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### Legal insanity and risk

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# **Legal insanity and risk: an international perspective on the justification of indeterminate preventive commitment**

## ***Abstract***

Modern legal systems typically link the insanity or diminished responsibility of an offender for a crime committed in the past to his future dangerousness. This nexus serves across legal systems as a justification for the indeterminate commitment of the offender with diminished or no criminal responsibility. Conceptually, however, insanity and risk are not related legal issues. Moreover, empirical research suggests that there is only a weak link between insanity, diminished responsibility and mental illness on the one hand and risk of recidivism on the other. Other risk factors seem to be more important. The inference of risk from insanity or diminished responsibility that lies at the heart of the indeterminate commitment of mentally disordered offenders is therefore problematic. This should lead to a reconsideration of the preconditions for indeterminate commitment of mentally disordered defendants.

*Keywords:* insanity; risk; preventive commitment

## ***1 Introduction***

Modern legal systems typically link the insanity or the diminished responsibility of an offender for a crime committed in the past to his future dangerousness.<sup>1</sup> The presumed nexus between criminal responsibility – or rather: the absence or diminution of responsibility – and risk serves as a justification for the indeterminate commitment of the ‘diminished or not responsible offender’ (‘DNR offender’). But is this link justified?

In this paper we challenge this strong connection. Legal insanity and preventive detention refer to very different legal issues. One concerns responsibility for an act in the past, while the other concerns dangerousness in the future. Moreover, empirical research shows no more than a weak link between mental illness and crime or recidivism. Also, in current risk assessment tools for recidivism, mental illness plays only a limited or very limited role compared with other risk factors.

Before elaborating these arguments, we will discuss four legal systems which, to various degrees, use a nexus between insanity or diminished responsibility and future dangerousness as a justification for indeterminate commitment: the United States, the Netherlands, Germany, and Norway. We conclude that, even though there is a weak connection between insanity and future dangerousness, this link is not sufficiently robust to justify the strong – sometimes even direct – connection between insanity and preventive commitment found in many legal systems.

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<sup>1</sup> We use ‘diminished responsibility’ in an informal sense, as expressing a lesser degree of responsibility due to mental disorder (cf. Meynen, 2016, 161-163). Typically, this form of diminished responsibility may mitigate punishment, but may also be a precondition for commitment (see section 2). We do not use it in the formal sense of Section 2 of the Homicide Act 1957 (UK), which states that diminished responsibility is a defense to a charge of murder. If this defense succeeds, the defendant is liable to be convicted of manslaughter.

## ***2 Insanity and risk: an international perspective on indeterminate preventive commitment***

The inference of risk from insanity or diminished responsibility seems to take four forms. In this paragraph, we will explore these by means of a comparative analysis of the preconditions for indeterminate preventive detention in four legal systems.

This comparative analysis is limited to forms of preventive detention that may last for an indefinite period of time. This excludes preventive sanctions that are limited in time, such as the Dutch commitment of a person to a facility for repeat offenders (*inrichting voor stelselmatige daders*). This form of preventive commitment is limited to a maximum of two years (Section 38n Dutch Criminal Code (*Wetboek van Strafrecht*, ‘Sr’)). Also excluded are forms of indeterminate commitment that are preserved for special groups of offenders, mentally disordered or not, such as the sexually violent persons laws in US jurisdictions (cf. Chapter 71.09 Washington Code). Indeterminate sanctions that do not consist of a deprivation of liberty, but rather a ‘mere’ restriction of liberty – for example indeterminate supervision of offenders (cf. Section 38z Sr) – are excluded as well. Nevertheless, parts of our analysis may well be relevant to these forms of preventive detention too. The four modalities are sketched in broad outlines.

### *2.1 United States: an automatic inference from insanity to risk*

The first modality to be explored is an approach in which commitment is mandatory after a finding of insanity. In this approach, dangerousness is automatically inferred from the offender’s lack of criminal responsibility.

If a defendant is found to be not criminally responsible because of his mental illness, US jurisdictions prescribe the special verdict of ‘not guilty by reason of insanity’ (‘NGRI’) or some equivalent (Simon & Ahn-Redding, 2008, 40-42). This special verdict was first used in the common law in the case against James Hadfield. Hadfield was declared not guilty by reason of insanity for the attempted assassination of King George III. According to the judgment, the special verdict would be a “legal and sufficient reason for his future confinement” (*R. v. Hadfield*, 27 St.Tr. (N.S.) 1281 (1800)). This verdict anticipated the Act for the Safe Custody for Insane Persons Charged with Offences, which was adopted shortly after Hadfield’s acquittal. This act made it mandatory for the judge to use the verdict of not guilty by reason of insanity when a suspect of a felony was acquitted because of a mental disorder and to have this person taken into strict custody for an indefinite period of time (“until His Majesty’s pleasure be known”).

The case against Hadfield and the subsequently adopted legislation introduced an absolute and direct link in the common law between insanity and dangerousness, and thus the need to have the offender committed. In the United Kingdom, this link no longer exists (cf. Section 5 Criminal Procedure (Insanity) Act 1964). NGRI offenders fall within the scope of the Mental Health Act and a hospital order (Section 37 Mental Health Act) may or may not be made. The 2007 Mental Health Act is based on the notion that every mentally ill person should receive adequate specialist treatment, explicitly including mentally ill offenders. In US jurisdictions, commitment of NGRI offenders often is discretionary. In other US jurisdictions, the commitment of an offender found not guilty by reason of insanity is nevertheless still mandatory (Torcia, 2018, § 109). Most notably, mandatory commitment of the offender found to be insane exists in federal criminal law (Section 18.4243(a) United States Code) and is also found in the Model Penal Code (Section 4.08 MPC). The Model Penal Code is nowhere fully in force, but it has been an inspiration for many criminal codes at the state level.

The presumption underlying statutes prescribing the automatic commitment of a person acquitted by reason of insanity is that he,<sup>2</sup> because of insanity at the time of the act, poses a danger to public safety.<sup>3</sup> In the *Commentaries* on the Model Penal Code, an additional rationale is advanced: automatic commitment may also be beneficial to the offender by making the defense of insanity more acceptable to the jury and the public (American Law Institute, 1985, 256).

### 2.2 *The Netherlands: a conditional inference from insanity to risk*

Perhaps the most common legal approach to defendants acquitted by reason of insanity is to make their preventive commitment dependent on the fulfillment of one or more additional requirements, most notably that he is proven to be dangerous.

In the Dutch penal code, for example, Section 37a(1) Sr states that a defendant can be put at the disposal of the government (hospital order; *terbeschikkingstelling*, ‘*tbs*’) if two conditions are met: (i) he suffered from a mental disorder at the time of the act and (ii) the public security of persons or goods demands the commitment. Commitment is permitted in the interest of public security of persons and goods. Indeterminate commitment is allowed only if the *tbs* was ordered for a crime that was directed against, or caused danger to, the physical integrity of persons (Section 38e(1) Sr).

Section 37a(1) Sr does not explicitly refer to the insanity of the defendant (*ontoerekenbaarheid*). In fact, only a mental disorder at the time of the act is required. However, it is usually derived from the legislative history of the *tbs* that the defendant either had to be not responsible at the time of the act or at least have diminished responsibility by reason of his mental disorder. The main reason for introducing the *tbs* order in the first half of the twentieth century was that there appeared to be a group of defendants who were not wholly responsible, or not at all responsible, for their crimes. Prison sentences were deemed to be insufficient to protect society against this group of assumedly dangerous offenders. They could not be sentenced at all because of insanity or only to a short term of imprisonment because of their diminished responsibility: hence the need arose for a commitment order for DNR offenders (Van der Wolf & Mevis, 2017, 562).

The existence of a commitment order exclusively for DNR offenders implies that the legislator presumes the existence of a link between diminished or absent responsibility and risk (Van der Wolf & Mevis, 2017, 562). In the system described in this section, the responsibility-risk nexus is conditional: an actual risk still has to be established. However, the mere fact that a group of defendants is singled out for a preventive measure of indeterminate duration cannot but mean that *this* group is considered to pose a potential risk that defendants who are fully responsible do not. In Dutch legal practice, responsible defendants are not subjected to indefinite commitment.<sup>4</sup>

### 2.3 *Germany: insanity, diminished responsibility, responsibility and risk*

In some jurisdictions, not only DNR offenders can be subjected to indefinite commitment based on their dangerousness, but responsible defendants as well, including when they do not suffer from a mental disorder. In these jurisdictions, two separate forms of indeterminate commitment exist: one for DNR offenders and another for responsible defendants.

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<sup>2</sup> References to the masculine pronoun ‘he’ also include the feminine ‘she’.

<sup>3</sup> Cf. *Jones v. US*, 463 U.S. 354 (1983), 363-364: “We turn first to the question whether the finding of insanity at the criminal trial is sufficiently probative of mental illness and dangerousness to justify commitment. A verdict of not guilty by reason of insanity establishes two facts: (i) the defendant committed an act that constitutes a criminal offence, and (ii) he committed the act because of mental illness. Congress has determined that these findings constitute an adequate basis for hospitalizing the acquittee as a dangerous and mentally ill person. [...] We cannot say that it was unreasonable and therefore unconstitutional for Congress to make this determination.”

<sup>4</sup> However, offenders sentenced to life imprisonment are deprived of their liberty for an indeterminate period of time (see Section 5).

Section 63 of the German Penal Code (*Strafgesetzbuch*, ‘StGB’) stipulates that a defendant who committed a crime in a state of insanity (*Schuldunfähigkeit*) or diminished responsibility (*verminderte Schuldfähigkeit*) can be committed for an indeterminate period of time to a psychiatric hospital if, because of this state, he is a danger to public safety. This indefinite commitment is comparable to the Dutch *tbs* order discussed in the previous section. In addition to the preventive commitment to a psychiatric hospital of Section 63 StGB, Section 66(1) StGB provides for preventive detention for *responsible* offenders (*Sicherungsverwahrung*) who have been sentenced to at least two years of imprisonment for a crime committed with intent (*Vorsatz*). The defendant must have been sentenced at least twice before to at least one year of imprisonment for a comparable crime, and he must have been sentenced at least once before to at least two years of imprisonment or deprivation of liberty by a preventive measure.<sup>5</sup> It also has to be established that the defendant has an inclination (*Hang*) to serious (*erheblichen*) crimes. The *Sicherungsverwahrung* may be ordered for an indefinite period of time (Section 67d StGB) and can last for the rest of the offender’s life.

Thus, in Germany, not only DNR offenders but also offenders responsible for their crimes can be subjected to forms of indeterminate deprivation of liberty based on their dangerousness. However, the threshold for commitment to a psychiatric hospital is considerably lower than for commitment to *Sicherungsverwahrung*. This implies that in Germany, the DNR offender is considered to belong to a category that constitutes a dangerousness that is unlike the danger posed by the responsible defendant and thus requires a lower threshold to be committed to preventive detention.

#### 2.4 Norway: insanity, responsibility and risk

To conclude this section, we briefly draw attention to a legal system that, unlike the ones previously discussed, does *not* infer dangerousness exclusively or predominantly from the insanity of the defendant. Section 62 of the Norwegian Penal Code (*Straffeloven*, ‘Strl.’) stipulates that an offender who committed a crime for which he cannot be held responsible (*tilregnelig*) due to the fact that at the time of the act, he was psychotic or suffered from a severe impairment of consciousness (pursuant to Section 20(1)(b) or (d) Strl.) can be committed for an indeterminate period of time to psychiatric care (*tvungen psyisk helsevern*; cf. Meynen, 2016, 36).<sup>6</sup> Two further conditions have to be met. First, the offender must have committed or attempted to commit a violent offence, sexual offence, unlawful imprisonment, arson or other offence that infringed on the life, health or freedom of another person or could have put these legal interests at risk. Second, there must be an ‘obvious risk’ that the offender will again commit a serious crime that infringes on or puts at risk the life, health or freedom of other persons.<sup>7</sup>

Like its German equivalent, Section 60 StGB, this indeterminate (see Section 65(1) Strl.) commitment is comparable to the Dutch *tbs* order. A notable difference from both Germany and the Netherlands is that it can only be imposed on offenders who have been found to be entirely *not* responsible for their crimes (the concept of *diminished* responsibility does not exist in Norwegian criminal law). In addition, however, Section 40 Strl. provides for preventive detention of offenders who are found to be responsible for their crimes (including those who, in other systems, would be deemed

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<sup>5</sup> Section 66(2) and (3) StGB make some exceptions to this requirement of double recidivism in case of convictions of a certain severity.

<sup>6</sup> Under the same conditions that apply for *tvungen psyisk helsevern*, Section 63 Strl. provides for indeterminate commitment to medical care (*tvungen omsorg*) for offenders who are not accountable (*utilregnelig*) pursuant to Section 20(1)(c) Strl. because they are ‘severely mentally disabled’.

<sup>7</sup> Section 62(1) and (3) Strl. does allow commitment under alternative conditions (cf. Grønning, Husabø & Jacobsen, 2016, 653).

to have diminished responsibility; cf. Section 40(4) and (5) Strl.; Gröning, Husabø & Jacobsen, 2016, 622). This preventive detention (*forvaring*) is an indeterminate form of punishment (Section 43(1) Strl.) that is available in cases where a determinate prison sentence is deemed insufficient to protect the life, health or freedom of other persons (Norway has no lifelong prison sentence; the maximum prison sentence is 21 or, in a few cases, 30 years).

The penalty of *forvaring* is largely subject to the same conditions as the indeterminate commitment to psychiatric care (cf. Gröning, Husabø & Jacobsen, 2016, 652).<sup>8</sup> This implies that the threshold for commitment to *forvaring* (contrary to the German *Sicherungsverwahrung* of Section 66 StGB) is not considerably higher than for commitment to psychiatric care. To this extent, it can be maintained that in Norway, the imposition of a form of indeterminate preventive commitment or detention based on a risk of future offences is *not* inferred from the insanity or diminished responsibility of the offender.<sup>9</sup>

As we have seen, modern legal systems infer dangerousness from the insanity or diminished responsibility of the defendant. The inference of risk from diminished responsibility or insanity is manifested in various forms of preventive detention for DNR offenders. Even in Germany, one of few jurisdictions that apply some form of indefinite preventive detention for fully responsible offenders, the threshold for preventive detention of DNR offenders is considerably lower. Of the four legal systems discussed above, Norway appears to be the only country where a risk of future recidivism is not predominantly inferred from insanity or diminished responsibility.

In the next two sections, we advance an argument against the inference of risk from insanity or diminished responsibility.

### ***3 Legal responsibility and risk: different normative evaluations***

The assumption underlying the inference of risk from insanity seems to be that if the defendant was not able to control his behavior rationally in the past, he will not be able to control his behavior in the future. The risks connected with the mental disorder then have to be dispelled by means of commitment and – in the course of the commitment – treatment (cf. Morse, 2011).

The assessment of whether the defendant was suffering from a mental disorder at the time he allegedly committed the offense is based on an examination conducted by a psychiatrist and/or a psychologist. These behavioral experts focus on the time frame of the offense: an event in the past that usually took from a few seconds up to maybe fifteen minutes. For instance, stabbing a victim with a knife does not usually take longer than several seconds. If the criteria for insanity have been met, the defendant is not responsible.

Whereas the relevant mental state of the defendant for the assessment of insanity during the offense normally concerns fifteen minutes at most, and occasionally a short time before that period, the

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<sup>8</sup> One juridically notable difference concerns the fact that, for *forvaring*, the offender must at least be guilty of an offense that has infringed on the life, health or freedom of another person or has put these legal interests at risk (Section 40(1) Strl.; *concrete* endangerment), whereas for *tvungen psykisk helsevern* or *tvungen omsorg* it may suffice that the offender committed an offense that has infringed on the life, health or freedom of another person or *could have* put these legal interests at risk (Section 62(1) and Section 63(1) Strl.; *abstract* endangerment; Gröning, Husabø & Jacobsen, 2016, 653-654).

<sup>9</sup> But note that, as previously mentioned, offenders with diminished responsibility can be sentenced to *forvaring*.; and: the fact that abstract danger can suffice for *tvungen psykisk helsevern* is based on the presumption that offenders committed to this measure can on average more easily be assumed to be dangerous than other offenders (Gröning, Husabø & Jacobsen, 2016, 654).

time frame within which the defendant's future dangerousness has to be assessed is neither defined nor specified. Therefore, its scope could in theory cover the rest of the defendant's life. The dangerousness relates to recidivism – the commission of similar, but also of different, offenses – and thus switches the temporal perspective from the past to the future. The scope of inquiry therefore shifts dramatically, from the pinpointed moment of the offense to the boundless future, and the specific nature of the offense committed is relinquished for a more general risk of committing offenses. However, the specific loss of control due to a mental disorder at the time of the act is thought to be necessary as an 'entrance requirement' for indeterminate commitment.

Thus, legal insanity and preventive detention are very different legal issues. Legal insanity concerns the establishment of a lack of legal responsibility for an act in the past, while preventive detention deals with the legal question whether or not a defendant is sufficiently dangerous to justify a commitment order. A positive answer to one of these two questions does not imply the same answer to the other. Conceptually, irresponsibility for a particular act in the past is not directly tied to an increased risk in the unspecified future. However, it could be that in practice, a link does exist between a finding of insanity and future dangerousness. At the empirical level, the continued existence of the mental disorder that was of influence on the criminal responsibility of the defendant may very well be indicative of future dangerousness. As we will see in the next section, however, there exists only a weak link between mental disorder on the one hand and a risk of recidivism on the other.

#### ***4 The weak link between insanity, mental disorder and dangerousness: empirical data***

It is at least doubtful that the presence of possibly severe mental illness as such leads to crimes. Elbogen and Johnson (2009) write that "severe mental illness alone is not an independent contributor to explaining variance in multivariate analyses of different types of violence". They conclude that "it is simplistic as well as inaccurate to say the cause of violence among mentally ill individuals is the mental illness itself". (Elbogen & Johnson, 2009; Meynen, 2016).

Often, psychosis is considered to be the typical mental condition leading to insanity. Slobogin (2017), for instance, writes that "the typical mental disorder associated with insanity is psychosis" (see also Morse, 2011, 1102). Therefore, it will be particularly informative to look at the relationship between this condition and crime/recidivism. Interestingly, according to Szmukler and Rose (2013, p. 135), psychosis as such is not a strong predictor of violence compared to the general population: "people with a psychosis, in the absence of substance abuse or antisocial personality, are not much more likely to be violent than the general population." Note that the general population is less violent, on average, than the offender population.

This quote is in line with Fazel et al. (2009), who aimed to clarify the relationship between violence on the one hand and schizophrenia and other psychotic disorders on the other. They performed a meta-analysis of 20 studies, which, in total, included results from 18,423 subjects with schizophrenia and other psychoses. They found "an increased risk of violence in those with schizophrenia and other psychoses compared with the general population". At first sight, this suggests that schizophrenia and psychosis are very relevant regarding risk. However, there was an additional finding, namely that "comorbidity with substance use disorders substantially increased the risk of violence". In fact, as it turned out, "the increased risk of violence in schizophrenia and the psychoses comorbid with substance abuse was not different than the risk of violence in individuals with diagnoses of substance use

disorders”. “In other words,” they conclude, “schizophrenia and other psychoses did not appear to add *any additional risk* to that conferred by the substance abuse alone.”<sup>10</sup> In the end, therefore, psychosis did not add any risk above the risk associated with substance abuse. In another study, Fazel et al. examined the risk of violent crime in subjects with schizophrenia (n=8,003) compared with general population controls (n=80,025) (Fazel, Långström, Hjern, Grann, & Lichtenstein, 2009). In this study, they also conclude: “The association between schizophrenia and violent crime is minimal unless the patient is also diagnosed as having substance abuse comorbidity.”<sup>11</sup> These data suggest that the link between psychosis – the main condition associated with insanity – and crime, including violent crime, is weak at most.

Another strand of empirical research concerns the development of risk assessment tools for offenders. For a couple of decades, a variety of risk assessment tools have been developed, tested, and implemented in many legal systems. Such instruments are, in general, used to determine whether offenders have a low, medium, or high risk of recidivism (this is therefore not a comparison with the general population, but with the group of other offenders). Some of these risk assessment tools are actuarial in nature, which means that their components as such do not rely on professional clinical judgment. For instance, the Static-99 is concerned with aspects of the crime and earlier criminal behavior (Hanson & Thornton, 2000), rather than the findings of a mental state examination. In fact, actuarial risk assessment tools have opened up a new way of looking at risk which reflects the way insurance companies perform their assessment. This is very different from the methods traditionally used in mental health care, where clinical assessments are common practice. Other tools include some professional clinical judgment (HCR-20, for instance).<sup>12</sup> Risk assessment tools may include all kinds of information, provided the information contributes to the assessment of a person’s risk. That is basically the idea of risk assessment tools: as long as the factors add to their predictive accuracy, they can be included. Such risk assessment tools are therefore ‘pragmatic’ and a-theoretical (Andrews, Bonta, & Wormith, 2006).

In these assessment tools, mental illness is often a factor, but only one among many. In an oft-cited meta-analysis, Gendreau et al. 1996 concluded about the strength of risk factors for recidivism: “The strongest predictor domains were criminogenic needs, criminal history/history of antisocial behavior, social achievement, age/gender/race, and family factors.”<sup>13</sup> In general, criminal history is often considered to be the best predictor of recidivism (Eaglin, 2017). Therefore, mental illness is not only just one of many factors, but also not the most important risk factor.

It is even the case that in one risk assessment tool, the violence risk appraisal guide (VRAG), the presence of schizophrenia – a psychotic illness – is associated with a *reduction* in the risk of recidivism.<sup>14</sup> In other words, in the VRAG, the condition most directly associated with a successful insanity defense reduces the risk of future dangerousness (Kooijmans & Meynen, 2012).

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<sup>10</sup> Emphasis added.

<sup>11</sup> More precisely, they state: “Among patients without comorbidity, adjusted ORs from comparisons with unrelated general population controls or unaffected siblings were 1.2 to 1.3.”

<sup>12</sup> Hart, Douglas, & Guy (2017, 102-103) write: “The Structured Professional Judgment (SPJ) approach is an analytical method used to understand and mitigate the risk for interpersonal violence posed by individual people that is discretionary in essence but relies on evidence-based guidelines to systematize the exercise of discretion.” (Ref. omitted.) In the HCR-20V3, SPJ not only involves determining the presence of a risk factor, but also its *relevance*: “Risk factors may have differential relevance to individuals within samples, although on average they elevate risk within the sample. They do not necessarily affect risk in the same way for all people.” (Douglas et.al., 2014.) The evaluator has to rate the relevance of the risk factors on a three-point scale.

<sup>13</sup> Quote from abstract.

<sup>14</sup> This association could not be proved in a sample of 136 German mentally ill offenders (Kröner, Stadtland, Eidt, & Nedopil, 2007, 97) and there is some debate about this association. Meehan et.al. found a “weak but definite association between schizophrenia and violence” in the general population (Meehan et.al., 2006). Meanwhile, it is important to distinguish between findings concerning the risk of *recidivism in the group of offenders* on the one hand and the risk of violent behavior from persons diagnosed with schizophrenia in the *general population* on



In summary, if we look at risk assessment tools, they do not in any way single out mental illness as the main risk factor for future dangerousness. Interestingly, even in a population of those who were discharged after a NGRI verdict (New York State), it turned out that re-arrest was predicted by the same factors as in the general offender population: “Characteristics that exerted the greatest influence on re-arrest among this mentally ill population were similar to those that predict re-arrest in the larger offender population (i.e., gender, age, antisocial diagnoses, and selective measures of prior arrests). These findings comport with prior research findings and speak to the importance of demographic and criminogenic factors in the prediction of arrest” (Miraglia & Hall, 2011). Therefore, even in a NGRI population – 83% had ‘psychotic’ as pre-release diagnosis – demographic and criminogenic factors were related to re-arrest rather than psychosis. The authors state: “Neither a history of psychosis nor one of substance abuse was predictive of re-arrest or re-arrest for violence within this population.” A diagnosis of antisocial personality did predict, but the authors also mention that such a diagnosis is related to criminal history – which is a very relevant point. Moreover, it is important to realize that an antisocial personality disorder is highly unlikely to lead to a successful insanity defense.

In conclusion, this section has shown that two important empirical approaches regarding risk of recidivism do not provide a justification for singling out insanity or diminished responsibility – and psychotic or other mental illness – as the main factor justifying indeterminate preventive detention; in fact, the opposite is true (cf. Beukers, 2017). Clearly, this does not mean that mental illness – and its treatment – is irrelevant regarding risk and risk reduction. More specifically, in individual cases severe mental illness may be an important risk factor.<sup>15</sup> However, these findings do challenge provisions in criminal law that rely on a presupposed link between severe mental illness – required for insanity – and risk of recidivism (and preventive measures).

## ***5 Discussion and conclusion***

Across different legal systems, the law exposes DNR offenders to potentially indeterminate commitment orders that are based on the defendants’ supposed future dangerousness. In contrast, responsible defendants typically are not subjected to these commitment orders. And even in legal systems where indeterminate commitment of *responsible* defendants is possible, the thresholds for ordering such a commitment are considerably higher than is the case with regard to mentally disordered defendants. The inference of risk of future recidivism from insanity or diminished responsibility that justifies the indeterminate commitment of mentally disordered offenders is, as we have shown, problematic.

In fact, based on the discussion above, this inference seems to amount to an unjustified unequal treatment of DNR offenders. This is ethically and legally problematic. At least since Aristotle, it has been a core ethical principle that equal cases should be treated alike, to the extent that these cases are in fact equal. Across legal systems, unjustified unequal treatment is considered highly problematic. Moreover, this principle is enshrined in constitutions worldwide, including in the US (Amendment XIV), the Netherlands (Section 1 *Grondwet*) and Germany (Section 3 *Grundgesetz*). Empirically, there

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the other. See also Carroll, Lyall, & Forrester 2004, 410-411: “Recent follow up studies of forensic patients suggest that the risk of serious reoffending is actually low. Earlier work suggests that even in the absence of statutory frameworks for ongoing surveillance, the future risk to the public from many forensic patients is not high.” (Ref. omitted.)

<sup>15</sup> See also footnote 12, on relevance: using HCR-20v3, forensic professionals can explicitly indicate the relevance of certain risk factors in individual cases.

is at best only a very weak link between mental illness and lack of responsibility for past criminal conduct on the one hand, and risk of future criminal conduct or recidivism on the other. This implies that, with regard to future dangerousness, the group of mentally disturbed offenders is in fact not very ‘unequal’ to the group of criminally responsible offenders. The differences that do exist between the two groups cannot satisfactorily justify why mentally disturbed offenders – who already form, to a certain extent, a stigmatized group in society – are exposed to potentially indeterminate commitment orders, whereas responsible offenders generally are not.

To be sure, responsible offenders may be sentenced to long prison terms, including life. The rationale for imprisonment or continued incarceration may very well – at least in part – be that the offender is considered dangerous. Hence, it might be argued that there is no need for indeterminate commitment of responsible offenders to address the risk they pose and that this could justify why mentally disturbed offenders can – and responsible offenders mostly cannot – be subjected to special forms of indeterminate commitment. Still, punishment is – except in rare cases of life imprisonment – typically *not* indeterminate (a notable exception, as we have seen, is the Norwegian penalty of *forvaring*), whereas the commitment of mentally disordered defendants often is. Punishment therefore does not necessarily adequately address the risk an offender poses (cf. Morse, 2011). Responsibility justifies punishment, but that does not imply that *no responsibility* as such justifies indeterminate commitment, which *responsible* offenders cannot be subjected to. Moreover, offenders with diminished responsibility may often be subjected both to punishment *and* indeterminate commitment. Therefore, the existence of sentences to which only responsible offenders may be subjected does not offer a justification for the indeterminate commitment of DNR offenders.

Indeterminate deprivation of liberty is one of the most intrusive and psychologically challenging means by which the state can interfere in the lives of its citizens. The empirical basis for unequal treatment that amounts to indeterminate detention has to be very robust to justify such unequal treatment. This is not the case for indeterminate commitment of DNR offenders.

The fact that mental illness is not an important risk factor has another serious implication for the justification of indeterminate commitment orders aimed at mentally ill offenders. Successfully treating the mental disorder during commitment may not lead to a sufficient reduction of risk for the person to be released. In Section 4.08(3) MPC, for instance, dangerousness is the criterion for release from commitment. In the *Commentaries* (American Law Institute, 1985, 259), it is noted that factors other than mental illness, such as personality and background, may also contribute to dangerousness. Successful treatment of the condition that is supposed to justify the unequal treatment of the mentally disordered offender, therefore, does not necessarily lead to his release, because dangerousness may continue to exist due to other risk factors.<sup>16</sup> These other factors may even be static, such as the offender’s criminal history or gender, so that it is not even possible to reduce these risk factors. It is difficult to see what justifies the continued commitment of DNR offenders if they are dangerous because of factors that on their own do not suffice for the imposition of commitment in the first place.

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<sup>16</sup> In the Netherlands and Germany, it is a legal prerequisite for the continuation of commitment that the mental disorder is the continuing cause of future dangerousness. Especially when general risk assessment tools are being used as described in section 4, in practice, the risk caused by the disorder may not be distinguishable from the risk caused by other risk factors. In effect, these other risk factors may very well be more important in the general risk assessment. Therefore, notwithstanding the requirement of causality between disorder and risk, the same problem may arise in these legal systems as well. (Kooijmans & Meynen, 2012.) A survey of Dutch case law on the imposition of *ths* orders shows that most judgments indeed rely on the need to treat a mental disorder to reduce dangerousness. However, it also is noted that mental health experts, in their treatment of those committed under *ths* orders, increasingly address risk factors other than mental disorder (Van der Wolf & Mevis, 2017).

In conclusion, in modern legal systems we typically find a strong and sometimes even direct connection between insanity on the one hand and risk and indeterminate preventive detention on the other. In this paper, we have challenged this connection. The inference of risk from insanity or diminished responsibility as a justification for indeterminate commitment for mentally disordered defendants should therefore be reconsidered by legislators. In addition, other factors reflected in risk assessment tools should receive more attention in this respect. In our view, it would be valuable to explore legal models of commitment that do not assume a link between insanity and dangerousness – such as the German *Sicherungsverwahrung*, the Norwegian *forvaring* and the English Mental Health Act – in future research.

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