

THE MYTH OF “IMMINENT” VIOLENCE IN PSYCHIATRY AND THE LAW

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I. INTRODUCTION

“Imminent” violence, toward self or others, is a term firmly embedded in the language of psychiatry and the law. It is used in clinical settings, in hospital and in professional organization policies and guidelines. In the law, the term “imminent” appears in civil commitment statutes, duty to warn and protect statutes, sexually violent predator assessments, restraining orders, domestic violence and self-defense cases, bail bond hearings, civil litigation, and court opinions.¹

There are, however, no risk factors that identify “imminent” violence. Imminence implies temporal prediction. No evidence-based research supports the proposition that clinicians can accurately predict *when*, or even if, an individual will commit an act of violence toward oneself or others.² The American Heritage Dictionary of the English Language defines “imminent” as: “about to occur; impending: *in imminent danger*.”³ Black’s Law Dictionary defines “imminent” as, “[n]ear at hand; mediate rather than immediate; close rather than touching; impending; on the point of happening; threatening; menacing; perilous.”⁴ “Imminent,” however, is not a psychiatric or medical term. The words “imminent” or “imminent violence” were not found in standard medical and psychiatric dictionaries spanning 3 decades.⁵ Similarly, a search of the National Electronic Library for Mental Health, the Cochrane Library, Pub Med, OVID and MD Consult data bases

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1. See Christopher Slobogin, *Involuntary Community Treatment of People who are Violent and Mentally Ill*, 45 HOSP. COMMUNITY PSYCHIATRY 711 (1994).

2. See Alex D. Pokorny, *Predictions of Suicide in Psychiatric Patients*, 40 ARCHIVES GEN. PSYCHIATRY 249 (1983); Douglas Mossman, *Assessing Prediction of Violence*, 62 J. CONSULTING & CLINICAL PSYCHOL., 783 (1994).

3. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 877 (4th ed. 2000) (emphasis added).

4. BLACK’S LAW DICTIONARY 750 (6th ed. 1990).

5. See WEBSTER’S MEDICAL DESK DICTIONARY 326 (1986); STEDMAN’S MEDICAL DICTIONARY 765 (25th ed. 1990); AMERICAN PSYCHIATRIC GLOSSARY (Nariman C. Shahrokh & Robert E. Hales eds., 2003).

using the terms “suicide, imminent” and “violence, imminent” yielded no results.⁶ A Google search using the same terms yielded 2,900,000 search results for suicide and 7,070,000 for violence toward others.⁷

II. “IMMINENT”

A. “Imminent” Suicide

Clinicians ascribe arbitrary time limits for “imminent” suicide, although most time frames are vague, usually given as a range such as 12–24 hours, 24–48 hours, 1–3 weeks, 1 month or 1 year. Hirschfeld suggests that “[o]nce a patient is considered to be at risk for suicide, the physician must decide whether the risk is imminent (48 hours or less), short-term (within days or weeks), or long-term.”⁸ Hirschfeld considers the risk of suicide “as imminent if the patient has expressed the intent to die, has a plan in mind, and has lethal means available.”⁹ Fawcett et al., in a 10-year prospective study of patients with major affective disorders identified acute, short-term indicators of suicide risk that were statistically significant for suicide within 1 year of assessment.¹⁰ Fawcett described treatable and modifiable symptoms of major depression that occur early in onset of the disorder.¹¹ The prediction of who will commit suicide and when is not possible from the prospective study data.¹² Fawcett, for example, describes acute or immediate (a synonym for “imminent”) risk of suicide as occurring within hours, days or weeks.¹³

B. “Imminent” Violence Toward Others

Monahan, in his early work, defined “imminent” danger as occurring “within three days” of the prediction of a violent act.¹⁴ In his most

6. See National Electronic Library for Mental Health, <http://www.nelnh.org> (last visited Feb. 8, 2007); Cochrane Library, <http://www.york.ac.uk/inst/crd/cochlib.htm> (last visited Feb. 8, 2007); Pub Med, <http://www.ncbi.nlm.nih.gov> (last visited Feb. 8, 2007); OVID, <http://www.ovid.com> (last visited Feb. 8, 2007); MD Consult, <http://home.mdconsult.com> (last visited Feb. 8, 2007).

7. See Google Homepage, <http://www.google.com> (last visited Aug. 6, 2006).

8. R.M. Hirschfeld, *The Suicidal Patient*, 33 HOSP. PRAC. 122, 127–28 (1998).

9. *Id.*

10. Jan Fawcett et al., *Time-Related Predictors of Suicide in Major Affective Disorder*, 147 AM. J. PSYCHIATRY 1189, 1189 (1990).

11. *Id.* at 1190–91.

12. *Id.* at 1192–93.

13. *Id.* at 1193.

14. See JOHN MONAHAN, *PREDICTING VIOLENT BEHAVIOR* (1981).

recent research, Monahan et al. state, "[a]lthough much attention is paid in the research literature to the *prevalence* of violence among patients during a given time period, little is known about the *imminence* of violent behavior, that is, the extent to which violence occurs early in time following hospital discharge."¹⁵ Monahan et al. found that in examining the timing of violent incidents following hospital discharge, patients were at higher risk for an initial incident within 150 days after discharge.¹⁶

Other researchers adopt different time frames to define "imminent" violence. In a study by Werner et al., the measure of "imminent" violence was whether patients would or would not engage in a violent act during the 7 days following assessment.¹⁷ Tardiff states that, "[a] clinician should be expected to have the capacity to determine a patient's risk of violence in the near future (i.e., days or a week or so)."¹⁸ No evidence-based research is offered to support this statement. Lidz et al. followed patients for six months who were initially examined in an acute psychiatric emergency service.¹⁹ The overall clinical accuracy of violence prediction was modest.²⁰ It was particularly low for females.²¹

McNeil et al. point out that, "[t]he utility of such [research] instruments for the evaluation of patients' short-term, acute risk of violence, an important aspect of clinical practice in emergency and inpatient psychiatric settings, is unknown."²² They evaluated the usefulness of 3 structured risk assessment tools for measuring acute risk of violence "within the next few days to weeks after the evaluation."²³ They concluded that assessment support tools focusing upon "clinical risk factors, have the potential to improve decision-making about violence risk in the context of behavioral emergencies."²⁴ Actuarial studies that focus on specific groups with high base rates of violence such as inpatient populations have demonstrated improved

15. JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT 31 (2001).

16. *Id.*

17. Paul D. Werner et al., *Aspects of Consensus in Clinical Predictions of Imminent Violence*, 46 J. CLINICAL PSYCHOL. 534, 535 (1990).

18. Kenneth Tardiff, *The Past as Prologue: Assessment of Future Violence in Individuals with a History of Past Violence*, in RETROSPECTIVE ASSESSMENT OF MENTAL STATES IN LITIGATION 181, 195 (Robert I. Simon & Daniel W. Shuman eds., 2002).

19. Charles W. Lidz et al., *The Accuracy of Prediction of Violence to Others*, 269 J. AM. MED. ASS'N. 1007, 1008 (1993).

20. *Id.*

21. *Id.*

22. Dale E. McNeil et al., *Utility of Decision Support Tools for Assessing Acute Risk of Violence*, 71 J. CONSULTING & CLINICAL PSYCHOL. 945, 945 (2003).

23. *Id.*

24. *Id.*

predictability.²⁵ Mossman, after a systematic review of the literature concluded that “[s]hort-term (1–7 day) clinical predictions [of violence] seem no more accurate than long-term (> 1 year) predictions.”²⁶

Even during a violent episode in progress, individuals have been dissuaded from committing acts of violence toward self or others. For example, of the twenty-six survivors who jumped from the Golden Gate Bridge, some changed their minds in mid-air.²⁷ Of 515 individuals restrained from jumping, 94% were still alive after 26-plus years or died from natural causes.²⁸

Slovenko, critical of the time limits that clinicians place on the accuracy of their predictions of dangerousness, observes: “These time limits seemed to be pulled out of thin air.”²⁹ Nonetheless, in prediction research it is appropriate to use the term “imminent,” so long as the time frame is specified, as in the Werner et al.³⁰ and Lidz et al.³¹ prediction studies.

III. CIVIL COMMITMENT

The substantive criteria for civil commitment of a patient require the presence of a mental illness and dangerousness to oneself or others, though state statutes are not uniform in the definition of mental illness and dangerousness.³² “Gravely disabled” is usually subsumed under dangerousness to self.

Dangerousness is a legal status, not a diagnosis. It is not a psychiatric term. The legislative determinations of dangerousness represent normative judgments.³³ Brooks, however, attempted a definition by dividing dangerousness into five components—nature of harm or conduct; magnitude of harm; probability; imminence; and frequency).³⁴ Imminence purports to address *when* a threatened violent act will occur.

25. ROBERT I. SIMON, CONCISE GUIDE TO PSYCHIATRY AND LAW FOR CLINICIANS 185–87 (2001)).

26. Mossman, *supra* note 2, at 783 (1994).

27. T. Friend, *Jumpers*, NEW YORKER, Oct. 13, 2003.

28. Richard H. Seiden, *Where Are They Now?: A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 SUICIDE AND LIFE THREATENING BEHAVIOR 203, 214 (1978).

29. RALPH SLOVENKO, PSYCHOTHERAPY AND CONFIDENTIALITY (1998).

30. Werner et al., *supra* note 17.

31. Lidtz et al., *supra* note 19.

32. ROBERT I. SIMON, CLINICAL PSYCHIATRY AND THE LAW 310–12 (1992).

33. ROBERT I. SIMON & DANIEL W. SHUMAN, CLINICAL MANUAL OF PSYCHIATRY AND LAW (2007).

34. See Alexander D. Brooks, *Notes on Defining the “Dangerousness” of the Mentally Ill*, in NATIONAL INSTITUTE OF MENTAL HEALTH CENTER FOR STUDIES OF CRIME AND DELINQUENCY, DANGEROUS BEHAVIOR 37, 54 (Calvin J. Frederick ed., 1978).

No time frame is provided.

Some states require the clinician to certify that the patient poses an "imminent" risk of violence to meet the criteria for civil commitment.³⁵ Melton et al. write, "[c]ivil commitment is premised on *imminent* dangerousness; short term rather than long term danger to self or other is the focus."³⁶ Some states require an "overt act" to increase the likelihood that the danger is "imminent," rather than distant.³⁷

A number of states employ synonyms for "imminent" such as, "immediate," "probability," "likelihood," "foreseeable," "impending," "near future," or some other predictive term.³⁸ Georgia, for example, defines dangerousness as "substantial risk of imminent harm."³⁹ Hawaii uses the term "imminently dangerous."⁴⁰ Virginia requires that a mentally ill person must present "imminent danger."⁴¹ In contrast, the Oklahoma statute states that "a person who because of mental illness of the person represents a risk of harm to self or others."⁴² Since "imminent" violence is meaningless and undefinable, it can be used to implement political and policy agendas that restrict mental health care for severely ill persons.⁴³

The clinician's violence risk assessment of the patient is a "here and now" determination. It is not a prediction of violence. The court will decide whether the patient meets the "substantial risk of harm standard" for civil commitment. The court's decision-making is much better informed by systematic risk assessments than by conclusory statements of "imminent" violence.

Slobogin observes that courts require a finding of imminence to prevent deprivation of liberty in the absence of clear and present danger.⁴⁴ In addition, shorter or "imminent" predictions of danger are presumed to be more accurate than long-term predictions. Other courts

35. See GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS* 308-09 (1997); James L. Werth, *U.S. Involuntary Mental Health Commitment Statutes: Requirements for Persons Perceived to be a Potential Harm to Self*, 31 *SUICIDE AND LIFE-THREATENING BEHAVIOR* 348, 354 (2001).

36. MELTON ET AL., *supra* note 35 at 327.

37. AMERICAN PSYCHIATRIC ASSOCIATION, *THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY* 8-9 (2001).

38. Legal Resources, <http://www.psychlaws.org/legalresources/index.htm> (last visited Nov. 7, 2006).

39. GA. CODE ANN. § 37-3-1 (2006).

40. HAW. REV. STAT. § 334-60.2 (2005).

41. VA. CODE ANN. § 37.2-808 (2006).

42. OKLA. STAT. ANN. tit. 43A, § 1-103 (2006).

43. Tom Jackman, *Rules Separate Mentally Ill from Treatment; With 'Imminent Danger' Requirement and Scant Resources Keeping Help Out of Reach, Some Become Violent*, WASH. POST, May 29, 2006, at B1, 8.

44. Slobogin *supra* note 1.

reject the imminence requirement in favor of a determination of substantial risk of violence in the reasonable foreseeable future, a phrase that merely creates another name for “imminent.” Foreseeability implies prediction. The law does not assign a time limit for foreseeability or imminence. The lapse of time, by itself, does not bar recovery in a lawsuit. It is only one factor to be weighed by the jury.⁴⁵

Strunk and White describe “[t]he foreseeable future” as “[a] cliché, and a fuzzy one. How much of the future is foreseeable? Ten minutes? Ten years? Any of it? By whom is it foreseeable? Seers? Experts? Everybody?”⁴⁶ “Foreseeability” and “near future” are legal fictions as applied to clinical assessment of violence toward one-self or others. This example is indicative of the imperfect fit between psychiatry and the law.

The justification for implementing involuntary hospitalization should be based upon adequate violence risk assessment rather than merely invoking the talismanic “imminent danger.” States have provisions in their commitment statutes granting psychiatrists and other mental health professionals immunity from liability, but they must use reasonable clinical judgment and act in good faith in petitioning for involuntary hospitalization.⁴⁷

In civil commitment and other legal proceedings, psychiatrists are asked by attorneys or judges to opine about an individual’s “dangerousness.” Dvoskin and Heilbrun advise the clinician as follows:

If the court is interested, entirely or in part, on the best available prediction of violence risk, then one should rely on an applicable actuarial tool. If the court wants to know how an individual’s violence risk might be reduced through hospital or community interventions, then one should provide a strategy that encompasses interventions addressing potentially changeable violence risk factors in a specific case or recommend interventions that have empirically demonstrated risk reduction value.⁴⁸

No actuarial instrument can predict “imminent” violence. No agreed upon definition of “imminent” exists. Clinicians should not make predictions about imminence. Instead, a current systematic assessment of the risk of violence can be helpful to the court’s treatment and dispositional decision-making.

45. *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988); *Davis v. Lhim* 335 N.W.2d 481 (Mich. Ct. App. 1983).

46. WILLIAM STRUNK, JR. & E.B. WHITE, *THE ELEMENTS OF STYLE* 59 (3d ed. 1979).

47. See ROBERT I. SIMON, *ASSESSING AND MANAGING SUICIDE RISK: GUIDELINES FOR CLINICALLY BASED RISK MANAGEMENT* 95–96 (2004).

48. Joel A. Dvoskin & Kirk Heilbrun, *Risk Assessment and Release Decision-Making: Toward Resolving the Great Debate*, 29 J. AM. ACAD. PSYCHIATRY & L. 6, 9–10 (2001).

While acknowledging that the use of "imminent" predictions in clinical settings is problematic, Slobogin notes that the term does serve an important function in the law.⁴⁹ He states:

Jurisdictions require imminent dangers in the commitment context in order to limit government power. If civil commitment were permitted on the basis of dangers to others at any time in the future (as seems to be the case with sexual predator laws, for instances), virtually any mentally ill person might be committable, since at least once during their lifetime such people are likely to be dangerous to self or others. If the predicted harm will not occur until next week (because that is when Tatiana Tarasoff returns from vacation or when the effects of medication will wear off), the imminence requirement acts to prevent premature confinement.⁵⁰

IV. DUTY TO WARN AND PROTECT

The criteria of "imminent" violence toward others can arise in duty to warn and protect cases. In *In re Viviano*, a patient sued his psychiatrist for breach of confidentiality in notifying a federal judge that the patient had threatened to kill her.⁵¹ The patient had purchased a hand gun.⁵² The plaintiff argued that the danger, if any, was not "imminent."⁵³ Therefore, the breach of confidentiality was not justified.⁵⁴ Numerous experts testified about the definition of "imminent."⁵⁵ The jury found for the defendant.⁵⁶ The Louisiana Supreme Court denied certiorari.⁵⁷ Slovenko noted that following the *Viviano* litigation, the word "imminent" was deleted from the American Psychiatric Association's *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* ("The Principles").⁵⁸ Slovenko states that the term "imminent" was originally included in *The Principles* as a qualification to "narrow the situation calling for a breach of confidentiality."⁵⁹

49. Personal communication with Christopher Slobogin, Professor of Law, University of Florida (Mar. 18, 2006).

50. *Id.*

51. *In re Viviano*, 645 So.2d 1301 (La. Ct. App. 1994).

52. *Id.* at 1307.

53. *In re Viviano*, 645 So.2d at 1307.

54. *Id.*

55. *Id.*

56. *Id.* at 1303.

57. *In re Viviano*, 650 So.2d 254 (La. 2005).

58. SLOVENKO, *supra* note 29, at 285.

59. *Id.*

The 1995 revised edition of “The Principles” deleted “imminent,” supplying “significant” in its place: “When in the clinical judgment of the treating psychiatrist the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.”⁶⁰ In the 1998 edition of “The Principles,” “imminent” mysteriously reappeared, a testament to the amazing resilience of a clairvoyance myth.⁶¹ The exact wording of the 1993 ethical guideline was restored, which changed again in the 2006 edition: “When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be *significant*, the psychiatrist may reveal confidential information disclosed by the patient.”⁶² Once more, “imminent” was banished.

As the *Viviano* case demonstrates, the psychiatrist or therapist is burdened with divining the meaning of “imminent” danger in duty to warn and protect cases—an impossible task.⁶³ The duty to protect, rather than to warn reflexively, allows the practitioner to utilize a number of clinical interventions to treat the potentially violent patient without breaching confidentiality.⁶⁴ Interestingly, in *Tarasoff v. Regents of the University of California*, the landmark duty to warn and protect case, the words “imminent” or “imminence” are not used.⁶⁵

V. ASSESSING THE UNPREDICTABLE: THE CLINICIAN’S ROLE

In the 1990s, the prediction of violence gave way to the actuarial assessment of the risk of violence.⁶⁶ Actuarial risk assessments produce statistically superior accuracy because of their reliance on the stability of historical and demographic factors.⁶⁷ Actuarial instruments, however, are insensitive to patients’ clinical changes that guide treatment interventions or gauge the impact of treatment.⁶⁸

60. AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS 6 (1995).

61. AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY (1998).

62. AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY 8 (2006) (emphasis added), available at http://www.psych.org/psych_pract/ethics/ppaethics.cfm.

63. David M. Gellerman & Robert Suddath, *Violent Fantasy, Dangerousness, and the Duty to Warn and Protect*, 33 J. AM. ACAD. PSYCHIATRY & L. 484, 494 (2005).

64. See SIMON, *supra* note 25, at 180–84.

65. See *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976) (requiring mental health professionals to take reasonable steps to prevent violence threatened by their patients).

66. See Henry J. Steadman, *From Dangerousness to Risk Assessment of Community Violence: Taking Stock at the Turn of the Century*, 28 J. AM. ACAD. PSYCHIATRY & L. 265, 268 (2000).

67. See, e.g., *id.*

68. See Michael A. Norko & Madelon V. Baranoski, *The State of Contemporary Risk Assessment*

The focus of actuarial assessment of risk of violence is different from clinical assessment (see Table 1 in Appendix). Actuarial assessment attempts to predict reasonably accurate risk probabilities for specific populations. Unaided clinical assessment, however, is an "on the spot" identification of patient risk factors that informs treatment and safety management. Clinical risk assessment is a process; actuarial assessment of violence is an event. Nonetheless, actuarial prediction studies can help clinicians identify evidence-based risk factors for violence. For example, clinical and risk management items on the Historical, Clinical, Risk Management – 20 (HCR-20) actuarial assessment instrument can assist clinicians in their "real time" assessment of violence risk.⁶⁹ Practitioners who rely primarily on "clinical experience" in performing violence assessments may overlook evidence-based risk factors. Utilizing risk factors derived from violence research enhances the reliability of clinical assessments.

Psychiatrists are trained to assess patients by direct observation and examination. Psychiatrists are neither trained in, nor rely upon actuarial instruments to inform their clinical decision-making. Mullen makes the following observation about clinicians and assessment instruments:

The problem is that models which are too simple irritate clinicians who confront the complexities of reality, whereas overly detailed models finish up with dozens of boxes linked by a multiplicity of criss-crossing arrows looking more like a painting by Jackson Pollock than any kind of guide to understanding or acting.⁷⁰

The psychiatrists' stock-in-trade is the treatment and management of acutely mentally ill patients. Treatment and risk reduction, not prediction, is their appropriate focus. At this time, the standard of care does not require the average or reasonable psychiatrist to use actuarial assessment instruments in the evaluation and treatment of potentially violent patients. Thus, although the use of actuarial instruments may be helpful to the clinician, it currently represents "best practices" rather than the practice ordinarily employed by practitioners.

Because no risk factors that predict "imminent" violence exist, the clinician's role is to identify, assess and aggressively treat individual patients who are assessed at risk for violence toward oneself or others (see Table 2 in Appendix). A patient described as "imminently" violent should alert the clinician to perform a violence risk assessment that informs clinical intervention in the "here and now." Even if it were

Research, 50 CAN. J. PSYCHIATRY 18, 22–23 (2005).

69. See McNeil et al., *supra* note 22, at 7.

70. Paul.E. Mullen, *Dangerousness, Risk, and the Prediction of Probability*, in NEW OXFORD TEXTBOOK OF PSYCHIATRY 2070 (Michael G. Gelder et al. eds., 2001).

possible to accurately predict that an act of violence would occur within a few hours, a day or a week, the clinician still would have to intervene quickly and aggressively. Thus, prediction becomes irrelevant. As Mossman states, "In many clinical situations, moreover, mental health professionals would treat someone with a 10 percent risk of serious violence little differently from someone with a 50 percent risk; for both types of patient, clinicians usually would exercise high levels of concern in making follow-up plans and other treatment arrangements."⁷¹

Although actuarial assessment instruments can help supplement clinical decision making, the individual patient at risk for violence treated in clinical practice often falls outside the scope of actuarial assessment. For example, a patient who stuttered characteristically spoke clearly as his potential for violence escalated. The patient was then hospitalized. As the patient's mental condition improved, the stuttering gradually returned and the patient was discharged. Stuttering is not identified in the psychiatric literature or in actuarial protocols as a risk for violence. For this patient, however, stuttering was a unique, acute, high risk marker for violence. In addition, violent behaviors are often triggered by highly specific situational stressors that may not be detectable by actuarial assessment instruments.

Violence risk assessments, both actuarial and clinical, have been analogized to weather forecasting.⁷² Weather forecasts, like actuarial predictions, are made within certain probabilities. Clinical risk assessments are "here and now" determinations,⁷³ more akin to sticking one's head out the window to check the weather conditions than predicting the forecast for the next 10 days. Similar to weather forecasts, clinical risk assessments of violence must be updated frequently according to the patient's changing clinical condition.

The analogy to weather forecasting, however, is imperfect. Meteorologists can predict the weather with reasonable accuracy but they cannot change it. By contrast, mental health professionals cannot predict who will commit violence or when, but they can reduce or eliminate their patients' risk of violence through clinical interventions. The purpose of clinical risk assessment is to identify and aggressively treat acute, high-risk factors and to mobilize protective factors. Clinical

71. Douglas Mossman, *Commentary: Assessing the Risk of Violence—Are "Accurate" Predictions Useful?*, 28 J. AM. ACAD. PSYCHIATRY & L. 272, 278 (2000).

72. See SIMON, *supra* note 32, at 278–81; John Monahan & H.J. Steadman, *Violent Storms and Violent People: How Meteorology Can Inform Risk Communication in Mental Health Law*, 51 AM. PSYCHOLOGIST 931, (1996).

73. See Robert I. Simon, *Suicide Risk: Assessing the Unpredictable*, in TEXTBOOK OF SUICIDE ASSESSMENT AND MANAGEMENT 1, 14 (Robert I. Simon & Robert E. Hales eds., 2006).

risk assessment of violence is an essential tool for treatment and safety management.

Risk assessment in other fields of medicine is similar. For example, physicians routinely identify risk factors for coronary heart disease that can be reduced or eliminated. The presence of obesity, hypertension, high cholesterol, diabetes and cigarette smoking increase the risk of coronary artery disease by almost a factor of 4.⁷⁴ The clinician, however, cannot predict which patient will have a heart attack, if any. Nonetheless, each patient must be treated. "Imminent" is not a consideration. It is not about prediction. The methodology of clinical assessment, whether violence is directed at oneself or others, is essentially the same. Systematic risk assessment encourages the clinician to gather sufficient information to perform a competent assessment. Clinicians assess risk and protective factors on a dimensional scale of low, moderate or high, according to the clinical presentation of the patient, and then make an overall assessment of whether the risk of violence risk is low, moderate or high.

The assessment of violence risk and protective factors creates an individualized mosaic of the patient's overall risk for suicide or violence toward others.⁷⁵ Acute, high risk factors for violence are identified.⁷⁶ "Acute" defines the patient's symptomatic state. It is not a prediction of violence.⁷⁷ Thus, "acute" describes the magnitude and intensity of symptoms; for example, early morning waking vs. debilitating global insomnia in a depressed suicidal patient.⁷⁸ A high risk factor is supported by an evidence-based association with suicide or violence toward others.⁷⁹

Dvoskin and Heilbrun observe that "[t]he field has carefully studied violence prediction but understudied violence intervention effectiveness."⁸⁰ Identification and treatment of current evidence-based suicide and violence risk factors can inform effective prevention.⁸¹

The American Bar Association's National Benchbook on Psychiatric and Psychological Evidence and Testimony states:

74. Paul Keck et al., *Managing Metabolic Concerns in Patients with Severe Mental Illness*, POSTGRADUATE MEDICINE SPECIAL, 7-89 (2003).

75. See Simon, *supra* note 73, at 25-26.

76. *Id.* at 14-20.

77. *Id.* at 24-25.

78. *Id.*

79. *Id.* at 14-20.

80. Dvoskin & Heilbrun, *supra* note 48, at 10.

81. See Simon, *supra* note 73, at 7-14.

Despite the commentary indicating that clinicians are better at addressing possible risk factors and probabilities than providing definitive predictions of dangerousness, courts have remained reluctant to totally exclude such evidence, in part, perhaps, because courts are ultimately responsible for making these decisions and though the information may remain open to challenge, it is the best information available. The alternative is to deprive fact finders, judges and jurors of the guidance and understanding that psychiatrists and psychologists can provide in such significant cases as capital punishment, civil commitment and release of insanity acquittees, among others.⁸²

Psychodynamic evaluations focus upon the individual's capacity for empathy, appreciation of consequences, insight, impulse control, conscience development and situational triggers that provoke violence as well as personality factors that can help inform the court's decision-making process.

In litigation, "imminent" violence testimony should be rigorously challenged. Moreover, on cross examination, it is unlikely that testimony offered in support of the validity of "imminent" violence could survive a *Daubert* hearing.⁸³

Daniel W. Shuman, Professor of Law at Southern Methodist University, makes the following observation about the use of the term "imminence" in violence assessments:

Rationing scarce health care resources, protecting civil liberties from unwanted governmental intrusion, and distinguishing health care that meets the standard of care in malpractice litigation from that which does not requires a discernible metric. In violence assessment, imminence has come to play an important role as a metric. But what scientific foundation underlies this choice of metric and what practical guidance does it provide?⁸⁴

VI. CONCLUSION

The clinician's role is to assess and aggressively treat individuals at risk for violence. Violence prevention rather than violence prediction is the appropriate focus of clinical attention. The clinician's role in

82. JOHN PARRY, NATIONAL BENCHMARK ON PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE AND TESTIMONY 49 (1998).

83. See *Daubert v. Merrell Dow Pharm.*, 516 U.S. 869 (1995) (establishing test for expert witness qualifications). As noted above, no evidence base exists for the "imminent" or short-term prediction of violence.

84. Personal communication with Daniel W. Shuman, Professor of Law, Southern Methodist University (Jan. 13, 2006).

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providing violence assessments for legal purposes is no different. Similarly, clinical assessments can help inform the court's decision-making process regarding treatment and dispositional choices.

The term, "imminent violence," is an entrenched illusion that bedevils both psychiatry and the law. It cannot deliver the prediction of violence that it promises. It merely casts a soothsayer's spell. It is a distraction and an irrelevancy. It can detract from patient care, interfere with critical decision-making and hamper the administration of justice. The term "imminent violence" is, to borrow a phrase from Shakespeare, "full of sound and fury, [s]ignifying nothing."⁸⁵

85. WILLIAM SHAKESPEARE, *MACBETH*, act 5, sc, 2 in JOHN BARTLETT & JUSTIN KAPLAN, *BARTLETT'S FAMILIAR QUOTATIONS*. (Little, Brown & Co., 16th ed. 1992).

APPENDIX

Table 1
Violence Risk Assessment

<u>Clinical</u>	<u>Actuarial</u>
<ul style="list-style-type: none"> • Treatment • Process • Individual • Judgment 	<ul style="list-style-type: none"> • Prediction • Event • General • Probability

Table 2
Examples of Treatable and Modifiable Violence Risk Factors

- Psychosis (paranoid, command hallucinations)
- Bipolar Disorder
- Substance abuse
- Dementia
- Anxiety and depression
- Toxic/metabolic disorders
- Situation stressors
- Impulsive aggression
- Lethal weapons
- Fear