The Prediction of Dangerousness and the Protection of the Public

Guest Editorial

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Among the many startling changes in our fast-moving society is a new humility among psychiatrists who now publicly proclaim that they are not good at predicting dangerousness. These proclamations are made as a defense against actions initiated against psychiatrists because their patients have been released too soon and have caused public damage. The psychiatrist who up to this point has maintained that he could predict dangerousness—that was the rationale which gave him custody of the patient in the first place—now reverses himself and says that dangerousness is too hard to predict, that he should not be blamed because his patient—discharged, placed in some "less restrictive alternative" in the community, or eloped from a facility not sufficiently guarded—has killed, raped, or robbed.

In its *amicus* brief in the case of *O'Connor v. Donaldson*,[1] the American Psychiatric Association stated, in defense of the actions of the defendant, a state hospital superintendent who had been sued on the ground that he held a nondangerous patient without treatment, that very few of the mentally ill are dangerous and that "the psychiatric community cannot assure this Court that there are any highly reliable techniques for identifying with certainty which of the mentally ill fall into this minority category of dangerous individuals."[2]

The brief does concede that there is a category of the "truly dangerous mentally ill." Some recent cases indicate that in order to justify possibly negligent care of the truly dangerous mentally ill, psychiatrists are willing, probably too willing, to deny that they can predict anything about future behavior.

When patients have committed serious crimes in the past, it should not be difficult to predict that they still represent a threat in the present and future unless they have undergone a long period of treatment and showed some indication of major psychological changes. Courts are increasingly diverting sexual and other offenders from the criminal justice system, where they would be subjected to long periods of detention, to mental health facilities. In the mental health system, many patients are released in a short period of time, transferred to some "less restrictive alternative" which gives them great opportunity to escape, or retained under less than maximum security conditions. When these are public hospital cases, the staff is often anxious to discharge the patient to a "less restrictive alternative" because the patient is hard or impossible to treat and because courts have insisted upon ever higher standards for the proof of dangerousness as the rationale for continued holding of the patient. When these cases are private hospital or private psychiatry outpatient cases, one motive for discharging the patient or moving him or her to a "less restrictive alternative" may be financial—family funds or third-party reimbursements have run out. In either case, the result is the same—someone who would have spent a long period of time in a prison for his past actions is in the mental health system for a short time and is then back in society.

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In *Semler v. Psychiatric Institute of Washington, D.C.*,[3] a Virginia man had molested young girls on at least three previous occasions and was arrested for abducting a fourth girl. While awaiting trial on the abduction charge, he entered a private psychiatric hospital, and his psychiatrist there wrote to his lawyer that the patient could benefit from continued treatment and that he would not "be a danger to himself or others as long as he is in a supervised, structured way of life such as furnished here at Psychiatric Institute." After a conference with the psychiatrist, the judge accepted a guilty plea and suspended a twenty-year sentence on the condition of continued treatment and confinement at the Institute. One year later the patient was not being held in the hospital; he was merely enrolled in a therapy group that met two nights a week. A few months later he killed another young girl.

The hospital and the probation officer have been held liable in a wrongful death action, and the decision has been affirmed by the Circuit Court of Appeals. Although the decision revolved around the fact that hospital and probation officer did not notify the court or seek its approval for transfer of the patient from day patient to outpatient status, the failure of the hospital and the probation officer to appreciate the potential danger of their patient seems equally negligent.

Civil libertarian lawyers have attacked this and similar holdings on the ground that they will discourage psychiatrists from releasing patients from closed institutions to less restrictive alternatives. That is an equally good reason to be in favor of the decision—some patients on the basis of their records can easily be seen not to merit the easy access to society that psychiatrists sometimes give. Some psychiatrists should be discouraged from providing a rapid return to society for patients who have committed actions which subject them to long criminal penalties.

Jonas Rappeport has attacked the court practice of allowing convicted child molesters and exhibitionists to see private psychiatrists and then suspending their sentences; he says that sexual offenders need "coerced, enforced therapy" and that seeing a private psychiatrist does no good because the offender breaks off treatment prematurely or continues his denial that he committed the act for which he was arrested.[4]

Another similar case in suburban Washington, D.C., involves a 21-year-old man who was convicted of sexually assaulting two eleven-year-old boys. He was given two suspended five-year prison terms and placed on probation on the condition that he voluntarily commit himself to the Maryland Spring Grove State Hospital. He left the hospital after a few months; authorities were only belatedly notified; he is now accused of killing two boys, aged nine and eleven, sexually assaulting two more, and abducting a fifth. The patient interrupted his string of alleged murders and assaults to return to the hospital voluntarily; he walked out, however, while his readmission papers were being processed.[5]

This and similar cases tell us that psychiatrists cannot take the place of the criminal justice system, that the protection of society is not given sufficient emphasis in the mental health establishment to justify a psychiatric disposition of dangerous offenders. George Dix has noted that psychiatric staffs are concerned about the duration of detention of sexual offenders and may give this factor weight independent of the condition of the patient.[6] He reports the circumstances which can lead to a favorable recommendation for discharge to the court: "It is no longer the case that a rapist has to spend three years here before going back to court. . . . Now, he can be sent back after sixteen months or so." A second staff observation, also concerning a sixteen-month detention, in this case of a convicted child molester, "Just how long can we keep a guy locked up for things like this?"

In many such cases it is not difficult to predict future dangerousness on the basis of past behavior and insufficient change while in psychiatric care. To the extent that psychiatrists defend their actions in prematurely releasing dangerous offenders on the ground that psychiatrists are not good predictors of dangerousness, they raise the ques-

tion of the adequacy of protection to the public when criminal offenders are diverted from the criminal justice to the mental health system.

References

1. O'Connor v Donaldson, 422 US 563 (1976)
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3. Semler v Psychiatric Institute of Washington, DC, 528 F2d ——— (4th Cir 2–27–76), 18 CrL 2519
4. The Washington Post, March 29, 1976, C–3
5. Washington Star, March 27, 1976, D–1; The Washington Post, March 30, 1976, C–1
6. Dix GE: Determining the continued dangerousness of psychologically abnormal sex offenders. Journal of Psychiatry and Law, III (3); 327–344, 1975