § 202A.011(2) (LexisNexis 2007).	substantial physical harm to self	"[I]ncluding actions which deprive self, family, or others of the basic means of survival including provision for reasonable shelter, food, or clothing"	N		N			No case . addresses meaning of "including" clearly
KY	KY. REV. STAT. ANN. § 202A.011(2) (LexisNexis 2007).	substantial physical harm to others		N	N				

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
LA	LA. REV. STAT. ANN. § 28:2(4) (Supp. 2011).	physical or severe emotional harm upon his own person	"[C]ondition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person."	N		Y			
LA	LA. REV. STAT. ANN. § 28:2(3) (Supp. 2011).	physical harm to another	"[C]ondition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future."	N	Y				
LA	LA. REV. STAT. ANN. § 28:2(10) (Supp. 2011).	gravely disabled	"[C]ondition of a person who is unable to provide for his own basic physical needs, such as essential food, clothing, medical care, and shelter, as a result of serious mental illness or substance abuse and is unable to survive safely in freedom or protect himself from serious harm; the term also includes incapacitation by alcohol, which means the condition of a person who, as a result of the use of alcohol, is unconscious or whose judgment is otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment"	N			Y		*In re* M.M., 552 So. 2d 528, 528, 530 (1989).
ME	ME. REV. STAT. ANN. tit. 34-B, §§ 3801(4-A)(A), 3864(6)(A)(1) (2010).	physical harm to self	"[R]ecent threats of, or attempts at, suicide or serious [bodily harm to himself]"	N		Y			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
ME	ME. REV. STAT. ANN. tit. 34-B, §§ 3801(4-A)(B), 3864(6)(A)(1) (2010).	physical harm to others	"[R]ecent homicidal or violent behavior or . . . recent conduct placing others in reasonable fear of serious physical harm"	N	Y				
ME	ME. REV. STAT. tit. 34-B, §§ 3801(4-A)(C), 3864(6)(A)(1) (2010).	severe physical or mental impairment or injury	"[R]ecent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury"	N			Y		
MD	MD. CODE ANN., HEALTH–GEN. § 10-622(a)(2) (LexisNexis Supp. 2010).	life or safety of individual	(not specified)	N		N			
MD	MD. CODE ANN., HEALTH–GEN. § 10-622(a)(2) (LexisNexis Supp. 2010).	life or safety of others	(not specified)	N	N				
MA	MASS. GEN. LAWS ANN. ch. 123, § 1 (West 2003).	physical harm to self	"[E]vidence of, threats of, or attempts at, suicide or serious bodily harm"	N		Y			
MA	MASS. GEN. LAWS ANN. ch. 123, § 1 (West 2003).	physical harm to others	"[E]vidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them"	N	Y				"[A]ny activity" (not necessarily recent). Commonwealth v. Rosenberg, 573 N.E.2d 949, 955, 958–59 (Mass. 1991) (citing United States v. Sahhar, 917 F.2d 1197 (9th Cir. 1990).
MA	MASS. GEN. LAWS ANN. ch. 123, § 1 (West 2003).	physical impairment or injury to self	"[E]vidence 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."	N			N		
MI	MICH. COMP. LAWS ANN. § 330.1401(a) (West Supp. 2010).	seriously physically injure another in near future	"[E]ngaged in an act or acts or made significant threats that [support] the expectation"	N	Y				

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
MI	MICH. COMP. LAWS ANN. § 330.1401(a) (West Supp. 2010).	seriously physically injure self in near future	"[E]ngaged in an act or acts or made significant threats that [support] the expectation"	N		Y			
MI	MICH. COMP. LAWS ANN. § 330.1401(b) (West Supp. 2010).	not attending to basic physical needs (food, clothing, or shelter) as needed to avoid serious harm in the near future	"[D]emonstrated that inability by failing to attend to those basic physical needs."	N			Y		
MI	MICH. COMP. LAWS ANN. § 330.1401(c) (West Supp. 2010).	significant physical harm to self or others	"[J]udgment is so impaired that he . . . [cannot] understand . . . need for treatment and whose continued behavior . . . can reasonably be expected, [based on] competent clinical opinion, to result in . . . harm"	Y	Y	Y			
MN	MINN. STAT. ANN. § 253B.02(13)(a) (West Supp. 2011).	physical harm to self	"(1) a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment; (2) an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and . . . person will [likely] suffer substantial harm [without treatment]; (3) a recent attempt or threat to physically harm self or others; or (4) recent and volitional conduct involving significant damage to substantial property."	N		Y			*In re* Civil Commitment of Anderson, No. A07-2294, 2008 LEXIS 408, at *4, *6 (Minn. Ct. App. Apr. 22, 2008).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
MN	MINN. STAT. ANN. § 253B.02(13)(a) (West 2011).	physical harm to others	"(3) A recent attempt or threat to physically harm self or others; or (4) recent and volitional conduct involving significant damage to substantial property."	N	Y				"The statutory definition of mentally ill and danger-ous . . . [is] designed both to protect mentally ill persons from MID commitment solely on the basis of predictions of future dangerous-ness . . . ." *In re* Jasmer, 447 N.W.2d 192, 195 (Minn. 1989).
MS	MISS. CODE ANN. § 41-21-61 (e)(ii)(A) (West 2010).	physical harm to self	"[R]ecent attempt or threat to physically harm himself."	N		Y			
MS	MISS. CODE ANN. § 41-21-61 (e)(ii)(A) (West 2010).	physical harm to others	"[R]ecent attempt or threat to physically harm . . . others."	N	Y				
MS	MISS. CODE ANN. § 41-21-61(e)(ii)(B) (West Supp. 2010).	disabled	"[F]ailure to provide necessary food, clothing, shelter or medical care for himself"	N			Y		
MS	MISS. CODE ANN. § 41-21-61(e)(ii)(B) (West Supp. 2010).	deterioration	"[B]ased on treatment history and other applicable psychiatric indicia, is in need of treatment . . . to prevent further disability or deterioration which would predictably result in dangerousness to himself or others when his current mental illness limits or negates his ability to make an informed decision to seek or comply with recommended treatment"	Y				Y	

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
MO	MO. ANN. STAT. § 632.005 (9)(a) (West 2006).	serious harm to self	"[R]ecent threats, including verbal threats, or attempts to commit suicide or inflict physical harm on himself [or] . . . information about patterns of behavior that historically have resulted in serious harm previously being inflicted by a person upon himself"	N		Y			
MO	MO. ANN. STAT. § 632.005 (9)(b) (West 2006).	grave disability	"[A]n impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his current mental disorder or mental illness which results in an inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care or his inability to provide for his own mental health care which may result in a substantial risk of serious physical harm . . . may also include information about patterns of behavior that historically have resulted in serious harm to the person previously taking place because of a mental disorder or mental illness which resulted in his inability to provide for his basic necessities . . . "	Y			Y		
MO	MO. ANN. STAT. § 632.005 (9)(c) (West 2006).	serious harm to others	"[R]ecent overt acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm. Evidence . . . may also include information about patterns of behavior that historically have	N	Y				*In re* O'Brien, 600 S.W.2d 695,697 (1980) (Evidence must be clear and convincing, meaning "instantly tilt[s] the scales" towards a

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
			resulted in physical harm previously being inflicted by a person upon another person . . ."						"likelihood of serious physical harm to others").
MT	MONT. CODE ANN., §53-21-126(1)(a) (2009).	grave disability	[U]nable to provide for the respondent's own basic needs	N			Y		*See In re* C.M., 635 P.2d 273, 274 (Mont. 1981).
MT	MONT. CODE ANN., §53-21-126(1)(b)–(c) (2009).	harm to self	[A]ct or omission	N		Y			
MT	MONT. CODE ANN., §53-21-126(1)(b)–(c) (2009).	harm to others	[A]ct or omission	N	Y				
MT	MONT. CODE ANN., §53-21-126(1)(d) (2009).	deterioration	Demonstrated by the respondent's recent acts or omissions	N				Y	
NE	NEB. REV. STAT. § 71-908(1) (2009).	harm to others	"[M]anifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm"	Y	Y				
NE	NEB. REV. STAT. § 71-908(2) (2009).	harm to self	"[M]anifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm"	Y		Y			
NE	NEB. REV. STAT. § 71-908(2) (2009).	deterioration	"[E]vidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety"	Y					*In re* Interest of Kinnebrew, 402 N.W.2d 264, 267-68 (Neb. 1987).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
NV	NEV. REV. STAT. ANN. § 433A.115(2)(a) (LexisNexis 2009).	deteoriation	"[A]cted in a manner from which it may reasonably be inferred that, without the care, supervision or continued assistance of others, he will be unable to satisfy his need for nourishment, personal or medical care, shelter, self-protection or safety, and if there exists a reasonable probability that his death, serious bodily injury or physical debilitation will occur within the next following 30 days unless he is admitted to a mental health facility"	Y			Y		
NV	NEV. REV. STAT. ANN. §433A.115(2)(b) –(c) (LexisNexis 2009).	harm to self	"Attempted or threatened to commit suicide or committed acts in furtherance of a threat to commit suicide, and if there exists a reasonable probability that he will commit suicide unless he is admitted to a mental health facility"; "Mutilated himself, attempted or threatened to mutilate himself or committed acts in furtherance of a threat to mutilate himself, and if there exists a reasonable probability that he will mutilate himself unless he is admitted to a mental health facility"	Y		Y			
NV	NEV. REV. STAT. ANN. § 433A.115(3) (LexisNexis 2009).	harm to others	"[I]nflicted or attempted to inflict serious bodily harm on any other person, or made threats to inflict harm and committed acts in furtherance of those threats, and if there exists a reasonable probability that he will do so again unless he is admitted to a mental health facility"	Y	Y				

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
NH	N.H. REV. STAT. ANN. § 135-C:27(I)(a)–(b) (LexisNexis 2006).	danger to self	Person has inflicted or threatened to inflict "serious bodily injury on himself or has attempted suicide or serious self-injury and there is a likelihood" of recurrence if not hospitalized	N		Y			
NH	N.H. Rev. Stat. Ann. § 135-C:27(II) (LexisNexis 2006).	danger to others	"[W]ithin 40 days . . . the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another"	N	Y				State v. Lavoie, 155 N.H. 477, 480-81 (2007).
NH	N.H. REV. STAT. ANN. § 135-C:27(I)(c) (LexisNexis 2006).	deterioration	"[B]ehavior demonstrates that he so lacks the capacity to care for his own welfare that there is a likelihood of death, serious bodily injury, or serious debilitation if admission is not ordered"	N			Y		
NH	N.H. REV. STAT. ANN. § 135-C:27(I)(d) (2010).	probability of deterioration	Severely ill, one previous involuntary admission, no guardian, has refused treatment, psychiatrist determines substantial probability of death, serious injury, or debilitation without treatment	N				N	
NJ	N.J. STAT. ANN. § 30:4-27.2(h) (West Supp. 2010).	dangerous to self	"[B]y reason of mental illness the person has threatened or attempted suicide or serious bodily harm"	N		Y			
NJ	N.J. STAT. ANN. § 30:4-27.2(i) (West Supp. 2010).	dangerous to others	"[D]etermination shall take into account a person's history, recent behavior and any recent act [or threat]"	N	Y				"Nothing established that she had done anything of that sort prior to her admission" *In re* Commitment of M.M., 894 A.2d 1158, 1172 (N.J. Super. Ct. App. Div. 2006).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
NJ	N.J. STAT. ANN. § 30:4-27.2(h) (West Supp. 2010).	deterioration	"[H]as behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical harm or death will result within the reasonably foreseeable future"	N			Y		
NJ	N.J. STAT. ANN. § 30:4-27.2(i) (West Supp. 2010).	dangerous to property	"[D]etermination shall take into account a person's history, recent behavior and any recent act [or] threat or serious psychiatric deterioration"	N				Y	
NM	N.M. STAT. ANN. § 43-1-3(M) (LexisNexis 2010).	danger to self	"[M]ore likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to the person's self by violent or other self-destructive means, including but not limited to grave passive neglect"	N		N			
NM	N.M. STAT. ANN. § 43-1-3(N) (LexisNexis 2010).	danger to others	"[M]ore likely than not that in the near future a person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense, as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from the person"	N	Y				*In re* Pernell, 590 P.2d 638, 645 (N.M. Ct. App. 1979).
NY	N.Y. MENTAL HYG. LAW §§ 9.01, 9.39(a)(1) (McKinney 2006).	danger to self	"[M]anifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself"	N		Y			Boggs v. New York City Health & Hospitals Corp., 523 N.Y.S.2d 71, 85–86 (N.Y. App. Div. 1987).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
N Y	N.Y. MENTAL HYG. LAW §§ 9.01, 9.39(a)(2) (McKinney 2006).	danger to others	"[M]anifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm"	N	Y				Robinson v. Sanchez, 168 Misc.2d 546, 553 (N.Y. Sup. Ct. 1996).
N C	N.C. GEN. STAT. ANN. § 122C-3(11)(a)(1)(I) (West 2010).	deterioration	"[A]cted in such a way as to show that he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety"	Y			Y		*In re* Holt, 283 S.E.2d 413, 414 (N.C. Ct. App. 1981).
N C	N.C. GEN. STAT. ANN. § 122C-3(11)(a)(1)(II) (West 2010).	deterioration	"[R]easonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given[,] . . . behavior that is grossly irrational, . . . actions that the individual [cannot] control[,] . . . behavior that is grossly inappropriate to the situation, or . . . other evidence of severely impaired insight and judgment [creates] a prima facie inference that the individual [cannot] care for himself"	Y			N		
N C	N.C. GEN. STAT. ANN. § 122C-3(11)(a)(2)-(3) (West 2010).	harm to self	"[I]ndividual has attempted suicide, threatened suicide[,] . . . mutilated himself[,] or attempted to mutilate himself and . . . there is a reasonable probability of [similar harm to self] unless adequate treatment is given"	Y		Y			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
NC	N.C. GEN. STAT. ANN. § 122C-3(11)(b) (West 2010).	harm to others	"[W]ithin the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted [so] as to create a substantial risk of serious bodily harm to another . . . and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others . . . may be considered . . . [as may] convincing evidence that an individual has committed a homicide in the relevant past."	Y	Y				
NC	N.C. GEN. STAT. ANN. § 122C-3(11)(b) (West 2010).	harm to property	"[W]ithin the relevant past, the individual has . . . engaged in extreme destruction of property, and . . . there is a reasonable probability that this conduct will be repeated."	Y				Y	
ND	N.D. CENT. CODE, § 25-03.1-02(12)(a) (2002 & Supp. 2009).	harm to self	"[S]uicidal threats, attempts, or significant depression relevant to suicidal potential"	N		N			
ND	N.D. CENT. CODE, § 25-03.1-02(12)(b) (2002 & Supp. 2009).	killing or inflicting serious bodily harm	"[A]cts or threats"	N	N				"Direct evidence of overt violence or an expressed intent to commit violence are not required." *In re* D.P., 636 N.W.2d 921, 924 (N.D. 2001); *In re* B.D.K, 742 N.W.2d 41, 46 (N.D. 2007).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
ND	N.D. CENT. CODE, § 25-03.1-02 (12)(c)–(d) (2002 & Supp. 2009).	deterioration	"[R]ecent poor self-control or judgment in providing one's shelter, nutrition, or personal care; . . . objective facts to establish the loss of cognitive or volitional control over the person's thoughts or actions or based upon acts, threats, or patterns in the person's treatment history, current condition, and other relevant factors, including the effect of the person's mental condition on the person's ability to consent."	Y			Y		"[A] generalized natural tendency [for schizophrenics to worsen] does not establish a substantial likelihood for a particular individual." *In re* W.K., 776 N.W.2d 572, 577 (N.D. 2009).
OH	OHIO REV. CODE ANN. § 5122.01(B)(1) (LexisNexis 2008).	physical harm to self	"[T]hreats of, or attempts at, suicide or serious self-inflicted bodily harm"	N		Y			
OH	OHIO REV. CODE ANN. § 5122.01(B)(2) (LexisNexis 2008).	physical harm to others	"[R]ecent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness"	N	Y				
OH	OHIO REV. CODE ANN. § 5122.01(B)(3) (LexisNexis 2008).	"serious physical impairment or injury to self"	"[T]he person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness"	N			Y		
OH	OHIO REV. CODE ANN. § 5122.01(B)(4) (LexisNexis 2008).	"Would benefit from [and needs] treatment in a hospital"	"[B]ehavior that creates a grave and imminent risk to substantial rights of others or the person"	N				Y	

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
OK	OKLA. STAT. ANN. tit. 43A, § 1-103(13)(a)(1), (18)(a) (West Supp. 2011).	"harm to self"	"[M]anifested by evidence or serious threats of or attempts at suicide or other significant self-inflicted bodily harm	N		Y			
OK	OKLA. STAT. ANN. tit. 43A, § 1-103(13)(a)(1), (18)(b)-(c) (West 2011).	"harm to others"	"[M]anifested by evidence of violent behavior directed toward another person or persons, [or serious and immediate threats that] . . . placed another person . . . in a reasonable fear of violent behavior . . . or serious physical harm"	N	Y				
OK	OKLA. STAT. ANN. tit. 43A, § 1-103(13)(a)(1), (18)(d)-(e) (West 2002).	grave disability	"[S]ubstantial risk that without immediate intervention, severe impairment or injury will result to the person [i.e., no evidence specified] . . . [or] evidence that the person is unable to provide for and is not providing for the basic physical needs of the person and that appropriate provision for those needs cannot be made immediately available in the community"	N			Y		
OR	OR. REV. STAT. ANN. § 426.005(1)(e)(A) (West 2009).	danger to others	"Verbal threats, while probative, are insufficient to support commitment unless they are accompanied by overt acts to follow through with the threat or otherwise demonstrate a clear risk of future violence."	N	Y				*In re* C.S., 208 P.3d 1009, 1011 (Or. Ct. App. 2009).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
OR	OR. REV. STAT. ANN. § 426.005(1)(e)(A) (West 2009).	danger to self	"[T]he state must show that an appellant's mental disorder either resulted in actual harm to herself or that the mental disorder 'created situations likely to result in harm.' . . . Although the threat of harm need not be immediate, it 'must exist in the near future.' . . . An expressed desire to die, by itself, is not sufficient to meet that burden. . . . Nor is the fact that an individual has attempted suicide years earlier."	N		Y			State v. T.M., 211 P.3d 359, 363 (Or. Ct. App. 2009).
OR	OR. REV. STAT. ANN. § 426.005(1)(e)(B) (West 2009).	Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety	"[C]lear and convincing evidence [showing a person] is either dangerous to himself or others or unable to provide for his basic personal needs"	N			Y		*In re* Christoffer-son, 615 P.2d 1152, 1153 (1980).
PA	50 PA. STAT. ANN. § 7301(b)(1) (West 2010).	harm to others	"[W]ithin the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated."	N	Y				
PA	50 PA. STAT. ANN. § 7301(b)(2)(ii)–(iii) (West 2010).	harm to self	In the past 30 days: . . . (ii) the person has attempted suicide, mutilated himself, attempted to mutilate himself, or has made threats to commit suicide or to mutulate himself and has committed acts which are in furtherance of such threats to commit suicide or to mutilate himself, and there is	N		Y			"[A]n act of 'substantial mutilation' would appear to require the real and permanent destruction of a part of the patient's body." Zator v. Coachi, 939 A.2d 349, 354 (Pa. Super.

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
			the reasonable probability of suicide or mutilation unless adequate treatment is afforded						Ct. 2007).
PA	50 PA. STAT. ANN. § 7301(b)(2)(i) (West 2010).	deterioration	In the past 30 days, the person has acted in such manner as to evidence that he could not, "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"	N			Y		
RI	R.I. GEN. LAWS ANN. § 40.1-5-2(7)(i) (2006).	physical harm to self	"[B]ehavior evidencing serious threats of, or attempts at, suicide"	N		Y			For all 3 types of risk, the court may consider previous acts, diagnosis, words or thoughts, R.I. GEN. LAWS ANN. § 40.1-5-2(7)(iv) (2006), but no case contains this phrase. Also, no civil case (only insanity acquittee cases) contains any of the "behavior" phrases.
RI	R.I. GEN. LAWS ANN. § 40.1-5-2(7)(ii) (2006).	physical harm to others	"[B]ehavior or threats evidencing homicidal or other violent behavior"	N	N				
RI	R.I. GEN. LAWS ANN. § 40.1-5-2(7)(iii) (2006).	grave disability	"[B]ehavior which has created a grave, clear, and present risk" to physical	N			Y		

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
			health and safety						
SC	S.C. CODE ANN. § 44-23-10(2)(1) (2002).	harm to self	"[T]hreats of, or attempts at, suicide or serious bodily harm"	N		Y			
SC	S.C. CODE ANN. § 44-23-10(2)(2) (2002).	harm to others	"[H]omicidal or other violent behavior and serious harm to them"	N	Y				
SC	S.C. CODE ANN. § 44-23-10(2)(3) (2002).	physical impairment or injury to self	"[P]erson'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"	N			N		
SC	S.C. CODE ANN. § 44-17-580(1) (2002).	n/a	"[L]acks sufficient insight or capacity to make responsible decisions with respect to his treatment"	Y				N	
SD	S.D. CODIFIED LAWS § 27A-1-1(4) (2004).	serious physical injury to others	"Treatment history and . . . recent acts or omissions which constitute a danger of serious physical injury for another individual. Such acts may include a recently expressed threats that indicate genuine intent to do harm	N	Y				
SD	S.D. CODIFIED LAWS § 27A-1-1(5)(b) (2004).	grave disability	"[T]reatment history and . . . recent acts or omissions which demonstrate an inability to provide for some basic human needs such as food, clothing, shelter, essential medical care, or personal safety, or by arrests for criminal behavior" that stem from a worsening of mental illness	N			Y		
SD	S.D. CODIFIED LAWS § 27A-1-1(5)(a) (2004).	serious physical harm to self	A person has threatened or attempted suicide or to inflict serious bodily harm on self	N		Y			
TN	TENN. CODE ANN. § 33-6-501(1)(A) (2007).	harm to self	"[P]erson has threatened or attempted suicide or to inflict serious bodily harm"	N		Y			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
TN	TENN. CODE ANN. § 33-6-501(1)(B)-(C) (2007).	harm to others	"[P]erson has threatened or attempted homicide or other violent behavior, or has placed others in reasonable fear of violent behavior and serious physical harm"	N	Y				
TN	TENN. CODE ANN. § 33-6-501(1)(D) (2007).	grave disability	[P]erson is unable to avoid severe impairment or injury from specific risks"	N			Y		
TX	TEX. HEALTH & SAFETY CODE ANN. §§ 574.034(a)(2)(A), (d)(1) (West 2010).	serious harm to self	"[U]nless waived, evidence of a recent overt act or a continuing pattern of behavior tending to confirm likelihood of serious harm."	N		Y			*In re* J.J.K., No. 14-03-00380-CV, 2003 WL 22996950, at *3 (Tex. App.—Houston [14th Dist.] Dec. 23, 2003).
TX	TEX. HEALTH & SAFETY CODE ANN. §§ 574.034(a)(2)(B), (d)(1) (West 2010).	harm to others	"unless waived, evidence of a recent overt act or a continuing pattern of behavior tendng to confirm likelihood of serious harm to others."	N	Y				*In re* F.M., 183 S.W.3d 489, 492–93 (Tex. App.—Houston [14th Dist.] 2005); K.E.W. v. State, 276 S.W.3d 686, 693 (Tex. App.—Houston [14th Dist.] 2008).
TX	TEX. HEALTH & SAFETY CODE ANN. §§ 574.034(a)(2)(C)(i)–(iii), (d)(2) (West 2010).	mental or physical deterioration	Severe and abnormal mental, emotional, or physical distress and mental or physical deterioration in ability to function independently, exhibited by inability to provide for basic needs; cannot make a rational and informed decision about getting treatment; unless waived, evidence of a recent overt act or a continuing pattern of behavior	Y			Y		G.H. v. State, 96 S.W.3d 629, 631 (Tex. App.—Houston [1st Dist.] 2002).
UT	UTAH CODE ANN. § 62A-15-602 (13)(a)(i)-(ii) (LexisNexis 2006).	harm to self	"[A]t serious risk to commit suicide or inflict serious bodily injury on himself or herself"	N		Y			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
UT	UTAH CODE ANN. § 62A-15-602 (13)(a)(iii) (LexisNexis 2006).	grave disability	"at serious risk to . . . suffer serious bodily injury because he is incapable of providing the basic necessities of life"	N			N		
UT	UTAH CODE ANN. § 62A-15-602 (13)(b)-(c) (LexisNexis 2006).	harm to others	"at serious risk to cause or attempt to cause serious bodily injury.; or has inflicted or attempted to inflict serious bodily injury on another"	N	N				
VT	VT. STAT. ANN. tit. 18, § 7101(17)(A) (2010).	harm to others	Has inflicted or attempted to inflict bodily harm on another, or thru threats or actions has placed others in reasonable fear of physical harm, or actions or inactions have endangered persons in his care	N	Y				"The Vermont statute requires evidence that the proposed patient presents a present danger of harm to himself or others, as evidenced by threats or behavior." *In re* L.R., 497 A.2d 753, 756 (Vt. 1985).
VT	VT. STAT. ANN. tit. 18, § 7101(17)(B)(i) (2010).	harm to self	"[H]as threatened or attempted suicide or serious bodily harm"	N		Y			
VT	VT. STAT. ANN. tit. 18, § 7101(17)(B)(ii) (2010).	grave disability	Has behaved so as to indicate that he cannot, without supervision and the assistance of others, satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, so that without treatment, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease would probably ensue	N			Y		"[S]ome behavior indicating the inability to care for oneself is required." *In re* L.R., 497 A.2d 753, 756 (Vt. 1985).
VA	VA. CODE ANN. § 37.2-809(B)(i)(a) (Supp. 2010).	harm to others	"[R]ecent behavior causing, attempting, or threatening harm and other relevant information, if any"	N	Y				

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
VA	VA. CODE ANN. § 37.2-809(B)(i)(a) (Supp. 2010).	harm to self	"[R]ecent behavior causing, attempting, or threatening harm and other relevant information, if any"	N		Y			
VA	VA. CODE ANN. § 37.2-809(B)(i)(b) (Supp. 2010).	grave disability	"[S]uffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs"	N			N		
WA	WASH. REV. CODE ANN. § 71.05.020(17) (West Supp. 2010).	gravely disabled	"[F]ailure to provide for . . . essential human needs of health or safety; or . . . severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over . . . actions and is not receiving such care" essential to health or safety	N			Y		
WA	WASH. REV. CODE ANN. § 71.05.020(25)(a)(i) (West Supp. 2010).	harm to self	"[T]hreats or attempts to commit suicide or inflict physical harm on oneself"	N		Y			
WA	WASH. REV. CODE ANN. § 71.05.020(25)(a)(ii)–(b) (West Supp. 2010).	harm to others	"We thus interpret RCW 71.05.020 as requiring a showing of a substantial risk of physical harm as evidenced by a recent overt act." *In re Harris*, 654 P.2d 109, 113 (Wash. 1982)	N	Y				"The requirement of a recent overt act as evidence of danger-ousness was first introduced in the context of the involuntary commitment statute, chapter 71.05 RCW." *In re* Albrecht, 51 P.3d 73, 76 n.9 (Wash. 2002) (referencing *In re* Harris, 654 P.2d 109, 113 (Wash. 1982).
WA	WASH. REV. CODE ANN. § 71.05.020(25)(a)(iii) (West Supp. 2010).	harm to property	"[B]ehavior which has caused substantial loss or damage to the property of others"	N				Y	

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
WV	W. VA. CODE ANN. § 27-1-12(a)(1)-(2), (b) (LexisNexis 2005).	harm to others	"(1) The individual has inflicted or attempted to inflict bodily harm on another; (2) The individual, by threat or action, has placed others in reasonable fear of physical harm to themselves"	N	Y				Pifer v. Pifer, 273 S.E.2d 69, 72 (W.Va. 1980) (reversing circuit court decision where respondent had acted bizarrely and shown signs of mental illness, but had not done "anything harmful to himself or anyone else").
WV	W. VA. CODE ANN. § 27-1-12(a)(3), (b) (LexisNexis 2005).	danger to self or others	"[B]y action or inaction, presents a danger to himself, herself or others in his or her care"	N		N			*Pifer*, 273 S.E.2d at 72.
WV	W. VA. CODE ANN. § 27-1-12 (a)(4), (b) (LexisNexis 2005).	harm to self	"The individual has threatened or attempted suicide or serious bodily harm to himself or herself"	N		Y			*Pifer*, 273 S.E.2d at 72.
WV	W. VA. CODE ANN. § 27-1-12(a)(5), (b) (LexisNexis 2005).	grave disability	"[I]ndicate[s] that he . . . [cannot], without supervision and the assistance of others, . . . satisfy his . . . need for nourishment, medical care, shelter or self-protection and safety" leading to "a substantial likelihood that death, serious bodily injury, serious physical debilitation, serious mental debilitation or life-threatening disease will ensue" without treatment	N			N		*Pifer*, 273 S.E.2d at 72.
WI	WIS. STAT. ANN. § 51.20(1)(a)(2)(a) (West 2006).	harm to self	"[R]ecent threats of or attempts at suicide or serious bodily harm"	N		Y			

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
WI	WIS. STAT. ANN. § 51.20(1) (a)(2)(b) (West 2006).	harm to others	"[R]ecent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them" through "a recent overt act, attempt or threat."	N	Y				"[R]ecent overt act, attempt or threat." *In* re William S., 570 N.W.2d 253 (Wis. Ct. App. 1997).
WI	WIS. STAT. ANN. § 51.20(1) (a)(2)(c) (West 2006).	physical impairment or injury to self	"[A] pattern of recent acts or omissions"	N			Y		
WI	WIS. STAT. ANN. § 51.20(1) (a)(2)(d) (West 2006).	substantial probability of serious physical harm	"[R]ecent acts or omissions" illustrate the person's inability to satisfy basic needs unless the individual gets prompt treatment	N			Y		
WI	WIS. STAT. ANN. § 51.20(1) (a)(2)(e) (West 2006).	loss of ability to function independently or loss of cognitive or volitional control over actions	Cannot express an understanding of "the advantages and disadvantages of accepting medication or treatment and the alternatives", or cannot apply an understanding of treatment options to his mental illness to make an informed choice about treatment; and evidences a substantial probability, demonstrated by both treatment history and the individual's recent acts or omissions, that he needs care or treatment to prevent further disability or deterioration	Y				Y	Each [of the 5] provisions "requires evidence of a recent, overt act." *In re* Mental Commitment of Vicki L.B., No. 03-2917-FT, 2004 WI App 68, (Wis. Ct. App. 2004).
WY	WYO. STAT. ANN. § 25-10-101(a)(ii)(A) (2009).	harm to self	"[R]ecent threats of or attempts at suicide or serious bodily harm"	N		Y			*See* Baker v. State, 50 P.3d 712, 716 (Wyo. 2002) (requiring evidence of recent acts of endangerment).

State	Statutory Citation	Risk	Evidence for Risk	Incompetent?	Danger to Others	Danger to Self	Grave Disability	Miscellaneous	Case citation
WY	WYO. STAT. ANN. § 25-10-101(a)(ii)(B) (2009).	harm to others	"[R]ecent overt homicidal act, attempt or threat or other violent act, attempt or threat which places others in reasonable fear of serious physical harm"	N	Y				
WY	WYO. STAT. ANN. § 25-10-101(a)(ii)(C) (2009).	physical or mental debilitation	"[R]ecent acts or omissions that, due to mental illness, he cannot satisfy basic needs for nourishment, essential medical care, shelter or safety"	N			Y		

Table 1 summarizes 166 statutory provisions from the 51 U.S. jurisdictions, an average of 3¼ provisions per jurisdiction. All jurisdictions' commitment laws address risk of harm to oneself and others. We classified 44 jurisdictions' laws as addressing grave disability, and 17 as addressing other concerns, mainly deterioration and harm to property.

Table 2 describes the jurisdictions' rules concerning overt behavior as evidence of risk. Where risk to others is concerned, thirty-nine states appear to require actual behavior, while eleven states and the District of Columbia do not. Concerning risk to self, thirty-eight jurisdictions require behavior, twelve jurisdictions do not, and West Virginia has one statutory provision requiring actual behavior and one statutory provision that does not require actual behavior. In most jurisdictions, requirements for actual behavior are the same whether the risk is to the respondent himself or to others; for easy apprehension, we have underlined abbreviations of those states where the behavior requirement differs in Table 2. Finally, sixteen of the forty-four states with "grave disability" statutes appear to allow proof of this risk without actually requiring that the respondent openly display behavior indicative of the risk.

[this section resumes after Table 2]

Table 2. – Requirements for overt behavioral evidence, by jurisdiction

Type of Risk	Overt behavioral evidence . . .	
	Required	Not required
To others	AR, CA, DE, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MO, MS, MT, NC, NE, NH, NJ, NM, NV, NY, OK, OR, PA, SC, SD, TN, TX, VA, VT, WA, WI, WV, WY	AK, AL, AZ, CO,CT, DC, IL, KY, MD, MN, ND, OH, RI, UT
To self	AR, AZ, DE, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MO, MS, MT, NC, NE, NH, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, VA, VT, WA, WI, WV, WY	AK, AL, CA, CO,CT, DC, IL, KY, MD, MN, ND, NM, RI, UT, WV
Grave disability	AR, AZ, CT, FL, HI, IN, IA, LA, ME, MI, MS, MO, MT, NV, NC, ND, NH, NJ, OH, OR, PA, SD, TX, VT, WA, WI, WI, WY	AK, CA, CO, GA, ID, IL, KS, MA, NC, OK, RI, SC, TN, UT, VA, WV

Perusal of Table 1 reveals that even within a specific type of risk (to others, to self, or grave disability), jurisdictions differ in the language they use to identify the risk. In Table 3, we summarize this phenomenon for risk toward others.

[this section resumes after Table 3]

Table 3.—Statutory language concerning harm to others

Jurisdiction	Specification of Type of harm
VT, WV, NH, WV	bodily harm
CO, NH, OR	danger; dangerous
AK, IN, KS	Harm
DC, MT	injure others
MD	life or safety
AZ, WV, CT, IL, RI, CA, ID, MA, ME, MN, MS, SC, WI, WA, GA, IA, MT	physical harm or injury
LA	physical harm in near future
HI	physical or emotional injury
AR, FL, NC, NJ, PA, NV, UT, OH, NY, OK, TN, VA, WY, SD, MO, SC, WI, MA, ME	serious bodily harm, serious physical harm, serious physical injury
ND	serious bodily harm or killing
DE, MO, NE, TX	serious harm
NM	serious, unjustified bodily harm; sex offense
MI	significant physical harm; seriously physically injure in near future
AL	substantial harm
KY	substantial physical harm

Looking at Table 3, one sees that what jurisdictions mean by risk of harm to others varies considerably. The modal concern is risk of "serious" *physical* harm or injury, which arguably is the same as "substantial" physical harm (Kentucky's phrase). In several jurisdictions, however, any physical harm or injury would suffice; in others, the concern could include emotional injury (Hawaii)[219] or any harm that is "substantial" (Alabama).[220] In at least six states, any harm or

219 HAW. REV. STAT. ANN. § 334-1 (LexisNexis Supp. 2009).

220 ALA. CODE § 22-52-10.4(a) (2006).

danger appears sufficient.[221]

This finding has implications for the use of risk assessment instruments in civil commitment determinations. Typically, ARAIs are normed or validated for detection of a specific type of behavior.[222] In some jurisdictions, the fit between the definition used to validate the ARAI and the statutory specification of risk may be close enough to make the ARAI findings relevant to most determinations of risk to others. But in those jurisdictions where emotional harm, "substantial" harm, or any harm at all is the statute's focus, ARAIs may not provide relevant information about risk.

V. CONCLUSION

Montana is one of four states that retain "imminent danger" provisions in their civil commitment statutes.[223] In Montana's case, a court may order the involuntary hospitalization of a mentally ill respondent whose mental disorder creates, "an imminent threat of injury to . . . others . . . . Imminent threat of . . . injury to others must be proved by overt acts or omissions, sufficiently recent in time as to be material and relevant as to the respondent's present condition."[224] In

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221 ALASKA STAT. § 47.30.735(c) (2010); COLO. REV. STAT. § 27-10-105 (1)(a) (2010); IND. CODE ANN. § 12-7-2-53 (LexisNexis 2006); KAN. STAT. ANN. § 59-2946(f)(3)(a) (2005); N.H. Rev. Stat. Ann. § 135-C:27(II) (2010); OR. REV. STAT. ANN. § 426.005(1)(e)(A) (West 2009).

222 *See, e.g.*, Henry J. Steadman et al., *A Classification Tree Approach to the Development of Actuarial Violence Risk Assessment Tools*, 24 LAW & HUM. BEHAV. 83, 86 (2000) (showing studies designed to validate the COVR used the following definition of violent behavior: "acts of battery that resulted in physical injury; sexual assaults; assaultive acts that involved the use of a weapon; or threats made with a weapon in hand.").

223 MONT. CODE ANN. §53-21-126 (2005). The other states are Georgia, Hawaii, and Ohio. *See* GA. CODE ANN. § 37-3-1(9.1)(A)(i) (1995) (permitting commitment of a person who poses "a substantial risk of imminent harm . . . as manifested by either recent overt acts or recent expressed threats of violence"); HAW. REV. STAT. ANN. § 334-60.2 (LexisNexis 2008) (permitting commitment of a person who "is imminently dangerous to self or others"); OHIO REV. CODE ANN. § 5122.01(B)(4) (LexisNexis 2008) (permitting commitment of a mentally ill person whose behavior "creates a grave and imminent risk to substantial rights of others or [himself]"). By contrast, Virginia removed its statutory "imminent danger" provision in legislative changes that followed the 2007 Virginia Tech shootings. For a discussion, see Alison Pfeffer, *"Imminent Danger" Standard for Involuntary Civil Commitment in the Wake of the Virginia Tech Tragedy*, 30 CARDOZO L. REV. 277, 277–80 (2008).

224 MONT. CODE ANN., § 53-21-126 (2005).

In re Mental Health of A.S.B., the Montana Supreme Court explained that for someone to pose an "imminent threat:"

> The danger must be fairly immediate. . . . The law requires only proof beyond a reasonable doubt that the threat of future injury presently exists and that the threat is imminent, that is, impending, likely to occur at any moment . . . . a present indication of probable physical injury which is likely to occur at any moment or in the immediate future . . . .[225]

"Imminence" or related terms do not appear in most civil commitment statutes, even in those jurisdictions that make proof of overt behavior a requirement for involuntary hospitalization. Yet the Montana Supreme Court's "present indication" language points to what we suggest are the core concerns of statutes that require "overt acts" as proof of risk. When people make credible threats to do harm or engage in potentially or actually harmful behavior, they make a feature of themselves—their dangerousness—manifest. Through their action, the danger that they represent to themselves or others becomes a presence in the environment, in the same way that reckless driving is a presence for other persons on or near the road, and in the same way that toxic waste may be a presence in the lives of persons who live near a dumpsite. Overt behavior establishes that a risk is present, though actual future harm remains a less-than-certain probability.

In this article, we have suggested that the probabilistic evidence established by mental health professionals' ARAIs may have, at most, ancillary significance for civil commitment proceedings in jurisdictions that require behavioral proof of danger, or as it is often termed, an overt act. In advancing this contention, we have suggested that the probabilistic reasoning underlying ARAIs implicitly incorporates economic connotations that increasingly influence current use of the word "risk," under which (for example) the prospect of a bad event is countered (or "managed") by insurance—an enterprise that requires monetary valuation of potential event-related losses and calculations of how probable those events are.[226] By contrast, the connotation of

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225 *In re* Mental Health of A.S.B., 180 P.3d 625, 631 (Mont. 2008).

226 For an introductory description that assumes this perspective on risk, see HAROLD D. SKIPPER & W. JEAN KWON, RISK MANAGEMENT AND INSURANCE: PERSPECTIVES IN A GLOBAL

risk evoked by overt act requirements relates to the demonstration of present dangers—an idea more closely related to the word's etymological origins.[227]

In advancing this notion, we have relied on wording of statutes and on how available published cases have treated statutes governing involuntary hospitalization. We recognize, however, that civil commitment proceedings are flexible in their actual operation and that statutory wording may reveal little about how courts actually interpret or implement laws concerning involuntary hospitalization.[228] We also acknowledge that no published case has squarely addressed whether ARAIs may serve as the primary evidence to support inpatient commitment—that is, as evidence adduced in the absence of an overt act that would, by itself, satisfy the statutory requirement to prove dangerousness. Finally, we note that in two jurisdictions that ostensibly have overt act requirements, courts either have commented favorably on ARAI-based evidence,[229] or have commented with disfavor on commitment decisions that did not have ARAI-based support.[230]

Even if courts with overt-act language insist that decisions ordering traditional mental health commitment require proof of actual harmful behavior, courts may one day prefer ARAI-based testimony about the probability of future harm, either to support opinions that significant risk persists or simply as a sign of the testifying clinician's

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ECONOMY 28–54 (2007).

227 "Risk" comes from Romance language words such as *risque* (French) and *risco* (Spanish), meaning "rock." WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY OF THE ENGLISH LANGUAGE, UNABRIDGED 1470 (1951). By referring to the etymological origins of "risk," we are not suggesting that etymology has definitive implications for a word's meaning. *See* Richard Nordquist, *Introduction to Etymology: Word Histories, available at* http://grammar.about.com/od/words/a/Etymologywords.htm (last visited December 5, 2010) (noting that "the original meaning of a word is often different from its contemporary definition" and using "salt" as an example).

228 *See* William H. Fisher et al., *How Flexible Are Our Civil Commitment Statutes?* 39 HOSP. COMM. PSYCHIATRY 711, 712 (1988) (noting that "[m]uch is made of the letter of commitment laws and the behaviors and persons they do or do not encompass .... In fact, though, the 'spirit of the law' is far more malleable and susceptible to influence by the public's perceived needs or desires," and providing examples).

229 *See supra* notes 203–212 and accompanying text.

230 *See supra* notes 178–188 and accompanying text.

thoroughness. Letting ARAIs function these ways fits well with how treating clinicians respond to the problems and needs of those of their patients who become respondents in civil commitment proceedings. Psychiatrists typically think of civil commitment as a vehicle for making sure their patients get the treatment they need, having made a clinical assessment that such treatment is critical.[231] In urgent treatment contexts, what psychiatrist Robert Simon calls "clinical risk assessment" is a process that results in the identification of problems and determinations of how to respond to those problems.[232] Making an analogy between what psychiatrists and other physicians do, Simon suggests that ARAIs should help clinicians to avoid overlooking evidence-based risk factors when they undertake clinical assessments.[233] However, the reason for considering such factors is that they tell clinicians what to do. "The psychiatrists' stock-in-trade is the treatment and management of acutely mentally ill patients. Treatment and risk reduction, not prediction, is their appropriate focus."[234]

Courts in jurisdictions with overt act commitment requirements may one day see their task and the evidentiary contribution of ARAIs similarly. At a hearing, the scientifically demonstrated validity of risk factors can help courts feel confident in making the statutory connection between certain features of a respondent's mental illness and the respondent's risk-generating behavior. Knowing this, courts will have scientific as well as legal justification for imposing involuntary

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231 *See, e.g.*, B. Todd Thatcher & Douglas Mossman, *Testifying for Civil Commitment: Help Unwilling Patients Get Treatment They Need*, 8 CURRENT PSYCHIATRY 50, 51 (2009) (telling psychiatric colleagues that providing testimony "is the only way to make sure dangerous patients get the hospital care they need"); *see also*, Steven K. Hoge, *Commentary: Resistance to Jackson v. Indiana – Civil Commitment of Defendants Who Cannot be Restored to Competence*, 38 J. AM. ACAD. PSYCHIATRY L. 359, 361(2010) (stating, "ordinary civil commitment is grounded in the doctor-patient relationship and underlying medical ethics that require physicians to act in patients' interests"); PAUL S. APPELBAUM & THOMAS G. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 37 (4th ed. 2007) ("Often, the only reasonable option for dealing with a psychiatric emergency is to seek the patient's hospitalization.").

232 Robert I. Simon, *The Myth of "Imminent" Violence in Psychiatry and the Law*, 75 U. CIN. L. REV. 631, 639 (2006).

233 *Id.* at 641 (noting that physicians regularly identify and seek to alleviate factors that increase risk for heart disease without attempting or being able to predict who will actually have a heart attack).

234 *Id.* at 639.

treatment aimed at alleviating symptoms of mental illness and the respondent's risk of harm.