A Legal Perspective on Dangerousness: Current Status

By GEORGE E. DIX, J.D.

Traditionally, legal proceedings have been conducted on the uncritical assumption that assessment of a subject's "dangerousness" is a part of any competent psychiatrist's clinical skill. Consequently, courts received input on this matter from clinicians in the form of testimony and reports and, insofar as can be determined, often relied upon this input without serious reservation. Those psychiatrists who participated in forensic matters implicitly asserted great predictive skill. The large number of practitioners who did not venture into the forensic arena voiced objection to neither their colleagues' assertion of such predictive skills nor to the courts' uncritical reliance upon their colleagues' clinical assessments of the dangerousness of particular subjects.

On the other hand, general psychiatric practice continued without significant concern regarding dangerousness assessments. To be certain, involuntary treatment of patients was occasionally sought and concerns regarding possible harm to others sometimes entered into the decision to seek such treatment. But few practicing psychiatrists contemplated that they might be held legally accountable for failing to identify and appropriately respond to any of their patients who posed a danger of physical harm to others.

The situation has significantly changed over the last few years. Many lawyers and psychiatrists have become increasingly concerned with the propriety of the traditional assumption that psychiatrists' clinical skills include an ability to make accurate assessments of dangerousness. In a brief filed in the US Supreme Court in 1980, the American Psychiatric Association asserted that the use of expert psychiatric testimony on the issue of long-term future criminal behavior in death penalty cases is inconsistent with the need for an especially reliable outcome of the proceeding.1

This increased sensitivity to the nature and number of problems posed by clinical assessment of subjects' violent propensities has coincided with (and perhaps caused) a number of perhaps inconsistent developments in the law and in clinical practice related to legal issues. These are examined here.

SPECIFICATION OF TERMS

There is increasing recognition that discussion of a person's "dangerousness" obscures a number of important although troublesome ambiguities. Any such discussion must involve anticipation of certain conduct by the subject. This may be conduct that causes or creates a risk of physical harm, perhaps serious harm. Or, it may be conduct that causes or creates a risk of "psychological" harm, or perhaps only discomfort. Such discussions also

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necessarily involve some definition of the time during which the subject's behavior is being considered. This may be only a short period, such as several hours or days, or a longer period, such as five or more years. Finally, such discussions must involve some quantification of the risk that the conduct at issue will be engaged in by the subject during the period under consideration. This may mean any likelihood at all (although this is not likely), a greater likelihood than average, a probability of more than 50%, or (also unlikely) a virtual certainty.

Unfortunately, framing the issue as one of "dangerousness" eliminates any need to address these ambiguities. As a result, these matters were resolved differently by different parties to the discussions or — perhaps worse — never considered at all. Clearly, the last ten years have seen a trend toward greater sensitivity to the need to address these matters directly. Given the difficulty that they present, of course, this has caused some discomfort. But there is widespread recognition that difficulties in making predictions and in quantifying judgments should be faced directly rather than being obscured under convenient but ambiguous language.

EMPIRICAL RESEARCH

Increasing interest in empirical verification of the reliability and accuracy of clinical judgments has extended to predictions of assaultive conduct. Research in this area is especially difficult, however, because of the obvious ethical and legal limitations upon controlled experiments. The research that has been done has involved use of opportunities for research occurring when persons clinically evaluated as assaultive have been discharged into the community for legal reasons that may have nothing to do with the risk they present of assaultive conduct. Most of this research has involved persons charged with or, more frequently, convicted of criminal offenses. Follow-up studies of these populations have tended to show that no more than 30% to 40% can be shown to have committed a serious and criminal assaultive act during the several years following release. This research is sometimes offered as supporting or establishing the proposition that clinical assessments of assaultiveness are erroneous at least half the time and perhaps more frequently. But this is an oversimplification. The studies have numerous methodological defects that may cause them to understate predictive accuracy. Many use arrest or even conviction as the criterion for commission of an assaultive act; many assaultive acts may thus go untabulated. The populations studied may be ones in which the legal system found the clinical assessment of assaultiveness to be insufficiently based and thus may test the accuracy of the least satisfactory clinical judgments. But perhaps most important, the studies concerned populations of persons without traditional mental illnesses and the assaultive conduct of these persons over a period of several years. Clinical assessment of assaultiveness may well be more accurate when the subject is a person within the clinician's traditional area of expertise, i.e., when the subject's possible assaultiveness is related to symptoms of mental illness. Moreover, assessment of short-term assaultiveness may involve less uncertainty as to environmental and other factors and thus could reasonably be expected to be more accurate than the assessments tested in the existing research.

It is true, then, that the demonstrated accuracy of clinical assessments of assaultiveness is no greater than 50%. Equally important, there is almost no useful research concerning the accuracy of assessments of short-term assaultiveness or assessments concerning persons whose potential assaultiveness is related to symptoms of traditional mental illnesses. To generalize from the existing research to these other situations is highly questionable analysis.

CIVIL "COMMITMENT"

Recent revisions and judicial constructions of compulsory treatment standards have tended to emphasize dangerousness. While the US Supreme Court has not spoken to the matter, many lower courts and legislatures have assumed that federal constitutional considerations greatly limit the nondangerous mentally ill who can be compelled to submit to treatment or institutional care and thus mandate this emphasis. While the formulations differ, many require for commitment that the proposed patient be determined to pose a substantial risk of physical harm to other persons or to the proposed patient himself. The potentially restrictive impact of these standards is somewhat reduced, however, by provision for commitment on the alternative ground that the person

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has been rendered unable to provide for his or her immediate needs for food, clothing, and shelter.\(^7\)

This emphasis upon dangerousness in the criteria contrasts with a discernible increase in the skepticism with which testimony concerning clinical predictions is being viewed. Witnesses are increasingly being pushed to testify in terms of the sub-issues identified above and to justify their conclusions. On cross-examination, psychiatrists are being challenged concerning the demonstrated accuracy of their opinions on dangerousness and their personal training and expertise on this subject. There is little indication, however, that the courts are regarding prediction of assaultive conduct as a subspecialty requiring special training and education. Qualification as an expert on mental health matters in general continues to be regarded as sufficient to permit a witness to express an expert opinion on the assaultiveness of a proposed patient.

Skepticism concerning clinical assessments has with some frequency been reflected in judicial and legislative development of a requirement of overt conduct confirming the clinical assessment.\(^8\) Under a number of commitment statutes, the evidence before a committing court is insufficient to establish that a proposed patient meets the dangerousness criteria unless it includes recent conduct (often defined as an assault, threat, or attempt to commit an assault) tending to establish the subject's dangerousness. This, of course, does not mean that expert testimony based on clinical assessment is irrelevant or unimportant. It does, however, reflect a judgment that an assessment based on clinical observations alone, without confirming conduct, is insufficiently reliable on which to base a relatively long-term deprivation of liberty.

Although intuition suggests that requiring that a proposed patient's assaultive propensities have been actually acted upon would improve the accuracy of clinical assessments of those propensities, this has not been empirically examined.

**DUTY TO IDENTIFY AND RESPOND TO DANGEROUS PATIENTS**

No other legal development relating to dangerousness has been viewed with greater concern by psychiatry than the so-called "duty to warn" potential victims of dangerous patients. This duty was first recognized in the California Supreme Court's 1974 and 1976 opinions in *Tarasoff v Board of Regents,*\(^9\) and has been accepted by many (although not all) other courts that have later considered it.\(^10\)\(^11\) Unfortunately, the duty is often misunderstood.

Properly read, Tarasoff and similar cases impose two distinct duties upon therapists.\(^12\) First, therapists must exercise reasonable care in identifying patients who pose a danger of harming third persons. Second, therapists must exercise reasonable care in protecting those potential victims from patients who are (or who should have been) identified as dangerous. Warning the potential victim and thereby violating confidentiality in an especially serious way is one potential manner of fulfilling the second duty. The Tarasoff case does not, however, establish that warnings are always or even frequently required. It does stand for the proposition that in some situations it is possible that warning the potential victim may be the only acceptable way for a therapist to perform his or her responsibilities under the duty. The California Supreme Court's action was not a holding that on the facts presented the failure to warn the victim was a violation of the therapist's legal duty. Rather, it was a holding that the plaintiffs were entitled to trial on that issue. The court held, in other words, only that the plaintiffs were entitled to an opportunity to prove that under the circumstances and given the alternatives the defendants' failure to warn the victim was unreasonable.

Even as so read, the Tarasoff cases rest upon an assumption of psychiatric expertise in predicting assaultive behavior. Generally, persons have no responsibility to protect third persons from clients or patients. But the Tarasoff cases assume that psychiatrists and other mental health professionals have almost unique skills in predicting whether those with whom they deal, at least in the therapeutic context, will assault others. Consequently, psychiatrists are singled out for an almost unique legal responsibility.

**CRIMINAL SENTENCING**

Several trends in criminal sentencing can be seen at least in part as the results of skepticism concerning clinical assessments of the dangerousness of convicted criminals. A number of jurisdictions have abandoned traditional "indeterminate" sentencing, in which the judge has...
considerable discretion as to penalty, in favor of so-called "determinate" sentencing, which greatly restricts the discretion of the judge. Among the reasons for this shift is undoubtedly a conclusion that the information available to sentencing judges, including clinical assessments of offenders, are insufficiently reliable to base important decisions upon. Perhaps more significant is the quite spectacular trend toward repeal of programs for identification of abnormal and dangerous offenders, followed by a commitment to a treatment-oriented program with authority to retain the offender until he is no longer dangerous. Most such programs have been limited to offenders determined to be sexually dangerous. A number of jurisdictions have recently repealed their so-called "sex psychopath" programs, in part because of concern regarding the ability to identify truly dangerous offenders. The Maryland Defective Delinquency program, which was not limited to the sexually dangerous, was so dramatically revised in 1977 that it no longer resembles the traditional dangerous abnormal offender programs.

This is not to say, however, that clinical assessments of dangerousness have no role in criminal sentencing. A number of states retain indeterminate sentencing. Even under determinate sentencing, the trial judge often has discretion whether to sentence an offender to imprisonment, and clinical assessments of dangerousness can, of course, be considered in deciding whether to place a defendant on probation. Some determinate sentencing states have so-called "presumptive" sentencing schemes, in which a statutory sentence is to be imposed unless either mitigating or aggravating factors are proved. Psychiatric assessments of defendants' dangerousness may be called into play in efforts to establish these other factors and thereby to increase or reduce the sentence which the judge is required to impose.

The one area in which there is a clear increase in the use of clinical assessments of dangerousness is capital sentencing.\textsuperscript{14} Federal constitutional considerations demand that in each death penalty case the sentencing authority, whether it be the judge or a jury, have considerable discretion to consider virtually all aspects of the defendant and his crime in making a decision as to whether or not to impose the death penalty. The likelihood that the defendant will kill or assault others if not executed is a relevant consideration under the procedures adopted in a number of states. Some states' schemes require the sentencing authority to specifically answer a question concerning defendants' dangerousness. In a number of jurisdictions, the prosecution's efforts to convince the sentencing authority to impose death have included presentation of expert testimony that the defendant is in fact dangerous.

It is arguable that in such cases clinical predictive accuracy will be highest, since the defendant has been found to have engaged in clearly dangerous conduct and the extreme nature of the penalty at issue will stimulate clinicians' exercise of maximum caution. Yet significant countervailing concerns have been expressed. The horrendous nature of the offenses committed may render even experienced clinicians unable to remain objective. Experts' conscious or unconscious belief that retribution demands the ultimate penalty may therefore color their evaluation of the defendant's assaultive potential. Witnesses may assert unrealistic claims of predictive skills that are difficult to refute given the reluctance of many psychiatrists who might give testimony challenging these claims to become involved in death penalty proceedings. Perhaps most important is the danger that a sentencing judge or jury will uncritically rely on such testimony as indicating that death is appropriate, in part to avoid the difficult and disturbing task of evaluating and balancing other and potentially competing considerations. The extreme and irrevocable result of erroneous reliance upon clinical assessments of dangerousness in this context have caused some to regard this as the most serious problem presented by forensic utilization of clinical assessments of dangerousness.

Generally, courts have rejected arguments that expert testimony to the effect that a convicted capital defendant will kill again is inadmissible, or even that a psychiatric witness must demonstrate special training or skill in prediction before being permitted to express such an opinion.\textsuperscript{15} Defense lawyers are left to the task of convincing the judge or jury that the difficulties of prediction require that such testimony be viewed with skepticism. The California Supreme Court, however, recently took the unusual step of holding expert prediction testimony inadmissible in capital sentencing.\textsuperscript{16} The court adhered to its view in the Tarasoff case that mental health professionals have sufficient skill in predicting violent conduct to justify imposing the Tarasoff duties upon them. But it concluded that these skills were insufficiently established and the cost of an erroneous reliance upon them in this context was so great, that on balance juries making the life or death decision must not hear such predictions.

CONCLUSIONS

"Dangerousness" has increased in importance in a number of legal areas, especially capital sentencing and the selection of impaimed persons for involuntary care or treatment. But there is some evidence that the legal system is becoming a more sophisticated consumer of expert opinion testimony on the matter. Some legal standards
have been honed so as to pose more specifically the inevitable questions of the sort of conduct at issue, the time over which prediction is being attempted, and the quantitative likelihood of such conduct occurring. Whether the legal standard is specific or not, expert witnesses are being increasingly pressed to address these matters, to defend their competence to express opinions on the issues, and to cite empirical verification of their claims of predictive skills.

Correspondingly, Tarasoff and its progeny have called the psychiatric profession to task for its silent acquiescence in the law’s traditional assumption that competence as a diagnostician and therapist necessarily involves clinical skill in assessing assaultiveness. If the profession accepts such an assumption, it may well be reasonable for the law to impose upon individual members of the profession a duty to exercise that skill with reasonable care in the course of a therapeutic practice.

Perhaps the most productive approach that the psychiatric profession might take to this state of affairs is to seriously consider relatively frank and open acknowledgment of limitations in this area. For example, members of the profession might acknowledge that assessments of the assaultiveness of particular persons is not a routine part of most psychiatrists’ training or therapeutic practice. Further, there is little reliable evidence verifying claims made by some members of the profession of predictive skill. Such research as is available concerns mostly long-term predictions concerning the conduct of persons without traditional mental illness; this research suggests minimal demonstrated predictive skill. Intuition suggests that psychiatrists’ predictive ability is substantially greater when it is called into play concerning the short-term risk posed by persons whose assaultive tendencies are related to symptoms of identifiable serious mental illnesses. But claims of predictive skill even in these situations might be acknowledged to rest only upon intuition.

Few would urge that psychiatric input into assessments of dangerousness be completely barred. What is needed is input that does not involve inflated claims of predictive ability. Moreover, it may well be the case that such assessment should be regarded as a distinct area of specialization. Testimony on dangerousness, then, might reasonably be regarded as permissible only if the psychiatrist demonstrates particular training and experience in this area over and above the psychiatrist’s qualifications as a diagnostician and therapist. A psychiatrist with such specialized clinical ability is quite properly regarded as often having useful information bearing upon the risk of assaultiveness posed by a particular person. But the psychiatrist’s skill is almost certain to justify no more precise an ultimate professional opinion than for specified reasons the subject poses a risk of serious assaultive conduct that is substantially greater than the risk posed by most persons.

More widespread acknowledgment of these limitations upon psychiatric skills might well persuade some courts to pause before imposing the Tarasoff duties. If psychiatrists in general therapeutic practice do not assert, and are not regarded by their profession as having, exceptional ability to anticipate assaultive conduct, it may be unwise and unjustifiable to select them for imposition of a legal duty to identify and react to dangerous patients. Insofar as the profession as a whole tacitly endorses the claims of some of its members to inherent and highly developed psychiatric expertise in predicting assaultiveness, however, the profession is inviting the imposition of Tarasoff-like responsibility.

REFERENCES

7. California Welfare & Institutions Code Section 5300 (90 day confinement of mentally dangerous persons).