Emerging Problems for Staff Associated with the Release of Potentially Dangerous Forensic Patients

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Mental health professionals have been concerned recently about their liability for the actions of patients in their outpatient practices. The history of suits against clinicians for negligent release of inpatients extends back several decades since before the *Tarasoff* decision. The authors suggest that the same consumerism/victims' rights trends that resulted in *Tarasoff* and its progeny are likely to rebound again on forensic clinicians and that such pressures are likely to add to other political and social pressures that already complicate the treatment of forensic inpatients. They present three cases to illustrate the dilemmas involved in the release of forensic patients and argue that clinicians must bear significant responsibility for their current plight because of overstated claims of capacities to predict and treat aggressive behavior.

Social forces that have become prominent in the past several decades have placed staff who attempt to deal with dangerous persons between the Scylla of individual rights and the Charybdis of public demands for protection. To understand the causes for these forces and how they have involved clinicians, it is necessary to trace the history of clinical involvement in the management and treatment of allegedly dangerous persons. In many ways it is a classical case of chickens coming home to roost. In this article we will trace the history of clinical attempts to deal with violent behavior, analyze the legal system's response to these claims, and then discuss the current dilemmas caused by that response.

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Clinical Claims of Expertise in Dealing with Violent Persons

Clinicians have always concerned themselves with dangerous persons, at-

tempting to understand them and to intervene in their behavior according to the prevailing theories of the times. Although the formal separation of criminals from the mentally ill came only in the 19th century with the establishment of asylums and prisons, these two broad groups had long been addressed differently.[1,2] Beginning with Gall's theory of phrenology,[3] Lombroso's criminal anthropology theory based on degenerative stigmata,[4] and Ray's theories of insanity (divided into general and partial intellectual and moral mania, imbecility, dementia, and delerium),[5] and continuing with explanations for criminality based on the increased incidence of XYY and XXY genotypes in prison populations,[6] clinicians have sought to understand criminal behavior within the framework of the medical disease model in order to develop effective treatment approaches.

The advent of psychoanalysis also contributed to the belief that criminal behavior was based on some underlying psychological condition that could be understood, and, by implication, treated effectively. Karl Menninger argued in the 1930's that crime "*should* be [considered] an illness; it *should* be treated, and it could be"[7] (p. 254), that "the majority [of criminals] would prove to be curable"[7] (p. 261), and that the treatment of criminals rather than their punishment would result in the "transformation of prisons, if not . . . their total disappearance." He went on to state that while detention might continue to be necessary for a few criminals, "this could more effectively and economically performed with new types of 'facility' [that strange awkward word for institution]"[7] (p. 251). Benjamin Karpman went even further to call for treatment to replace punishment for all criminals, and to argue that such treatment could not be accomplished in prisons[8] (p. 299).

Although the trend toward indeterminate sentencing of criminals had begun in the late 19th century with broad-based support from legal scholars as well as clinicians,[9] the advocacy of respected leaders of the psychiatric profession exerted a significant influence on the passage in the 1950s and 1960s of a variety of indeterminate sentencing laws to permit hospitalization instead of incarceration in prisons for a variety of lawbreakers, called variously sexual psychopaths, and moral or defective delinquents, for whom clinicians held out the hopes of cures if given sufficient time.[10]

While such well-meaning attempts to fit all deviant behavior into a clinical framework have fallen into disrepute, more limited efforts to explain specific types of aggressive behavior have led to the identification and treatment of persons suffering from partial complex seizures (formerly called temporal lobe epilepsy or psychomotor seizures).[11] There is a considerable body of research on the experimental use of medications such as anticonvulsants, beta-adrenergic blockers, and lithium in the control of aggressive behavior, based on the conceptualization of aggression as a biologically-determined behavioral response to the environment.[12] There is also growing evidence that many mental disorders formerly understood within a psychodynamic learning model of behavior,

such as generalized anxiety disorder,[13] panic disorder,[14] phobic disorder,[15] and antisocial personality disorder,[16] may derive in part from biological predispositions in some patients.

But despite the lack of demonstrated efficacy of psychiatric approaches, society from the beginning has been all too willing to defer to clinicians' claims of expertise in dealing with aggressive persons. When psychiatry became established as a separate discipline within medicine in the mid-19th century, it took as its domain those persons with significant behavioral as well as mental deviancy. The early psychiatrists practiced their craft in the newly created asylums and in the criminal courtrooms and prisons. Isaac Ray, one of the first asylum superintendants, was an early champion of what has come to be called the "psychiatrization" of criminal behavior. His influential 1838 text, *The Medical Jurisprudence of Insanity*[5] offered one of the first detailed theoretical expositions of the clinical basis of insanity, and of the legitimacy of psychiatric participation in its determination. He was quite emphatic in arguing that because only psychiatrists possessed the necessary understanding and therapeuitc skills to deal with the mentally disordered, courts should defer completely to their clinical expertise. These claims were echoed by his fellow asylum superintendents who vied with each other to report the highest cure rates in what has come to be called the "cult of curability."[17] Thus began psychiatry's role as what the anthropologist Leon Birtwhistle has called the "garbage collectors of society."[18]

Despite occasional challenges from reformers such as Mrs. E.P.W. Packard and Clifford Beers, the hegemony of psychiatry over the sequestration and social control of the mentally ill that had begun with the first asylums in the mid-Nineteenth Century remained secure until the late 1960s, when a combination of civil rights reforms, availability of effective antipsychotic and antidepressant medication, and the rise of the Community Mental Health Movement led to the deinstitutionalization movement.[19] The century-old practice of sequestration of the mentally ill in remote, overcrowded public hospitals was attacked by leaders of the American Psychiatric Association[20] as well as by social and legal critics.[21,22] Once again clinicians promised more than they could deliver. Seduced by the promise of effective medications and by huge infusions of federal money, they convinced legislatures that the public hospitals could all be closed within a short period of time, and that all patients could be effectively (and voluntarily) treated at the to-be-built community mental health centers.

The Onset of Reality

Unfortunately it is now clear that none of the assumptions upon which the deinstitutionalization movement had been based was entirely correct. Medication proved to be less than completely effective in eliminating the symptoms of schizophrenia and to have side effects to which many patients objected.[23] A significant proportion of hospitalized pa-

tients and those who would previously have been hospitalized continued to deny their illnesses and therefore also their need for treatment.[24,25] Fewer than half of the planned community mental health centers were ever built,[26] and the majority that were built quickly found that treating the "walking worried" was more rewarding both professionally and financially than attempting to track down and treat the chronically severely mentally ill patients who were supposed to have been their target population.[27] As documented most devastatingly by Chu and Trotter,[28] once again clinicians had promised more than they could deliver. In a vicious spiral, Congress withdrew the federal funding; combined with the nationwide economic reversals in the 1970s that decreased state funding as well, many of the centers that had attempted to provide services to the chronically mentally ill were forced to focus on other populations that could provide income.[29]

Despite this less-than-impressive list of accomplishments, there is little evidence of an outbreak of modesty within the mental health professions. The pressure for cost-containment from governments, other third-party payors, and HMOs has led to intense scrutiny of clinical claims and methods and to the first serious efforts to evaluate the results of treatment.[30] And with increased competition has come the escalation of the guild wars among the mental health professions that has reinforced the traditional need to make extravagant claims of capability.[31]

In addition to somewhat unsubstantiated treatment claims, clinicians have also portrayed themselves as experts in the prediction of dangerousness, and have in the past virtually demanded that judges and other decision makers defer to their judgments.[7] When statutes were revised in all but one state to require evidence of dangerousness to self or others as a necessary criterion for civil commitment,[19] there was no lack of clinical volunteers to relieve judges of their burdensome decision making,[32] despite the mounting research evidence that clinical predictions of future dangerousness are accurate less than half the time.[33]

To be fair, attempts to predict future dangerousness have hardly been limited to clinicians. The criminal justice system has traditionally relied on such predictions at all stages of a prosecution, from bail hearings to sentencing to parole decisions. Despite the recent trend toward determinate sentences,[34,35] mandatory incarceration for certain crimes,[35] and calls for abolition of plea bargaining,[36] it is clear that considerable flexibility of dispositions will remain in the criminal justice system. Indeed, clinicians have traditionally supported individualization of such determinations, to fit the disposition to the criminal rather than to follow Gilbert and Sullivan's Mikado and "let the punishment fit the crime."[37] But the long-standing willingness of clinicians to offer themselves as experts whose opinions deserve to be determinative of the outcome of a variety of legal proceedings, from civil commitment to the release of sex offenders and insanity acquittees, has now come back to haunt them as they are being held

accountable for that same expertise when their patients harm third parties.

Current Legal Responsibility of Clinicians

The legal professionals who make such determinations have long been accustomed to virtually absolute immunity from liability for the results of their decisions,[38] although there is a movement afoot either to limit their discretion significantly[39] or in fact to permit findings of liability for the results of their decisions.[40] However, clinicians are already learning that they no longer enjoy such protection. Law suits seeking to recover damages for negligent release of inmates or patients who subsequently commit dangerous acts are not new; what has changed is the increased receptivity of the civil courts to such suits.

During the 1960s and early 1970s courts almost uniformly accepted two types of defenses in negligent release cases: since most occurred in state hospitals, clinicians relied successfully on state immunity from liability under state tort statutes.[41] As courts began to stop recognizing such claims, another defense that frequently succeeded was the argument that implementation of deinstitutionalization required society to assume some risk of harm in order to permit increased freedom for the mentally ill.[42]

Beginning in the 1960s, however, a trend toward recognition of societal rights began to challenge the preeminent place which had been granted to individual civil rights of minorities, including the mentally ill; and the growing momentum of the consumer and victims' rights movements tipped the balance in civil courts toward compensation of victims from whatever source had the "deepest pockets."[43] Nowhere is this determination to sacrifice fairness to defendants in order to compensate plaintiffs more clear than in the principle of joint and several liability, whereby damages are assigned according to defendants' ability to pay rather than according to their degree of culpability.

The most important recent manifestation of this trend for purposes of this discussion has been the line of cases emanating from the California *Tarasoff* decision.[44] Citing a previously little-used section from *The Second Restatement of Torts*,[45] the California Supreme Court held that therapists had a "special relationship" to their clients that imposed on them the responsibility to protect potential victims of those clients. *Tarasoff* itself grew from the relatively limited initial 1974 decision that therapists had a duty to warn identifiable victims, to the ultimate broader 1976 decision holding that there was a duty to take some type of (unspecified) action to protect identifiable victims. Other jurisdictions have expanded the principle even further, to include responsibility to all potential victims, identifiable or not.[46]

Even in jurisdictions with court decisions or statutes limiting liability to cases of identifiable victims (and at least 9 states have already passed statutes so specifying), courts have broad powers to interpret words such as "readily identifiable".[47] The extent of that definitional power was clearly demonstrated in *Davis v. Lhim*,[48] in which clinicians who

released a chronic schizophrenic patient who stopped taking his medication and subsequently killed his mother several months later and several thousand miles from the releasing hospital were found liable on the basis of the patient's remark two years before the admission in question that he was angry with his mother for withholding his social security money from him.

The psychiatric profession, which had demonstrated its willingness to predict future dangerousness when such predictions were required in order to effect the involuntary commitment of patients who appeared to need it clinically, or to facilitate the release of forensic patients who were perceived not to require further hospitalization, is now surprised to find that other courts are holding them accountable for that claim of expertise in areas where they had not chosen to assert it.

Current Dilemmas Concerning Release of Forensic Patients

Traditionally, clinicians working in correctional facilities and secure forensic facilities have shown little concern for their liability for release decisions, which are most usually made by courts or parole boards. However, these considerations do not apply to patients or inmates who serve the maximum possible sentences, and are thus automatically released without conditions or continuing supervision. It would seem logical to assume that clinicians in prisons and forensic facilities would have the same responsibility to act upon evidence that their patients might pose a danger after release as do clinicians treating civil patients under the *Tarasoff* rationale. Indeed, the fact that their patients have been labeled as more dangerous than other mentally disordered persons by virtue of their involvement with the criminal justice system (whether or not they are actually more or less dangerous) might well increase the likelihood of a successful suit against clinicians who failed to take action when they knew (or in the language of *Tarasoff, should* have known) of their patients' potential dangerousness. Such a distinction, in another context, was used by the United States Supreme Court in its decision in *Jones v. United States*,[49] when the majority held that the mere fact that Jones had been found to have committed a criminal act (shoplifting), even though the crime had not been violent and he had no history of violence, was sufficient evidence of dangerousness to justify initial commitment after an insanity finding, and continued commitment beyond the statutory term of imprisonment for the crime charged. If the trend toward determinate sentences continues, there will be a growing number of inmates and patients being released at the end of their sentences or periods of commitment, and therefore a greater frequency of such decisions for forensic clinicians.

There are few reported cases dealing specifically with the liability of clinicians for the actions of forensic patients. In *Maroon v. Indiana*,[50] clinicians were held liable for a murder committed by an inmate convicted of sexual deviancy who had escaped from a state hospital in Indiana. In *Hicks v. United States*,[51]

St. Elizabeths Hospital was held liable for negligence in not more fully informing the court of the condition of a defendant whose competency to stand trial was questioned, to permit the court to pass intelligently on the information in its decision to release the defendant. The Appeals Court affirmed, holding that the hospital had an obligation to go beyond a mere report on competency, especially as it indicated in the report that the defendant was "recovered" from his acute brain syndrome, allowing the court to infer that he was safe to release into the community. The hospital records in fact contained ample evidence of the defendant's history of violence, and of threats made to his wife while he was in the hospital; this information should have been shared with the court.

In *Cain v. Rijken*,[52] an insanity acquittee was committed by Oregon's Security Review Board to a community mental health center under contract to provide such services to patients under Board supervision. The patient (whose offense had been reckless driving) was permitted to regain driving privileges and subsequently killed a third party in an automobile accident. The Oregon Supreme Court rejected immunity arguments, and remanded the case to be heard by a jury, holding that the patient's committed status increased the center's responsibility for his actions.

But in *Seibel v. Kemble*,[53] psychiatrists evaluated a defendant, found him insane, and the court concurred and followed their recommendations that the defendant enter into treatment, which he did. He subsequently killed a third party, and relatives of the decedent sued both the evaluating and treating psychiatrists. The court held, and the state supreme court affirmed, that the psychiatrists had absolute judicial immunity because they were court appointed. It stated that it was not condoning negligence, but was protecting the integrity of the judicial system. It pointed out that the trial judge had other remedies if the evaluating psychiatrists were negligent.

Based on these few cases, it is impossible to predict how individual courts in other jurisdictions will define the responsibilities of clinicians who evaluate or treat forensic patients. It would probably be prudent to assume that liability may in fact attend upon such actions if released patients harm others, and to make extra efforts at least to inform courts as to the probable behavior of such patients who have been evaluated or treated.

Another example of the trend toward protection of victims that actually preceded the *Tarasoff* duty to protect society in general was the passage of child abuse reporting laws in every state between 1963 and 1967. Such laws are the only major exception to the general legal principle that citizens (including therapists) have no duty to report *past* crimes.[54] Although few would argue against the desirability of protecting children from abuse, strict interpretation of many such statutes can cause problems for therapists treating sex offenders, inasmuch as they usually provide either no statute of limitations or require reporting of abuse until the victim is past the age of majority. Under most state

laws therapists treating sex offenders, even those already convicted and committed for treatment, may be required not only to report their patients' confidences concerning other offenses, but even to testify against them in subsequent criminal proceedings, as well as being required to report any suspicions that they might commit further sex crimes upon release.[55]

In addition to making release decisions, clinicians are also often required to testify as experts in their patients' release hearings. The principal author has argued elsewhere[56] that requiring treating clinicians to testify in such hearings (particularly when they disagree with their patients' wishes to be released) is not only contrary to the ethical principles of all the clinical professions, but also ultimately counterproductive to society's needs for protection because it can result in disruption of the therapeutic alliance necessary for treatment to help the person overcome the very problems that make his behavior of concern to the public. It also raises complicated issues of what warnings and promises of confidentiality need to be given to patients in advance of beginning treatment. The current pressures to protect the public might well be seen as requiring treating clinicians to go beyond responding to court subpoenas to taking proactive actions when forensic patients are about to be released.

Alan Stone[57] and others[58] have levied the same criticisms about the potential effects of a legally mandated duty to warn or to protect for outpatient therapists; but we believe that the situation is clearer in the case of forensic patients and inmates, inasmuch as most states provide for explicit evaluation of patients or inmates who are about to be released. Thus, unlike private therapists, who may in fact be the only ones in a position to evaluate their patients, inmates facing parole hearings and insanity acquittees or sex offenders facing release hearings can be (and at least in Wisconsin, usually are) evaluated by clinicians independent of the treating facility. Nevertheless, there is still the likelihood that at least some patients or inmates will reveal information to their in-house therapists that they would conceal in formally identified release evaluations. In such cases, if the treating clinicians have not already provided that information to the independent evaluators, they well may be under some obligation to report it to the hearing officer proactively or risk being found negligent later. In some jurisdictions clinicians themselves are required to go beyond deciding whether or not to initiate commitment proceedings, or even testifying at hearings, to serving as release officers; in such situations, political pressure to avoid liability may place such clinicians in significant ethical dilemmas.[59]

We now present three cases to illustrate the types of situations that we feel will become more common in the future.

Case 1

Mr. A, an insanity acquittee on the basis of antisocial personality disorder who had a long history of aggressive behavior, had threatened several staff at

a medium security forensic hospital, and was transferred to our maximum security facility. There was no history of any psychotic behavior. Less than a year after transfer, his determinate commitment was about to end, which would require him to be released, despite the fact that he had continued to make threats against staff at the previous hospital. We therefore notified those staff of his impending release and initiated civil commitment proceedings although his treating psychiatrist (RM) felt that he did not satisfy the statutory definition of mental illness, and despite the fact that Mr. A had consistently refused treatment during his entire hospitalization. The evidence for mental illness was not questioned at the probable cause hearing; but at the final commitment hearing the independent evaluators concurred with the lack of mental illness, and Mr. A was released. Over a year later we have had no report that he has engaged in any criminal behavior.

Case 2

Mr. B had previously been committed under the state sex crimes law on charges of incest, and had also been imprisoned for sexual crimes. While on parole he was arrested and found insane on charges of possession of a firearm. He was admitted to a medium security facility and transferred to maximum security after repeatedly threatening and attacking staff. His diagnoses in our facility were exhibitionism, substance abuse, and antisocial personality. In the year he spent in our hospital, he continued to require numerous seclusions for attacking staff or patients; like Mr. A, there was no evidence of any psychosis; behavioral treatment was tried without noticeable impact. As his insanity commitment neared expiration, we felt compelled to petition for civil commitment. As with Mr. A, probable cause was found but he was released at the final commitment hearing; less than a year after release he has been arrested for armed robbery and accessory to murder.

Case 3

Mr. C was committed to a medium security hospital under the state's sex crimes law, but escaped and had made a successful adjustment to the community for over three years, working full time and living with his family. He was accidentally recognized by police and returned to our hospital, where he was a model patient during the subsequent year. At his internal hospital release hearing, unit staff reported no evidence of mental disorder and no evidence of dangerousness. The hearing officer (RM) recommended release, despite departmental policy to refuse all such recommendations because they could result only in unconditional release. The examiner was reprimanded for the recommendation, and the Department of Health and Social Services requested another evaluation, which resulted in a recommendation for continued commitment; that recommendation was accepted. Mr. C was released 4 months later at his next hearing before the parole board, which had the power (unlike the internal hearing officer) to order conditional release. We have had no report of

any criminal behavior on the part of Mr. C in the two years since his release.

Conclusions

As can be seen from Cases 1 and 2, the threat of liability forced clinical staff to initiate commitment proceedings despite their conviction that neither patient would benefit from treatment, and the fact that a successful petition would amount to preventive detention.[9] Because release criteria for forensic patients invariably involve predictions that they are no longer dangerous, there is a significant chance that forensic facilities will gradually fill their beds with nontreatable patients who cannot be released because of perceived dangerousness;[60] and that the clinicians themselves will have to take the lead in providing the evidence to justify the continuation of commitment, whether requested to testify or not. With the low risk of liability attendant upon recommendations for commitment,[61] compared with the uncertainty associated with liability for the actions of released patients, the direction of clinical recommendations seemed to be only too clear.

In conclusion, clinicians' long history of promising more than they have been able to deliver has now come back to haunt them. Although it is clear that the trend toward increasing reliance on "experts" in a variety of fields has diminished significantly in the past two decades,[62] courts have discovered that clinicians make convenient scapegoats because of their previous claims of expertise and because of their deep pockets. Furthermore, there is little evidence that the trend will decrease in the future, despite legislative efforts in some jurisdictions to limit the scope of liability. All we can do is to continue the ongoing research and clinical efforts to provide the best treatment possible, to avoid making definitive-sounding predictions that are unwarranted by current knowledge, and to document everything that we do carefully.

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