Commentary: Dangerousness—A Failed Paradigm for Clinical Practice and Service Delivery

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J Am Acad Psychiatry Law 28:282–9, 2000

The issue of dangerousness has become such an accepted aspect of contemporary mental health practice that we rarely, if ever, stop for a moment to consider the propriety of this arrangement between societal expectation and our professional performance. Yet, there was a time not that long ago when dangerousness was not such an integral part of the work of psychiatry. Legal decisions regarding the use of dangerousness in mental health proceedings surfaced in the 1960s. Prominent mental health professionals began expressing their alarm about this trend in the 1970s.

Birth of a Paradigm

In 1966 in *Baxstrom v. Herold*,[1] the U.S. Supreme Court required a judicial determination of dangerousness to permit civil commitment of inmates. That same year, Judge Bazelon limited the use of civil commitment in managing danger to self (*Lake v. Cameron*),[2] implying the need to legitimize involuntary hospitalization by a standard more stringent than concern for the individual. In 1974 in *Hawks v. Lazaro*,[3] West Virginia's highest court upheld the dangerousness prong of civil commitment and its source in the state's police powers while striking down the *parens patriae* prong as vague and prone to abuse. The 1975 U.S. Supreme Court ruling in *O'Connor v. Donaldson*[4] confirmed the important role of dangerousness to others as part of the civil commitment formula.

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This trend prompted Bernard Diamond to comment on "The Psychiatric Prediction of Dangerousness" in 1974.[5] He expressed his concern that psychiatrists had no ability to predict dangerousness and should routinely advise the courts of this fact when asked to make such predictions. (John Monahan's 1981 review[6] of the existing research literature noted that such predictions were wrong in two of three cases, confirming Diamond's opinion.)

In 1978, Saleem Shah[7] cited more than 15 ways in which determinations of an individual's dangerousness were being used in civil and criminal law. He expressed his concerns about the scientific reliability of such determinations, particularly within a social context that powerfully directed a preference for false positive errors and unfairly marked some categories of persons ("mentally ill") as worthy of preventive confinement, while others who are clearly dangerous (repeat drunk drivers, for example) are not so marked.

In 1975, Alan Stone[8] warned that the use of dangerousness as the standard for civil commitment would deprive the traditional psychiatric population, which is rarely dangerous, of access to inpatient care. He also predicted that hospital wards would be filled with untreatable individuals who are dangerous, transforming those environments into jails, with the psychiatrists as wardens. Stone further argued that in such a scenario, civil commitment would become "almost nothing but preventive detention."

These criticisms were generally ignored in the law, which continued to expand the legal conception of psychiatric practice regarding dangerousness. *Tarasoff* (1976),[9] as well as progeny cases like *Lipari*

(1980),[10] established and amplified our duties to predict and control the dangerousness of our patients. In two separate cases in 1981[11] and 1983,[12] the U.S. Supreme Court supported the use of psychiatric testimony on the prediction of dangerousness in capital sentencing proceedings. In 1983, the U.S. Supreme Court also ruled in *Jones v. U.S.*[13] that a judicial finding of insanity (even for a nonviolent property crime) was sufficient evidence of dangerousness to permit indefinite commitment of an insanity acquittee who had not proven his sanity or lack of dangerousness.

These developments must also be contextualized within the developments of two other phenomena: deinstitutionalization and the decreasing use of involuntary hospitalization. Prior to 1972, the majority of psychiatric inpatients in the United States were involuntarily committed.[14] Thus the 1960s saw not only the beginning of increased community treatment but also increased reliance on voluntary inpatient treatment. These developments were accompanied by the need to establish criteria for distinguishing those individuals who should be involuntarily hospitalized from among all those suffering from mental illness. In prior eras, when the majority of mentally ill persons were rather automatically thought to be in need of involuntary institutionalization, there was no need for such selection criteria.

Such automatic thinking, of course, was part of the stigma of mental illness and its association in the minds of the public with violence, a stereotype that had been prevalent for millennia. But the fight against stigma and the pursuit of libertarian ideals must also be seen as contributing to the emergence of dangerousness as the defining criterion for treatment decisions and service delivery. In the pursuit of the highest possible rationale for the deprivation of liberty inherent in forced confinement for treatment, the police power of the state became the main vehicle for care-giving, while the care-giving power of the state (*parens patriae*) was increasingly ignored as a legitimate authority for providing care. Within these developments, our profession must also take responsibility for its part in the existence of the poor care-giving institutions that inspired such zealous pursuit of "freedom" at all cost.

Today, as Stone predicted,[8] only the specter of danger permits admission to inpatient psychiatric care. Long-term and intermediate-term care are reserved almost exclusively for forensic populations, while other seriously disordered individuals (who are not so "fortunate" as to be considered dangerous or have not yet become "forensic") often live in the squalor and deprivation that policy-makers refer to as "wrap-around services in the community." Acute care admissions are controlled by the managed care concept of "medical necessity," a term meaning dangerousness to self/others or significant self-care impairment.[15] Practically, however, the latter can rarely be justified, and thus medical necessity essentially equates to dangerousness.

Recent study findings by Phelan and Link[16] suggest that the dangerousness criterion seems to have backfired with regard to fighting stigma as well. In 1950, 7.2 percent of respondents mentioned violence in describing a person with mental illness, but only 4.2 percent of that sub-group used "dangerous to self or others" language in their description. In 1996, 12.1 percent of respondents mentioned violence in their description, and 44.0 percent of them used the dangerousness language. The 44 percent sub-group accounted for all the increase in total percentage of respondents associating violence with mental illness.

Problems with the Paradigm

Reliance on Police Powers

Before turning to the subject of how police powers affect psychiatric practice, it must first be acknowledged that the police power to confine individuals is applied unevenly and unfairly to the mentally ill. As Shah[7] noted, there are many categories of people in the world who are clearly more dangerous than the category of individuals suffering from mental illness regarding whom we do not employ the state police powers to accomplish preventive detention (drunk drivers, repeat violent offenders). Link and colleagues[17] suggested that data from their epidemiological study of the factors correlated with violence would provide just as rational an argument for confining men relative to women, or high school graduates relative to college graduates, as it would for confining individuals with identified mental illness relative to never-treated individuals.

The effect on professional practice of our near-exclusive contemporary fixation on this police power is to remove us from the core of our clinical work—and we all suffer for it. The ethical and effective practice of psychiatry requires more than the police

power and the concept of danger bring to practice. This point has been made, and ignored, previously.

In 1975, Stone[18] advanced his "Thank You Theory of Paternalistic Intervention," a model for civil commitment based on the presence of reliably determined and treatable mental illness causing significant distress to the person, when the person's judgment about accepting treatment was impaired by the illness and when the treatment would be acceptable to a reasonable person. This approach was criticized, however, because of difficulties in defining and assessing the competency element; in 1979, Loren Roth[19] suggested ways to tighten the competency concept, and in 1981 Paul Appelbaum[20] cautioned that solutions based on competency were unworkable and needed experimental study.

The American Psychiatric Association (APA) Assembly and Board of Trustees nonetheless adopted a similar approach in approving the APA Model Commitment Law in 1982.[21] The APA criteria de-emphasized the control of dangerousness and emphasized the ability to provide treatment for a severe mental disorder to an individual who is incapable of giving informed consent and who is at risk of deterioration, self-harm, or harming others as a result of the mental disorder. It is within this Stone-Roth-APA continuum that we find the proper clinical conceptualization of our role.

But this is not the role we have come to play. Instead, we are increasingly called upon by our society to play the roles of police and jailer. We are expected to identify dangerous individuals, sound alarms at their discovery, and incapacitate them without failure. The presence of treatable disorder has become an inconsequential aspect of such expectations. Distinctions between patients and criminals that once seemed obvious are now challenged and breached.[22]

Even worse, many mental health professionals have come to identify with these societally enforced roles. I draw this conclusion, in part, from discussions with a variety of licensed mental health professionals with whom I have been meeting in a series of seminars on risk assessment and management. There are those who have adopted the notion that because they work in the public sector, they owe a primary duty to the public (the taxpayers who pay their salary) to protect them from mentally ill people who might be dangerous. Others have expressed their concern that the duty of confidentiality is a bar set too high to permit the kind of easy disclosure that potentially endangered citizens should enjoy.

Nearly all express their anxious perceptions of societal expectations to provide control and warnings; not one expresses comfort with the level of resources available to provide good care. We have lost our essence as healers and as a result feel frustrated, angry, and anxious about our work.

Limits of Research

The research on violence of the last two decades has been productive. Monahan's 1981 conclusion[6] that we are wrong in two-thirds of our predictions of violence was replaced by his 1997 appraisal that we have a better than chance ability to predict violence, and that epidemiological studies have demonstrated that mental illness is a modest risk factor for violence.[23]

For a time, the research of the past decade seemed to be moving in a direction of narrowing the mental illness factors specifically identified with higher risk of violence. In 1990, Swanson *et al.*[24] identified major mental disorders as modest risks. In 1992, Link *et al.*[17] identified level of active psychosis as operative. In 1994, Link and Stueve[25] identified particular psychotic symptoms of threat/control/override as the important variables, and Swanson *et al.*[26] replicated those findings in 1996.

In 1999, Swanson and colleagues[27] failed to find associations between violence and paranoia, psychoticism, or diagnosis in a sample of North Carolina patients meeting outpatient commitment criteria. This year, Appelbaum and colleagues[28] published MacArthur Risk Assessment Study data, in which no association was found between delusional beliefs (when rated by the interviewer) and violent behavior. The European data, on the other hand, continue to support an association between psychoticism and violence.[29]

It is at present difficult to draw firm conclusions from these developments in the research literature. One exception is that it is clear that the contribution of any of these factors is quite small relative to other factors that are repeatedly found to be strongly associated with violence: young age, male gender, low socioeconomic status, and sociopathy. Perhaps the most notable exception is that no study that has examined the subject has failed to find a very strong association between substance abuse and violence. In fact, substance abuse is the one finding that stands

out as universally and most strongly associated with violence.

From a cynical perspective, what all this means is that, with decades of modern research, we now have the science to support Prohibition. An alternate conclusion is that our science would now support the preventive detention of all active substance abusers. Of course, in such an involuntary mode only the biological aspects of detoxification would be possible. Rehabilitation for substance dependence/abuse generally requires motivation (which we can possibly enhance) and voluntary participation. But, in contemporary legal thought there is little concern for treatability anyway (as evidenced by *Kansas v. Hendricks*[30]), so long as we can statutorily redefine the creation of danger to the public as a mental abnormality.

Perhaps the main shortcoming of our research literature is that it is not particularly useful in clinical care and decision-making. Clinicians face the reality that a great many individuals with serious mental illness have impaired insight and judgment and commonly experience chronic psychosis, including delusions of the threat or control/override nature. Yet we manage nearly all of these people in the community, struggling to wrap enough service around them, manage our own anxiety, and make appropriate decisions about when to seek inpatient (or other more intensive) care.

As Mulvey and Lidz[31] have rightly pointed out, knowing how accurate we are at assessing risk and knowing which patients are more likely to engage in some violence are not the essential issues. Good clinical management requires "knowing *when and under what conditions* a violent incident will occur and *how accurately clinicians can assess which patients are at particular risk under those conditions related to violence*" [italics in original].[31]

This next era of research is underway. Mulvey and Lidz are beginning to research the conditional nature of these judgments. The MacArthur Risk Assessment researchers (as described in this issue by Dr. Steadman, as well as elsewhere)[32, 33] are exploring the use of decision tree analysis in an effort to produce more clinically meaningful results. No doubt these efforts will produce advances in scientific knowledge. However, the prospects for significant clinical advance seem more limited.

In his paper appearing in this issue, Dr. Steadman[42] rightly describes the limitations of much of the previous research and techniques associated with risk assessment. While this research has been very useful in demonstrating scientifically the limited extent of the correlation between mental illness and violence, it has been significantly less useful to practicing clinicians, as he points out. But even the contemporary research projects he describes have serious limitations in the clinical realm.

The authors of the HCR-20[34] are careful to describe their instrument as a research tool and are to be credited for acknowledging limits to its clinical utility, as noted by Dr. Steadman. The authors of the Violence Risk Appraisal Guide (VRAG),[35] on the other hand, are not cautious in this way and have argued that their instrument is so superior to clinical assessment that the latter should be used only to make minor adjustments to risk appraisals anchored by the VRAG score.

It is worth amplifying the problem with such an approach. The factors that determine the VRAG score (and thus the level of risk for violent recidivism) are entirely static. Thus, no clinical intervention can ever change the risk assessment, and a committed patient can never appear to be any less dangerous or more ready for discharge than he/she appeared on the day of commitment. The authors' suggestion that the VRAG score can be used in conditional release situations to match the level of treatment and supervision with the level of risk is out of touch with the reality that forensic patients identified as high risk are simply not released. For them, the actuarial assessment constitutes a potential life sentence of preventive confinement. Under such situations, in what meaningful clinical work can patient and treater engage? And if there is no clinical work to be done, we are once again left with the prospect of functioning as jailers.

The Iterative Classification Tree (ICT) approach[33] suffers from much of this same problem because many of the crucial decision elements involve static factors, such as seriousness of past arrest or history of one's father using drugs. Under the latter condition, the individual would not even have the solace of facing the consequences of his/her own history. That would be hard to explain to a patient, even if the science is completely accurate.

Another concern about the ICT approach is related to its pigeon-hole construct and the arbitrary assignment of high and low risk status. At the end of multiple decision points, one arrives at a group char-

acterization with a percentage risk for violence. Such a determination would be labeled "high risk" if that percentage were twice the average risk, which seems a reasonable operational definition of "high risk" for research purposes. But how would a real-life clinician make a distinction regarding appropriate response between a person in a 26.9 percent risk group and a person in a 39.2 percent risk group? The model would call only the latter "high risk" but would in my view fail to provide meaningful direction or guidance.[33]

For some of the ICT determinations, there seems to be little benefit to the approach over clinical assessment. For example, the determination that an individual previously arrested for a serious violent offense and who is experiencing violent fantasies is at high risk does not seem to require computer analysis. For other ICT determinations, there is little connection to clinical issues. The assessment that an individual with a history of minor arrest and a father who used drugs is at high risk might well generate some kind of imperative for a clinician to act, without any recognizable or reasonable direction for an intervention. In such situations, the characterization of the model as "clinically useful," and the aura of reliability attached to computerized instruments (ICT software is currently in development)[33] would only make matters worse for the hapless clinician.

Techniques are traps; they will always oversimplify the situation and lead to a false sense of security. Human behavior and interactions are too complex, and violence is too over-determined to permit useful rule-making. The clinical assessment and management of risk will remain highly individualized, even though properly informed by scientific knowledge and management concepts. The actuarial assessment of risk will remain a process for the long-term (if not life-long) categorization of individuals by levels of risk. It is unlikely to ever assist clinicians in the real-time decisions they are called upon to make on a daily basis in their real world of responsibility for large numbers of high risk individuals.

Finally, given what we already know from this body of research, one must ask the question: "What testable hypothesis could we yet explore, the confirmation or disconfirmation of which would represent a significant breakthrough in our clinical understanding or management of mental illness and violence?" I would argue that we have exhausted this mine, and continue to toil only for small nuggets. The trouble is not with the research or the researchers, it is with the limited usefulness of the paradigm.

Perils of Dangerousness

In its abstract form, the concept of using dangerousness as a major determinant in seeking treatment requiring involuntary confinement was not particularly startling. After all, no treater seriously interested in the welfare of patients could be uninterested in the protection of their civil liberties. Therefore, psychiatrists regularly participated in this aspect of the civil commitment process (perhaps believing that we could be faithful to an appropriate clinical role, as articulated in the APA Model Commitment Law, despite the common lack of statutory endorsement of these values); but such assumptions proved perilous.

When the APA argued that the use of psychiatric prediction of dangerousness was unscientific and therefore unreliable in capital sentencing procedures, the U.S. Supreme Court blithely dismissed such concerns. The Court reasoned that if prediction of dangerousness could be performed for civil commitment proceedings, it could be performed for capital sentencing proceedings as well.[12]

Further, the fact that we routinely engage in some process of assessing risk of violence (or predicting dangerousness) creates an expectation that we should do so. And thus we become accountable for the outcomes of a type of assessment in which our accuracy is only modestly better than chance. (While the more recent concept of "risk assessment" may have advantages for academicians and forensic consultants, there is no shelter in the subtle probabilism of risk levels for clinicians and administrators who have to make actual decisions.)

Mossman's[36] re-analysis of research data (using receiver-operating characteristic analysis) from 44 published studies suggests that past behavior may be a better predictor of violence than clinical judgment. This conclusion would imply that, at the very least, we should not claim any special ability at this work and should inform the courts and others that attention to history alone (not requiring clinical expertise) may be equally, if not more, meaningful. Downplaying the value of our contribution might ease expectations. On the other hand, Lidz and colleagues[37] determined that the clinical prediction of violence was better than chance even when clinicians were not predicting on the basis of history. So, there may be

some additional contribution that clinical evaluation makes, but we are not sure what it is. Perhaps we could learn more about this from future research.

Dangerous Populations and Resource Allocation

One of the effects of deinstitutionalization is that long-term hospital-level care is a scarce resource now reserved almost exclusively for identified forensic populations. Many other individuals with serious mental illness and high risk for violent behavior must be managed in the community. At the same time, because public mental health agencies are seen as being in the business of managing dangerousness, other populations of individuals have been sent our way for expected management of their dangerousness, regardless of the presence of serious mental illness. For all of these high-risk or "special" populations there is a tremendous demand for supervised housing arrangements that rarely exist. Agencies become forced to create *ad hoc* solutions to continuous supervision, which generally require expensive special staffing in situations that do not permit economies of scale or reliable management.

We have become full partners in an elaborate pretense. Society demands protection from individuals who could not be civilly committed, and we oblige with strategies that: are intrusive (yet incite no libertarian objection merely because they are carried out in the community); are cost-ineffective (but are not questioned because they do not involve bricks and mortar); are ultimately impotent (because community staff have no authority to touch, much less control or confine, the behaviors of their "clients"); and which set community providers up to take the blame when things go wrong. Holloway's[38] criticism of such supervisory practices in the U.K. as "paper tigers" seems quite applicable to the American experience as well.

We must also remember that the contribution to the overall rate of violence in our society that is related to mental illness is vanishingly small.[23] In the community control data of the MacArthur Risk Assessment Study, that association was statistically nonexistent (in the absence of substance use).[39] Why then, if these links between mental illness and violence are so small, would we rationally devote so much of our limited mental health resources to the control of potential violence?

Social Context and the Inexhaustible Demand for Control

The dangerousness approach to mental health decisions has always held the potential for extensions to situations in which society would wish to create mechanisms to house and isolate unacceptably dangerous individuals who were not appropriate candidates for civil commitment or were not even mentally ill. The sexual predator commitment laws of a number of state legislatures and the *Kansas v. Hendricks* decision of the U.S. Supreme Court have actualized that potential. Predictably, psychiatric facilities have been chosen as the vehicle for this actualization, or at least for its *façade*. Those offenders whom we cannot deposit in psychiatric facilities, we register on web pages filled with photos, addresses, and rap sheets. Surely, this cannot represent more than an "electronic tiger."

It is a most certain reality that our society has zero tolerance for violent behavior by individuals with mental illness. This intolerance is almost always manifested in criticism of mental health professionals and agencies. Whatever problems are brought to the doorstep of those agencies will be subject to the same zero tolerance, whether we accept delivery of the problems or adamantly, but vainly, attempt to refuse them. We are a society obsessed with risk and filled with expectations of simple and simplistic relief. And the more we know, the worse we feel, for the other side of the coin of scientific advance seems to be communal anticipatory anxiety.

In such a risk-focused environment, we will never free our patients from unwarranted associations with violence, nor ourselves from the responsibility for controlling violence. Our best research efforts to challenge the stigma of mental illness (like our efforts to champion civil liberties with the dangerousness standard) are likely, paradoxically, to heighten anxiety about links between mental illness and dangerousness. Even the smallest associations will confirm common fears; science and public opinion are rare bedfellows.

Death to the Paradigm

The paradigm of dangerousness is a failure and a trap. It is fairly clear how we got to this point, but understanding how we came to be where we are does not make our willingness to stay here understandable or defensible. Our patients are not treated with more dignity or care, their liberties are false, and their

rights are challenged by ever-increasing attention to the needs of third parties and public fears. There are no breakthrough discoveries to be had regarding mental illness and violence, and the idea of "treating" dangerousness is a false and perilous construct.

Dr. Steadman[42] points out that scientists must be optimists. So too must clinicians be optimists regarding their ability to help people change, grow, and improve their state of well-being. But we can only be helpful regarding dynamic variables. And since the past, which neither our patients nor we can do anything about, seems to correlate best with dangerousness, there is yet another compelling reason for us to abandon dangerousness (even in its modern semblance of risk assessment) as a primary focus of clinical care.

We must recognize that the dominant use of police power as the tool to deal with manifestations of clinical syndromes represents a paradigm-reality mismatch with serious negative consequences for our patients and our profession. We are not the police. So we must engender a replacement paradigm that better explains and supports clinical reality, a reality in which we act like doctors.

Such a reality would attend more clearly and closely to the endeavors of healing, to the prevention and alleviation of suffering. It would manifest public policy grounded in the doctrine of *parens patriae* without manifesting fears of malignant paternalism. In such a reality, treatment would never serve as the *façade* for preventive detention.

I believe the time has come for us to re-examine the models proposed by Stone and the APA, as well as the modifications and criticisms of Roth, Appelbaum, and others. We now have the benefit of 25 years of advances in the treatment and management of serious mental illness, including new biological therapies and treatment algorithms, cognitive-behavioral therapies, psychoeducational and rehabilitative therapies, and creative management models. We have an entire research literature on the assessment and understanding of competence that did not exist when those models were originally proposed and argued.[40, 41] Our understanding of diagnosis and prognosis have evolved considerably, especially considering that our research-based diagnostic system was first introduced five years after Stone published his original model.

Surely, with all these advances, we can make a more compelling argument for our role as healers. In such an argument, we would gladly abdicate the roles of jailers and fortune tellers cast upon us in the failed paradigm of dangerousness.

Acknowledgment

I wish to express my gratitude for and acknowledge the contributions of many discussions about risk assessment and dangerousness with my colleague and friend, Madelon Baranoski, PhD.

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