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Parallels in Predicting Dangerousness - What Price Security

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Parallels In Predicting Dangerousness— What Price Security?*

Participants:

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PROFESSOR MERTON:¹ One question is: why should an employer have *any* duty to intervene, respond, or warn when an employee is deemed “dangerous”? What expertise in making these predictions can your average business manager bring to the table? As lawyers we tend never to look at law that is more than a week old. Similarly, scientists prefer not to rely on science that is more than a few months old. Yet, here is an article² written almost 20 years ago when I was a young Associate for Law at the Hastings Center for a symposium honoring the great forensic psychiatrist Dr. Jonas Robitscher, whom I had the pleasure of working with there.

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1. Vanessa Merton is Associate Dean for Clinical Education and Professor of Law at Pace University School of Law, where she teaches health law and directs the clinical and externship programs. Professor Merton is also the Executive Director of John Jay Legal Services, the law school's free legal clinic, and co-founder of the Access to Health Care, Health in the Workplace, and Prosecution of Domestic Violence Clinics. Professor Merton has lectured and published extensively on issues of biomedical and legal ethics and on health issues of importance to women, most recently domestic violence, the exclusion of women subjects from medical research, and the phenomenon of female genital mutilation. Professor Merton was the founding chair of the Institutional Review Board of the Community Research Initiative of New York, one of the first centers for community-based biomedical research on AIDS, and the first Associate for Law at the Hastings Center Institute for Society, Ethics, and the Life Sciences. The honor of which she is most proud of is being chosen as Outstanding Professor by the 1995 graduating class of Pace University School of Law.

2. See Vanessa Merton, *Confidentiality and the “Dangerous” Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 EMORY L.J. 263 (1982).

When in preparation for this meeting I began to update this article, I assumed that the law and the science of violence prediction would have evolved substantially; I expected to see great differences in both the quality of the scientific predictions and the law of legal authority and responsibility for such predictions. However, I must say that I found very little change over the last 20 years. Further, my own predictions about what would be the effect of the *Tarasoff*³ decision have turned out to be completely wrong.⁴

Back in 1982, shortly after the *Tarasoff* decision, I was responding to the enormous sense of injustice among my colleagues in psychiatry and other mental health professions, who felt that the law was terribly unfair, as well as very stupid, for imposing any responsibility for poor predictions of violence on them.

In fact, the mental health professions had bought into this position of power, based on a claim of expertise—to be able to predict violence—that the occupants of no other profession, group, or role in our society have. The role conflict for mental health professionals that was ascribed to the *Tarasoff* decision was not created by the law, but merely became embodied in the law.⁵

Psychiatrists and mental health professionals in this society function as agents of social control in a great variety of ways. Perhaps the clearest example is death penalty jurisprudence⁶ which continues to utilize “scientific predictions” of future violent behavior. Dangerousness is admittedly a legal construct rather than a clinical one. However, that kind of prediction can make the difference between life and death for a

3. See *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334 (Cal. 1976).

4. See Merton, *supra* note 2, at 308-17; 322-25; 329-35.

5. See Merton, *supra* note 2, at 276.

6. See *Estelle v. Smith*, 451 U.S. 454 (1981); see *Barefoot v. Estelle*, 463 U.S. 880 (1983); see also John C. Johnson, *Survey of Developments in North Carolina and the Fourth Circuit*, 73 N.C. L. REV. (1995); Sheri Lynn Johnson, *1988 Survey of Books Relating to the Law; Crime and Punishment: The Politics of Predicting Criminal Violence*, 86 MICH. L. REV. 1322 (1988); Robert J. Kane & George Sigel, *Violence Prediction Revisited*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 63 (1993); Mark David Albertson, *Can Violence Be Predicted?*, 3 CRIM. JUST. 18 (1989).

given individual in our legal system, and it can happen every day.

In my original article I argued that if mental health professionals felt imposed upon and that *Tarasoff* represented an unfair, unjust, and unwise rule of law, then their recourse was immediate, and a classic case of "Physician, heal thyself."⁷ If they would renounce their claims to be able to make such predictions, it would become extremely difficult for the legal system to try to hold them accountable for not making them.

The unanticipated consequences⁸ flowing from the *Tarasoff* decision that I feared were a little different from those most voiced by psychiatrists.⁹ One of my concerns was that the evidence enabling therapists to be sued for failing to predict violence, or failing to intervene appropriately after making a prediction, may often come before the court when therapists cooperate by testifying in defense of a perpetrator.¹⁰ Consequently, I thought therapists would be deterred from working with criminal defense lawyers to present evidence of mental problems that would have bearing on the guilt or innocence or mitigation of punishment, of the person who had committed an act of violence. That does not seem to have happened, in part because of subsequent state legislation.¹¹

My second concern was that lawyers would be unwilling to advise therapists confronted with *Tarasoff*-type issues, believing that they, the lawyers, would in turn be held responsible if they gave therapists wrong advice about how to handle the situation.¹² The third issue that I anticipated was that the law seemed, at that point, to contemplate imposing on the legal profession, quite gratuitously, the same responsibility that had been imposed on psychiatrists.¹³ That is, there were indications at that time that lawyers might be held responsible for not revealing threats or otherwise failing to act in response to our

7. See Merton, *supra* note 2, at 267, 342.

8. See *id.* at 322-24, 334-38.

9. See *id.* at 298-300, 312.

10. See *id.* at 322-23.

11. See George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The Tarasoff Duty and the Jaffe Footnote*, 74 WASH. L. REV. 33, 42-45, 48-49, 52-54 (1999), and authorities cited therein at notes 83 and 101.

12. See Merton, *supra* note 2, at 317.

13. See *id.* at 329-31, 335.

dangerous clients.¹⁴ As someone who at that time had been a criminal defense lawyer for 10 years, had heard a lot of threats from clients, had worried a lot and not known what to do about it, this concept was highly salient to me and the idea of imposing that kind of ethical and legal responsibility on lawyers left me feeling rather unequipped to respond.

Of course, lawyers had never claimed relevant expertise or an ability to predict dangerousness. This expertise had never been a part of our societal role. In fact, you could argue the exact opposite. Our job is to speak for the patient or the client, not speak about that person, and not to be objectively descriptive.

What has happened, interestingly enough, in several states, is that lawyers have done just that. We have imposed on ourselves a quasi-*Tarasoff* duty: a mandatory, non-discretionary responsibility to act,¹⁵ and in some cases to report credible threats of imminent, serious physical injury.¹⁶ Therefore, I wondered whether there had been a burgeoning of case law. Had disclosure been imposed on lawyers as a result? The one decision that I have been able to find which moves in that direction is *State of Washington v. Hansen*.¹⁷ Washington was also the jurisdiction of the one comparable decision back in 1979,¹⁸ when I wrote the article, which was the first time a court suggested that lawyers could be accountable for failing to disclose a risk of danger.¹⁹ That earlier court rebuffed the idea of mandatory disclosure compelled by ethical or court rules, but left open the possibility of a "common law duty to volunteer in-

14. *See id.*

15. *See* Standards Relating to the Admin. of Crim. Just., Standard 4-3.7(a), A.B.A. SEC. ON CRIM. JUST. (2d ed. 1980) (proposed mandatory disclosure when threat to endanger the safety of any person).

16. *See, e.g.,* FLORIDA RULES OF PROFESSIONAL CONDUCT Rule 1.6(b) (a lawyer shall reveal information necessary to prevent death or substantial bodily harm); *but see* Model Rules of Professional Conduct Rule 1.6(b)(1) (1998) (disclosure permitted but not required); *see also* Proposed NEW YORK DISCIPLINARY RULE 5-109(B) (organization counsel has mandatory duty to reveal employee's violation of law to highest authority within organization, but not outside organization), *discussed in* Lazar Emanuel "The Misdeeds of Clients and the Lawyer's Response," New York Professional Responsibility Report, Nov. 1999, at 5-6.

17. 826 P.2d 117 (Wash. 1993).

18. *See* *Hawkins v. King County Dep't of Rehabilitation Servs.*, 602 P.2d 361 (Wash. 1979).

19. *See id.* at 365.

formation about a client to a court considering pretrial release where information gained convinces counsel that his client intends to . . . inflict injury upon unknowing third persons.”²⁰

The *Hansen* decision involved a lawyer who received a phone call from someone who had recently been released from prison.²¹ He was looking for a lawyer because he wanted to sue the judge who had sentenced him, the prosecutor that prosecuted him, the lawyer who defended him, and everyone else involved.²² When the lawyer he consulted stated that he did not think that such lawsuits would be feasible, the caller’s response was, “. . . [w]hat I am going to do . . . I am going to get a gun and blow them all away, the prosecutor, the judge and the public defender.”²³ Subsequently, the lawyer consulted his partner and the local bar association, trying to decide the appropriate course of action under the circumstances.²⁴ Finally, the lawyer decided to call the judge and tell the judge that this comment had been made in a phone call.²⁵

Now, talk about a basis for an accurate prediction of violence: the lawyer had never met or seen this person. He knew *nothing* about him, except for the comment he made. It would seem unlikely that a court would require a therapist, let alone a lawyer, to act on the basis of such limited information. However, we are talking about danger to a judge. Thus, the court held that, in fact, the lawyer had a duty.²⁶ The decision’s language is quite interesting, because it is so vague: whenever an attorney “has a reasonable belief that the threats are ‘real,’” the attorney must communicate the threats.²⁷ However, the holding is limited to a situation where the threats are made about a judge.²⁸ It will be interesting to see whether lawyers struggle with these issues as much as mental health professionals have. I continue to wonder whether this analogy is not anomalous,

20. *Id.* at 366.

21. *See Hansen*, 862 P.2d at 118-19.

22. *See id.* at 118.

23. *Id.*

24. *See id.*

25. *See id.* at 118-19.

26. *See Hansen*, 862 P.2d at 122.

27. *Id.*

28. *See id.* at 122-23.

given the very different history, social functions, and claimed expertise of these two disciplines.

Today, in light of our discussions about domestic violence and workplace violence predictors, where do we seem to be coming out? Increasingly, we seem to be returning to common sense, an intuitive or "clinical judgment" approach, one that is not grounded in statistically sound science.²⁹ If that is the case, and if in fact the pendulum is swinging more in the direction of clinical intuition, and away from social science, then perhaps the entire edifice of my claim that lawyers should be exempt from any such responsibility falls, because there is no reason why lawyers or any other professionals or nonprofessionals should not be held to a standard of common sense.

PROFESSOR BERNHARD:³⁰ We have workplace lists and domestic violence lists. What indicators do we look at? What do you think of all the lists that we have seen? How are we doing?

DR. STEADMAN:³¹ I am very troubled. A panel like this is supposed to bring everybody together, make everybody feel

29. See Janet Johnson et al., *Death by Intimacy: Risk Factors for Domestic Violence*, 20 PACE L. REV. 263 (2000); see also Ann Hayes et al., *Workplace Violence: Prediction and Prevention*, 20 PACE L. REV. 297 (2000). On the willingness of the general population to engage in "common sense" predictions of dangerousness, and perception of its relationship to mental illness, see Bruce G. Link et al., *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 AM. J. PUB. HEALTH 1328 (1999).

30. Adele Bernhard is an Associate Professor of Law at Pace University School of Law where she directs the Criminal Defense Clinic. Prior to coming to Pace, Professor Bernhard created and directed continuing legal education for New York City's Assigned Counsel Plan Attorneys. Professor Bernhard began her career as a public defender with the Legal Aid Society of New York. She currently serves on an eight-member Appellate Division Committee which monitors and evaluates the quality of criminal defense services provided to poor people in the Bronx and Manhattan.

31. Henry J. Steadman is President of Policy Research Associates, Inc. Dr. Steadman directed for seventeen years the nationally known research bureau of the New York State Office of Mental Health. His work has resulted in six books, over 100 journal articles in a wide range of professional journals, eighteen chapters, and numerous reports. Among Dr. Steadman's current projects are (1) the National GAINS Center for Persons with Co-occurring Disorders in the Justice System; (2) the John D. and Catherine T. MacArthur Foundation Violence Risk Assessment Study; (3) the National Resource Center on Homelessness and Mental Illness under contract to the Center for Mental Health Services; and (4) the Women and Violence Coordinating Center funded by SAMHSA. In 1987, Dr. Steadman received the Amicus Award from the American Academy of Psychiatry and the Law. He also received the Philippe Pinel Award from the International

warm and fuzzy, so you go home feeling as if you had spent your eight hours productively. I resonate with some of the things Vanessa just said, but with a more critical eye.

PROFESSOR BERNHARD: Well, we would like to hear your comments.

DR. STEADMAN: There was nothing more important said today than one of the very first comments that Vanessa made at the beginning of her remarks, and that is the difference between doing things poorly and being wrong. Whether we are specifically discussing release decisions from acute psychiatric hospitalizations, forensic hospitalizations, outpatient commitments, workplace violence, domestic violence or sexual predators, we are really talking about predicting low base rate behaviors.³² There is a mathematical phenomenon that occurs anytime you try to predict a low base rate behavior (i.e., infrequent sunspots, hurricanes, things that do not happen very often).³³ Even physical sciences do not make accurate predictions. Most often you are as accurate as the rate of the phenomenon.

One example of this is parole violations among felons being released from the prison system. It is pretty easy to be accurate because felons violate parole fifty-five to seventy percent of the time.³⁴ It is harder to predict something that does not happen very often. For example, Megan's Law³⁵ where approximately one and a half percent of all the people are in the high-risk group and there are almost no violations.

Academy of Law and Mental Health in 1988, the Saleem A. Shah Award in 1994 from the State Mental Health Forensic Directors, the 1998 Distinguished Contribution to Forensic Psychology Award from the American Academy of Forensic Psychology, and the 1999 Isaac Ray Award from the American Psychiatric Association. Dr. Steadman received his B.A. Degree and his M.A. Degree in Sociology from Boston College and his Ph.D. in Sociology at the University of North Carolina at Chapel Hill.

32. See Henry J. Steadman & J.P. Morrissey, *Predicting Violent Behavior: A Cross Validation Study*, 61 SOC. FORCES 475-83 (1982).

33. See Henry J. Steadman, *Predicting Dangerousness Among the Mentally Ill: Art, Magic and Science*, 6 INT'L J.L. & PSYCHIATRY 381-90 (1983).

34. See Henry J. Steadman & J.P. Morrissey, *The Statistical Prediction of Violent Behavior: Measuring the Costs of a Public Protectionist Versus a Civil Libertarian Model*, 5 LAW & HUM. BEHAV. 263-74 (1981).

35. See Procedures for Notification, N.J. STAT. § 2C:7-8 (1999).

What really troubles me is what I would describe as a pretense that the speakers had, with the exception of Patrick Reilly, who was critiquing what the Legislature did. I feel as if I am back in the early seventies when I first came out of graduate school, went to work at the New York State Office of Mental Health, and started working on a project to assess the accuracy of psychiatric predictions. In fact, I was trained in medical sociology and I ended up in mental health purely by happenstance when that was my job assignment. At that time, I read a book that really influenced me. It was written by Seymour Halleck, and it was called *Psychiatry and the Dilemmas of Crime*.³⁶ Halleck was a forensic psychiatrist and his book discussed some of these issues. In 1967, Halleck made a statement that affected my entire career. He stated that if a psychiatrist or any other mental professional was asked to show empirical evidence to support the ability that they can predict violent behavior, none could be offered.³⁷

I started doing research in 1970, and it was something that really shaped my whole career because I could not find a single study at that point in time where someone had taken actual predictions and compared them to the behavior of people for whom the predictions had been made in order to determine the accuracy of the predictions. In my first study, I found these predictions were about eighty percent wrong and twenty percent right.³⁸ Although some people contest my interpretation of the data, I still stand by it. Most psychiatrists who saw my presentations and publications attacked me because I questioned whether they should have been making clinical decisions when they had no empirical basis, no systematic clinical experience, and no idea whether they were wrong or right.³⁹ My data suggested that they were wrong four times as often as they

36. See SEYMOUR HALLECK, *PSYCHIATRY AND THE DILEMMAS OF CRIME* (1967).

37. See *id.* at 11.

38. See HENRY J. STEADMAN & J.J. COCOZZA, *CAREERS OF THE CRIMINALLY INSANE: EXCESSIVE SOCIAL CONTROL OF DEVIANCE* (1974).

39. See Henry J. Steadman, *Mental Health Law and the Criminal Offender: Research Directions for the 1990's*, 39 RUTGERS L. REV. 323, 323-37 (1987).

were right.⁴⁰ Other literature had also come out stating that they were wrong at least twice as often as they were right.⁴¹

When I would go to professional meetings, I would see people giving checklists, saying 'I've really ruminated about this, and I've really given it the best thought that I can, so here is my list.' To illustrate, I went to a meeting of the American Academy of Psychiatry and Law in the early seventies, and a very well known forensic psychiatrist, Park Deitz, discussed a presentation he made when he was a newly minted psychiatrist. At his meeting he presented a checklist that he had put together based on his clinical hunches of what he thought were the best predictors of future violence by people with mental disorders. What next happened so frightened him that he tried to collect the checklists that he had handed out from the twenty-five to thirty people in the room, and he never once published an article on it. The reason for this was that his audience wanted to take his checklist, run off, and start using it the next day. It had no empirical basis except his best thinking, which probably was very valuable, but left open questions concerning the circumstances in which this list would work. If it worked in Westchester, did it work in the South Bronx, in Harlem, or in Raleigh, North Carolina? Thus, one of the things that really concerns me is that when people develop these checklists, while they can be a very important first step, others are going to use them as if they produce accurate predictions.

If what Victoria presented on her domestic violence checklist or guidelines for the judges was compiled, it would be used by the judges to make decisions.⁴² As a result, it would be used as a predictive risk assessment tool in those cases, whether or not that was its intended use.

I argue about Ann Hayes' material,⁴³ and asked her where it came from. I believe that the world of workplace violence is an emerging non-field. I am saying this not against Ann, but against the burgeoning cadre of consultants in this field. You

40. See *id.*

41. See JOHN MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* (1981).

42. See Janet Johnson, et al., *Death by Intimacy: Risk Factors for Domestic Violence*, 20 *PACE L. REV.* 263, 284-85 (2000).

43. See Ann Hayes et. al., *Workplace Violence: Prediction and Prevention*, 20 *PACE L. REV.* 297 (2000).

have consultants making a fortune giving advice on workplace violence when, empirically, they have little support for what they are talking about. They do not know how many people had those same experiences and did not commit workplace violence. Furthermore, they do not know whether it is different for different types of employees or employers, in different parts of the country, or, for example, by different racial characteristics. The employers are so frightened of being sued and being put out of business, they pay these people millions of dollars a year, and I do not believe these people are on firm footing at all. In addition, workplace violence research is very difficult because it is all proprietary information. Employers do not want researchers coming in and looking at data from their corporations because they are afraid they are going to get sued with their own data. As a result it is hard research to do.

I hope that you are very cautious with what you heard today. I do not mean to demean it, because I think the work that we heard about, particularly Victoria's work in the domestic violence area, are wonderful first steps. However, do not pretend it will not turn into something you do not intend for it to be because that is what happens. It has happened in other fields, and it will happen here. So I challenge you to take away from the conference what was good, but recognize that it is a first step. Do not pretend it is something that is not.

PROFESSOR BERNHARD: I will just play the devil's advocate for a minute. A response to your critique might be that the judge is going to have a checklist anyway in his or her mind, and is going to be using those factors to help make a decision. Why not work together to come up with a better checklist? The judge is going to decide who gets the order of protection or who gets bail. Why not combine the lists that we have drawn from interviews with victims of domestic violence into one guide?

DR. STEADMAN: That is just what the U.S. Supreme Court said in *Barefoot v. Estelle*.⁴⁴ The Court held that even if we agree with all of this omnibus evidence that was presented indicating that psychiatrists cannot accurately predict future violent behavior, it is the best we have, so we'll use it anyway.⁴⁵

44. 463 U.S. 880 (1983).

45. *See id.*

Barefoot was a Texas case involving the death penalty. In order to apply the death penalty in Texas, you have to demonstrate a propensity for continuing violent behavior.⁴⁶ Dr. Devlin, a psychiatrist in a Texas mental hospital, was always called in to testify, and he would always testify that the defendants were potentially violent. His testimony was very predictable. In *Barefoot*, the Supreme Court only considered whether the expert testimony was valid and held that it was.⁴⁷

AUDIENCE MEMBER: The psychiatrist did make a disclaimer, as you suggested, that he could not accurately predict long-term future behavior and the court said that these predictions were not necessarily a power hold. Yes, the Court accepted the data, but the Court acknowledged that everybody else in the universe also made these decisions. Judges are making them every day. Probation officers are making them every day. Why should we exclude only psychiatrists from being able to make these predictions? Death penalty cases are different, and the weight of expert testimony obviously plays a different role. We were obviously upset about that kind of prediction, especially when *Tarasoff*⁴⁸ started to come back to haunt us. In California, if you make a *Tarasoff* warning and then the patient kills the person, the psychiatrist is called back at the penalty phase of a bifurcated trial to show that this was premeditated because he knew about it and had made a warning.⁴⁹

PROFESSOR MERTON: Subsequently, the psychiatrist may get sued because of his or her testimony. That was what I anticipated at the time of the *Tarasoff* decision, when we heard tremendous outcry from the American Psychiatric Association saying, 'No, no, we psychiatrists can't do this' (predict violence). Dr. Steadman's research was heavily relied on to establish that point. Yet, every day in courtrooms and mental hospitals across America, psychiatrists take oaths and render opinions on the likelihood of future violent behavior. That willingness to make the predictions, despite the dearth of empirical evidence validating their predictions, is the foundation of *Tarasoff* liability. I

46. See *id.* at 883-84.

47. See *id.* at 893-96.

48. See 551 P.2d 334 (Cal. 1976).

49. See *id.*

was arguing for a somewhat radical step: that psychiatrists refuse to, and acknowledge that they cannot, make such predictions with any greater or lesser accuracy than the judges, jurors, parole boards, etc., who desperately want them to make the predictions, so as to get the real decision-makers off the hook. Society would then have to find another mechanism to make these determinations, perhaps the far more imperfect mechanism of the average Family Court judge, who is operating, I can assure you, with very little familiarity with any of these factors that have been discussed today as predictors of violence. Someone cannot be committed to a mental hospital based on *my* opinion that he is dangerous. Both as a current prosecutor and as a former defense lawyer, there have been many situations where I have been as positive as I could possibly be that someone was going to commit future violence, and in many cases it turned out that I was right. However, I have no power in our legal system to do anything about it. Only the psychiatrists do.

DR. STEADMAN: Well, let me give you the second half of that because I do not want to be as negative about the process that you talked about. I think it is important to be honest about what the process is. For example, take Victoria's study which I think is empirically based, although she does not give herself credit. She has taken some literature, and various personal experiences, and by tapping the people in this broad audience, she is going beyond the experiences of a few people and bringing others in. I think that is the first step.

Next, I think, you have to have a two-part commitment. One step in the right direction is to admit that it is our best informed judgment based upon personal experience that has been carefully contemplated. It goes beyond a single person sitting on the bench just making his or her best guess, so it is a good first step. Next there then has to be a commitment to take another step, not to see that as the end, but in fact to test it, and do more research. It may not be a massive NIH-funded research project, but you have to take the ideas, really challenge them, and test them to see if they work in other places.

PROFESSOR BERNHARD: It is important for us to look at how the checklists are being used. I think there is a difference between presenting a set of factors to a judge who is mak-

ing a decision about whether to issue an order of protection in one case, and the legislature in New Jersey coming out with a list of supposed predictors of sexual offender recidivists and stamping that on a group of people who will be marked and affected by that stamp forever. Therefore, the latter will have an enormous effect on a huge group of people.

Another area that previous panelists have discussed earlier today is the continuing effect of the *Tarasoff*⁵⁰ decision. In other words, do psychiatrists and psychologists feel more pressured to warn? Do they feel more inhibited about making predictions while the rest of the world is feeling more confident about making predictions? Has there been a seesaw effect? So, I would like to turn that question over to Dr. Rogge.

DR. ROGGE:⁵¹ I would say that all New York State mental health practitioners—psychiatrists included—feel more of a “pressure” to warn threatened third parties when confronted with a *Tarasoff* situation in their offices, in which their patient directly threatens harm to the third party. This is true whether they are seeing the patient in an inpatient, outpatient clinic, or private practice office setting. Ironically, the therapist’s “duty to warn” is often perceived as a mandatory obligation in spite of the fact that no New York State statute or case law has ever explicitly recognized *Tarasoff*. Practitioners nevertheless perceive it to be the commonly practiced standard of care, and are thus understandably fearful of incurring malpractice liability if they do not act as if *Tarasoff* applied in New York State.

While the New York courts have not decided a *Tarasoff* case, many other jurisdictions have not only recognized *Tarasoff*, but applied its principles in an ever-expanding set of clinical situations.⁵² Conversely, a few jurisdictions have re-

50. See *id.*

51. Dr. Rogge is an Assistant Professor of Psychiatry at Albert Einstein College of Medicine and Associate Director of the Law and Psychiatry Fellowship program. He currently serves as Director of Psychiatry at North Central Bronx Hospital and is Associate Chair of the Department of Psychiatry for the North Bronx Healthcare Network. He is board-certified in forensic psychiatry and is Director of the Assisted Outpatient Treatment Program for the Bronx established under Kendra’s Law. Dr. Rogge is a graduate of Albany Medical College (M.D.) and Rutgers Law School (J.D.).

52. See *Schrempf v. State*, 487 N.E.2d 883, 884 (N.Y. 1985).

fused to adapt *Tarasoff*,⁵³ or even rejected its reasoning outright.⁵⁴

It is difficult to predict the impact of this divergent line of "*Tarasoff* progeny" case law on psychiatric practice. Besides engendering confusion and anxiety among New York State clinicians, they increasingly feel a "pressure" to warn and protect threatened third parties in more questionable cases. For example, when a patient in anger threatens harm to a third party, the therapist is more prone to "play it safe" and issue a warning, rather than rely on the patient's subsequent explanation or retraction of the threat. How this form of defensive medicine has affected patient care is unclear.

Professor Merton suggests that psychiatrists have brought this "pressure" upon themselves, and created their *Tarasoff* vulnerability, by claiming that they have special expertise in predicting dangerousness in their patients.⁵⁵ The psychiatrists benefit financially and otherwise when they testify as forensic experts as to the likely future dangerousness of parties before the court. Have they not invited the judiciary to take their claims of predictive power seriously, and thereby to impose obligations upon them to use their predictive powers to warn and protect the public in *Tarasoff* situations?

I take issue with Professor Merton's underlying premise: That a duty to respond, warn, or otherwise intervene is being imposed by courts on psychiatrists and other professionals in *Tarasoff* situations because of their perceived expertise or abilities in predicting dangerousness. It is true that the *Tarasoff* court placed a new affirmative duty on therapists to take reasonable steps to warn or protect third parties from their patients' threats to harm them.⁵⁶ The rationale for this reconceptualization of common law tort obligation is convoluted and controversial, and has been the subject of much legal discussion.⁵⁷ But one thing seems clear—it was *not* based on the belief that psychiatrists can predict dangerous behavior in their

53. See *Schrempf v. State*, 486 N.Y.S.2d 1010 (1985).

54. See *Schrempf*, 487 N.E.2d at 884, 886.

55. See Merton, *supra* note 2.

56. See *Tarasoff*, 551 P.2d at 343.

57. See, e.g., *Cain v. Rijken*, 717 P.2d 140, 146 n.8 (Or. 1986) (en banc) (noting that "*Tarasoff* has inspired many law review articles and case notes"); see also Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 101 n.14 (1994).

patients, and therefore should be held accountable for this behavior.

The *Tarasoff* court instead based its decision on a "special relationship" analysis.⁵⁸ In traditional common law, parties have no affirmative duty to protect others from threatened harm, unless they are in a "special relationship" with either the threatening or the threatened party.⁵⁹ The *Tarasoff* court held that the therapist-patient relationship was such a "special relationship" which justified invoking such an affirmative duty on the therapist.⁶⁰ The Court did not explain why the therapeutic relationship should qualify as such a "special relationship." Most legal scholars⁶¹ have argued that a combination of factors led the Court to its conclusion: (1) the therapist has special knowledge (of the threat) unknown to the potential target; (2) the therapist has a unique capacity to assess the seriousness of the threat—i.e., to predict the patient's actual dangerousness to the potential target—because of his training and his contact with the patient; (3) the therapist has the ability to take charge or control of the threatening patient (e.g., by initiating hospitalization proceedings), or at least to warn the threatened party, fairly, easily, and with little risk to the therapist; (4) the therapist's liability for inaccurate predictions or insufficient interventions could be fairly contained by limiting liability to "foreseeable" and "readily identifiable" victims; and (5) therapists are covered by malpractice insurance.⁶²

Lest I appear unfairly critical of the New York State judiciary, let me make one last point. While New York's Court of Appeals has never decided a *Tarasoff* case, and thus left mental health practitioners in a state of uncertainty, the highest court

58. See *Tarasoff*, 551 P.2d at 343.

59. See *id.* (citing RESTATEMENT (SECOND) OF TORTS § 314 cmt. c (1965)).

60. See *id.*

61. See Lake, *supra* note 57, at 97; John M. Adler, *Relying Upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties to Aid or Protect Others*, 1991 WIS. L. REV. 867 (1991); James P. Murphy, *Evolution of the Duty of Care: Some Thoughts*, 30 DEPAUL L. REV. 147 (1980).

62. See *Tarasoff*, 551 P.2d at 342. Justice Tobriner lists 7 major considerations which he restates as: (1) foreseeability; (2) degree of certainty that plaintiff's injury occurred; (3) closeness of conduct and injury; (4) moral blame; (5) the policy of preventing future harm; (6) burden and consequences of imposing a duty on defendant and community; and (7) insurance cost, availability, and prevalence.

should be recognized for its decision in *Schrempf v. State*,⁶³ which in my opinion addresses a far more common situation that therapists face, while giving us a preview as to how the highest court might approach a *Tarasoff* case in the future.

In *Schrempf* the defendant psychiatrist was treating a patient with a long history of chronic psychotic mental illness and violent behavior.⁶⁴ The patient was being seen in a state hospital outpatient clinic and treated with antipsychotic medication.⁶⁵

One day the psychiatrist received word that the patient had stopped taking his medications a week previously. The psychiatrist saw the patient in session and could not detect any signs of clinical deterioration. The patient had not threatened or been violent towards anyone. The patient claimed that he stopped his medication because it made him too sleepy, a common side effect. The psychiatrist lowered the dose of the patient's medication, then referred him to a vocational rehabilitation center for more regular day program follow-up. The psychiatrist maintained contact with the patient's counselor at the center and other professionals involved in the patient's care to monitor his progress.⁶⁶

This is a common outpatient approach in such clinical situations, where a high-risk patient has become non-compliant

63. 487 N.E.2d 883 (N.Y. 1985).

64. *See id.* at 885. The patient was variously diagnosed as manic depressive, or more rarely, paranoid schizophrenic. His long psychiatric history included six hospitalizations in the previous two years due to violent altercations with his family, property damage, and attempted assaults, but not personal injury, which the patient claimed were in response to inner voices. His hospitalizations were often on a voluntary legal status, as he resented involuntary admission and sometimes responded with violent threats or resistance toward hospital staff. In the summer of 1981 he broke windows in his mother's house, pleaded guilty to criminal mischief, and was sentenced to probation.

65. *See id.* The patient's last involuntary hospitalization was in January, 1981, and his last voluntary hospitalization was in September, 1981. Upon discharge he was assigned to a special clinic for recalcitrant outpatients due to his poor history of medication compliance. He was also referred by his probation officer to a vocational rehabilitation center, which he began attending on a trial basis in November, 1981. Throughout this period his outpatient clinic attendance and medication adherence diminished.

66. *See id.* at 885-86. The psychiatrist monitored her patient's behavior through his probation officer, his vocational rehabilitation counselor and other outpatient clinic staff. They reported finding no evidence that the patient's condition was deteriorating.

and thus is at increased risk for relapse, but has not threatened anyone or otherwise become acutely dangerous to self or others. In spite of the inherent potential for future violence, therapists often choose less restrictive alternatives than rehospitalization in an effort to re-engage the patient in longer-term treatment. These interventions may even be contrary to generally accepted community practice—such as *lowering* the medication dose of a paranoid patient who actually needs an *increased* dose, but is refusing, in order to increase patient trust and build a more collaborative therapeutic alliance, so that the patient will be more receptive to medication increases in the future. In many cases this longer-term and more patient-centered approach proves fruitful in the long run.

Tragically, in *Schrempf* the outcome was the very opposite. The patient went to his day program appointment a few weeks later and killed one of the staff members in an apparently sudden, unpredictable act. It is unclear from the facts whether the patient knew his victim, and whether he was high on drugs and/or acutely manic or psychotic at the time.⁶⁷

The victim's widow sued the state and the psychiatrist for wrongful death, based on allegations of tort malpractice. The Court of Claims found for the widow, ruling that the psychiatrist should have "done something more" in view of the patient's history when she learned he was not taking his medication.⁶⁸ The Appellate Division affirmed.⁶⁹

The State appealed, arguing that the psychiatrist had no special relationship with the victim which justified imposing liability, and that the psychiatrist had acted within the area of her professional medical judgment.⁷⁰ The Court of Appeals agreed, unanimously reversed the lower court decision, and dismissed the widow's claim.⁷¹

In an opinion written by Chief Judge Wachtler, the highest Court reasoned that the plaintiff was not required to establish a "special relationship" between the state and the victim, where the state was engaged in a *proprietary* function (like providing

67. See *id.* at 886.

68. See *Schrempf*, 487 N.E.2d at 884, 886.

69. See *Schrempf v. State*, 486 N.Y.S.2d 1010 (1985).

70. See *Schrempf*, 487 N.E.2d at 884.

71. See *id.*

medical or psychiatric care) rather than a *governmental* function (like providing police or fire protection).⁷² Thus the state had the same duty of care to the victim as a private facility or individual.⁷³

The Court acknowledged that this duty of care was particularly difficult to define in psychiatric cases.⁷⁴ First, competing state interests are involved: to humanely care for the mentally ill individuals in the community, on the one hand, while protecting society from them, on the other.⁷⁵ Second, psychiatry is "an inexact science."⁷⁶ Thus, clinical decisions in psychiatry involve a calculated risk, about which experts might disagree.⁷⁷ For this reason a broader application of the "professional judgment" rule is indicated. In the Court's words:

"These circumstances necessarily broaden the area of professional judgment to include treatments tailored to the particular case, where the 'accepted procedure' does not take into account factors which the treating physician could reasonably consider significant. [Citations omitted]."⁷⁸

Applying these principles to the case at hand,⁷⁹ the Court noted that the patient was a voluntary outpatient, so that the psychiatrist's duty to prevent him from harming others was more limited due to his relative lack of control over the patient. Upon learning that the patient was not taking his medications, the psychiatrist personally evaluated him, referred him to a day program, and continued to monitor his progress via his probation officer and his day program counselor, who reported that he remained stable. Based on this information, and her knowledge of this patient's particular history, she made the clinical judgment that the patient was not clinically deteriorating, and even improving off his medications. She felt that a more aggressive approach (such as forcing involuntary hospitalization upon him) posed a significant risk of inducing a relapse and imminent violence, while a less aggressive and more collaborative approach

72. See *id.* at 886.

73. See *id.*

74. See *id.* at 887.

75. See *Schrempf*, 487 N.E.2d at 888.

76. See *id.*

77. See *id.*

78. *Id.*

79. See *id.*

(with close monitoring) posed increased chances of fostering her patient's trust and treatment adherence.

In this situation, the Court pointed out that even the experts disagreed about what steps the psychiatrist should take, as "there were risks either way."⁸⁰ Given this fact, although in hindsight the psychiatrist's calculation of relative risks (and prediction of future violence) was mistaken, the Court concluded that "it must be recognized as an exercise of professional judgment for which [the psychiatrist and] the state cannot be held responsible."⁸¹

The Court's decision and reasoning in *Schrempf* reflects an informed and sophisticated appreciation of the inherent difficulties in managing the care of psychiatric patients. The therapists often find themselves in a clinical "Catch-22" situation, where all available options pose risks. New York's highest court has justifiably laid down a "professional judgment" standard in *Schrempf* which allows therapists some flexibility in making clinical decisions based on individual patient considerations, without being held to the more stringent "common local practice" standard of care.

In my opinion the *Schrempf* decision and its reasoning gives us the most promising advance look at how New York's highest court will likely view a *Tarasoff* case which comes before it in the future. The court would likely rely on the "professional judgment" standard enunciated in *Schrempf* in deciding a *Tarasoff* case and allow the therapist greater latitude in deciding whether to warn or take other steps to protect the threatened third party, given all the considerations presented by the particular case.

New York State psychiatrists and other mental health professionals would be well advised to read the *Schrempf* decision carefully. Perhaps they need not be so anxious and feel such pressure after all when facing a *Tarasoff* situation in their clinical practice.

AUDIENCE MEMBER: I just want to go back for a minute to the Family Court judge and the order of protection. If, for

80. *Schrempf*, 487 N.E.2d at 888.

81. *Id.* at 889.

example, the checklist was limited to empirically based research, would it then be reliable or helpful? Is that enough?

DR. STEADMAN: No. I do not think one could merely say, 'Judge, here are some guidelines that were created that are empirically based on our front line practice in the domestic violence area and people we have talked to.' Beyond that there is an obligation to actually look at the decisions that the judges make using these checklists to see if it migrates to other places. Additionally, if other judges start to use it, there is an obligation to watch and track the decisions that they make. Are they making the decisions that would be suggested? When they make decisions that are different from what the guidelines would suggest, are theirs equally correct? How do we modify it? Without tracking, we do not know if they are making better decisions. I think that anyone who creates these checklists has the obligation to find ways of tracking their use, seeing whether they work in the way he or she thinks they are going to, and, if they do not, refining them.

PROFESSOR MERTON: The reason we need to do this is that these judges rely heavily on experts for every type of decision, not just in domestic violence situations. For example, they make many custody decisions that involve predictions of violence or sexual abuse, in which the forensic expert is heavily relied upon. As Dr. Steadman says, there is no tracking of the outcomes of these decisions, no analysis of the validity of the judges' decisions. The judges are just going to apply any guidelines you provide. I agree with Dr. Steadman, that is what scares me.

But when you turn to the subject of intuition, there is another problem. Those who work with domestic violence victims have always said that we must trust the victim; that she usually does have good, sound intuition regarding the timing of the next violent act, and anecdotally, this perception has proven accurate. At least the victim who has lived with and been abused by a partner for a long time seems able to analyze the violent partner's micro-behaviors, perhaps not explicitly in terms of a checklist, but globally and holistically, and predict the next outbreak of violence, albeit too often with false negatives. I think that has been accurate. In this sense, a victim's intuition may be as reliable as a psychiatrist's purported expertise.

DR. STEADMAN: Checklists may inform, but they must be checked out and refined because they may give you a partial answer that is not an answer for everyone or is not the same answer all the time.

AUDIENCE MEMBER: My question is also for Dr. Steadman. I was curious about your criticism of Dr. Websdale's suggestion that sometimes you have to use common sense. You pointed out that the checklist does not include all the information or truth that there is. I am wondering why you responded so negatively to the idea that sometimes we have to fill in those blanks with common sense. If checklists cannot give us all the information we need, why shouldn't we take our best shot at filling in the gaps with our common sense, including our experiences with battered women, or the people whose lives we are trying to affect?

DR. STEADMAN: Because when you rely on common sense, it is often wrong. Furthermore, you need to know when it is wrong and when it is right. If you just take one's informed common sense, and compare it to someone else who is either doing research or is a clinician, the two may differ. Whose common sense is better? We do not know.

PROFESSOR MERTON: I have two quick points. First, the idea of doing any kind of follow-up research to validate, e.g., judicial predictions, is almost inherently impossible because they are intervening in the situation. How are you going to figure out whether or not the judges are missing a lot of positives or finding a lot of false negatives? If the judge issues the protection order and intervenes in that situation, it changes the variables and makes it impossible to figure out whether or not the violence would have occurred if the judge had not made the intervention. The same is true if the judge fails to issue the order. This is a serious methodological problem in trying to validate, or invalidate, the decisions that judges make based on intuition and/or "checklists."

My other point concerns the pedophile case we talked about earlier.⁸² For example: what would I do in the Clinic if one of

82. See Linda C. Fentiman et al., *Current Issues in the Psychiatrist-Patient Relationship: Outpatient Civil Commitment, Psychiatrist Abandonment and the Duty to Continue Treatment of Potentially Dangerous Patients-Balancing Duties to Patients and the Public*, 20 PACE L. REV. 231, 232-33 (2000).

my law student-attorneys who was interested in acting as a law guardian taking care of children in the legal system confided in me as an attorney that he had had legal problems with pedophilic behavior? Or perhaps, even just pedophilic fantasies? I have a very visceral and common sense reaction to this scenario. Putting myself in the role of a professional who is trying to make a clinical judgment about whether or not to intervene, I am troubled by the fact that I come back to the limits of my expertise. In fact, I do not feel adequately prepared to make those kinds of judgments in the absence of some kind of science. On the other hand, science may be telling us that this is something that is too difficult for human beings to do. Yet, do we have the luxury of making no decisions at all? As Professor Bernhard pointed out, one way or the other, these decisions will get made. Today, we end up with judges having to act without the benefit of research, and without the benefit of that obligation. As people who educate the people who are going to be working on these cases and making these decisions in the future, we have a very important responsibility to at least equip everyone we train with a lot of skepticism about the validity of these predictions.

AUDIENCE MEMBER: I want to defend the checklist to the degree that I think it broadens the range of things to which judges need to be alerted. New York has, within the last few years, required that judges consider domestic violence when assigning custody.⁸³ One would have thought that was a no-brainer, but in fact, it could not be done until the New York State law was changed.⁸⁴ To the extent that we can take off the blinders and alert judges to the fact that there are things that need to be looked at, I think we are doing something with the checklists, even if we cannot predict dangerousness with accuracy.

PROFESSOR MERTON: Then maybe we do not need psychiatrists in the process at all. The real question I have to pose to the psychiatrists here is "Do you or do you not have this capacity, this expertise? Does it have a scientific, empirical basis or not?" If yes, than *Tarasoff* requires you to exercise it respon-

83. See N.Y. DOM. REL. LAW § 240 (1) (McKinney 1999).

84. See *id.*

sibly. If not, there is a temptation to say please get out of our courtrooms.

AUDIENCE MEMBER: I have two responses to some of the domestic violence issues and questions which you might address, Dr. Steadman. First, I think in some ways domestic violence is very different from the other issues we have discussed. In many of the other areas, you are talking about very uncommon kinds of events. While domestic homicide is a rare event, domestic violence is not. That makes it somewhat different from other kinds of behaviors we are talking about.

In fact, domestic violence is not a series of incidents or violent incidents that happen over a period of time, but an ongoing pattern of behavior that may be punctuated by violent episodes. So again, predicting the continuation of domestic violence (not necessarily homicides), is a very different ball game than predicting some of these other, rare, uncommon offenses. I am wondering how an understanding of the context of domestic violence as an ongoing pattern and the understanding of the frequency of domestic violence affects your view as to what we can do regarding some of these assessments.

DR. STEADMAN: You have made very good points, and my answer would be that I would be much more optimistic about the possible success of doing it in those instances because it is so much more frequent.

AUDIENCE MEMBER: I would just like to say one thing. In the field of domestic violence research, the approach that you can control this variable and that variable, that you can identify and pin-point specific kinds of behaviors, that we can relate scientifically as dependent/independent variables, is part of the problem rather than part of the solution. If you look at what we knew twenty or thirty years ago about variables concerning domestic violence, you would find that we knew incredibly little. We did not have the data. When the police would respond to a scene, they did not do anything; they did not log it. Our data today is different.

I would suggest to you that positivistic, scientific approaches to the study of that issue, or indeed many issues involving predicting violence, are deeply problematic, and that is one of my objections to the issue of prediction as a whole. It is riddled with problems. The idea that you can say one approach

is wrong and imply that with the right techniques that we can arrive at the truth, I think, is very dangerous.

DR. STEADMAN: I would not put us in a contest. I think ethnographers, sociologists, psychologists and psychiatrists need to collaborate on teams. I believe that one of the weaknesses of the MacArthur data⁸⁵ is that we do not have a perceptual, contextual understanding of the violent incidents. Also, I think that you need to have an empirical, more positivistic approach and to be more systematic. Otherwise, you end up just relying on clinical lore, which does not give you a lot of confidence.

PROFESSOR MERTON: There is another issue which has not been raised. Should we be broadening the groups of people who are subjected to the *Tarasoff* requirement? Why is it the psychiatrists alone who suffer from this responsibility? They are not the only people involved in making clinical assessments. We ask many people to do this. I do not know how well they do it or whether we ought to hold them responsible, but what about the police officer who does an investigation or goes to the house of a domestic violence victim and does not do anything; or the physician who sees that victim in the emergency room and does not intervene to prevent further violence, which may be highly predictable? Perhaps the conversation should be expanded to include all of those people who end up involved in all the various aspects of predicting dangerousness, and whose "predictions," whether explicit or implicit, become the basis for decisions to intervene or not.

85. See Henry J. Steadman et al., *Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES OF GEN. PSYCHIATRY 393-401 (1998).