TARASOFF AT THIRTY: HOW DEVELOPMENTS IN SCIENCE AND POLICY SHAPE THE COMMON LAW

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> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.[1]

Much has changed in the thirty years since Justice Tobriner wrote these words. I will address two areas of change in this article: change in the science of violence risk assessment, and change in American mental health policy. I will argue that changes in these two areas impact the manner in which a therapist "pursuant to the standards of his [or her] profession should determine" the risk of violence, and the steps that he or she should take in the event that the level of assessed risk exceeds the threshold necessary to trigger "reasonable care to protect the intended victim."[2]

In 1976, when *Tarasoff* was decided, only two empirical studies existed on the validity of predictions of community violence among people with mental disorders.[3] The results of the studies were such that, in a review cited—dismissively—by the court in *Tarasoff*, I concluded that "[e]fforts to prophesy the perpetrators of violence appear to be doomed."[4] What a difference three decades make: the field of violence risk assessment has burgeoned and is now a vast and vibrant area of interdisciplinary scholarship.

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1. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976).

2. *Id.* For a discussion of what that threshold level of assessed risk is, *see* John Monahan & Eric Silver, *Judicial Decision Thresholds for Violence Risk Management*, 2 INT'L J. FORENSIC MENTAL HEALTH 1 (2003) (judges chose a 26% likelihood of committing a violent act as their threshold for the short-term civil commitment of a person with a mental disorder on the grounds of "danger to others.").

3. *See* Harry Kozol et al., *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQ. 371 (1972); Henry Steadman, *Implications from the Baxstrom Experience*, 1 BULL. AM. ACAD. PSYCHIATRY & L. 189 (1973).

4. John Monahan, *The Prevention of Violence, in* COMMUNITY MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM 13, 29 (John Monahan ed., 1976) (cited in *Tarasoff*, 551 P.2d at 344–45 n.10).

In addition, in 1976 a therapist was largely limited to three steps to discharge his or her "obligation to use reasonable care to protect the intended victim against . . . danger."[5] First, a therapist making a positive assessment of violence risk could attempt to reduce that risk by modifying the course of voluntary treatment. For example, the therapist could see the patient more frequently, or could change the content of the therapy (or the type of medication) to more directly address the issue of violence. Second, if the patient met the state's legal criteria for civil commitment, the therapist could attempt to incapacitate the patient by initiating involuntary mental hospitalization. Finally, either instead of or in addition to these two steps, the therapist could warn the intended victim of the patient's predicted violence to enable the intended victim to take precautions to protect him- or herself. Now, however, in many states there is a fourth option by which a therapist might be able to fulfill his or her *Tarasoff* duty: the therapist may be able to initiate involuntary treatment as an outpatient in the community, rather than, or in addition to, involuntary treatment as a hospital inpatient.

The implications of these developments in risk assessment research and in mental health policy for the "standards of the profession" by which violence risk assessments should be conducted and violence prevention should be undertaken in evidence-based practice are the topics that I consider here. In Part I, I analyze the growing body of empirical research supporting the proposition that in order to maximize validity, violence risk assessments must be either partially or completely *structured*. In Part II, I consider current developments in American mental health policy on outpatient commitment and its implications for violence prevention.

I. POST-*TARASOFF* DEVELOPMENTS IN THE SCIENCE OF VIOLENCE RISK ASSESSMENT

There are two basic approaches to assessing the risk of violence. One approach, called unstructured risk assessment, relies on the subjective judgment of people experienced at making predictive judgments, termed "experts." Typically, in the case of violence, such experts include psychologists, psychiatrists, and social workers. In unstructured risk assessment, risk factors are selected and measured based on the mental health professional's theoretical orientation and prior clinical experience. What these risk factors are, or how they are measured,

5. *See* John Monahan, *Limiting Therapist Exposure to* Tarasoff *Liability: Guidelines for Risk Containment*, 48 AM. PSYCHOL. 242, 245 (1993).

might vary from case to case, depending on which seem most relevant to the expert doing the assessment. At the conclusion of the assessment, risk factors are combined in an intuitive manner to generate an overall professional opinion about an individual's level of violence risk.[6]

The other approach, termed structured risk assessment,[7] relies less on subjective judgment and more on objective rules. Those rules specify in advance *at least* which risk factors are to be measured in making a prediction and how they are to be measured. In some forms of structured risk assessment, rules also govern how the measured risk factors are to be combined to yield an overall estimate of violence risk. In the most structured form of risk assessment, these actuarial estimates of the likelihood of violence are offered as the final products of the risk assessment process: they are meant to replace, and not to inform, professional judgment. I will first address unstructured violence risk assessment, and then consider three types of increasingly structured violence risk assessment.

A. Unstructured Violence Risk Assessment

Tarasoff is predicated on the assumption that mental health professionals can, "within the broad range of reasonable practice,"[8] distinguish between those people with mental disorders who are likely to be violent toward others and those who are not. The form of violence risk assessment at issue in *Tarasoff* was unstructured: as far as can be determined,[9] the clinicians who assessed Prosenjit Poddar, Tatiana Tarasoff's eventual killer, did not try to measure a pre-determined set of violence risk factors, nor, perforce, did they combine those risk factors in a rule-bound manner. Indeed, they could not have done so: no instruments for structuring violence risk assessments were available in 1976. Rather, Poddar's clinicians assessed whatever risk factors they believed to be most relevant to his particular case, and combined those

6. *Cf.* Drew Westen & Joel Weinberger, *When Clinical Description Becomes Statistical Prediction*, 59 AM. PSYCHOL. 595 (2004).

7. Also referred to as "structured professional judgment." *Cf.* Kevin Douglas et al., *Evaluation of a Model of Violence Risk Assessment Among Forensic Psychiatric Patients*, 54 PSYCHIATRIC SERVICES 1372 (2003).

8. *Tarasoff*, 551 P.2d at 345.

9. The published record states that Prosenjit Poddar was diagnosed by his psychologist, Dr. Lawrence Moore, as having a "paranoid schizophrenic reaction, acute and severe" and that Poddar "at times . . . appears to be quite rational, at other times he appears quite psychotic." A direct threat was no doubt the most salient risk factor in the case: "[A]t a psychotherapy session on August 18 [1969,] Poddar had informed Moore that he was going to kill 'an unnamed girl, readily identified as Tatiana Tarasoff, when she returned home to Berkeley from Brazil.'" Tarasoff v. Regents of the Univ. of Cal., 108 Cal. Rptr. 878, 880 (Cal. Ct. App. 1973), *vacated*, 551 P.2d 334 (Cal. 1976).

risk factors in a subjective manner to generate their clinical opinion about his violence risk.[10]

One early review of the research challenging the accuracy of unstructured predictions of violence such as that performed on Poddar—the review that the *Tarasoff* court had available to it—concluded that "[o]f those predicted to be dangerous, between 54 percent and 99 percent are false positives—people who will not, in fact, commit a violent act."[11]

Little has transpired in the intervening decades to increase confidence in the ability of mental health professionals, using their unstructured clinical judgment, to accurately assess violence risk.[12] Five studies of the validity of clinicians' unstructured predictions of violence in the community by people with mental disorder have been published since *Tarasoff* was decided.[13] In the first study, indicted felony defendants who had been found incompetent to stand trial due to mental illness received an unstructured violence risk assessment by two psychiatrists. The accuracy of the unstructured risk assessments were at chance levels: only 14% of the defendants assessed as dangerous were arrested for a violent offense during a three-year follow-up, compared to 16% of the defendants assessed as non-dangerous being arrested for violence.[14]

The second study was an analysis of unstructured violence risk assessments of mentally disordered offenders done in conjunction with discharging them from the hospital. The arrest rate for a violent crime over a three-year follow-up for those offenders recommended by the clinicians for discharge (i.e., those assessed as non-dangerous) was 31%, somewhat lower than the 41% rate for those predicted to be violent by the clinicians but discharged anyway by a judge.[15]

The third study followed a large group of mentally disordered offenders whom a court[16] had ordered discharged. All of these offenders

10. Ironically, Dr. Moore's unstructured risk assessment of Poddar was accurate. Moore concluded that Poddar was "at this point a danger to the welfare of other people," and sought to have him involuntarily committed. However, the police and Moore's psychiatric supervisor disagreed. Two months later, when Tarasoff returned home from Brazil, Poddar shot and stabbed her to death. *Id.*

11. Monahan, *supra* note 4, at 21.

12. *See* John Monahan, *The Scientific Status of Research on Clinical and Actuarial Predictions of Violence*, *in* 1 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 9-2.0 (David L. Faigman et al. eds., 2002).

13. The findings from these five studies are summarized in Table 1 in the Appendix.

14. Joseph Cocozza & Henry Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L.J. 1084 (1976).

15. Henry Steadman, *A New Look at Recidivism Among Patuxent Inmates*, 5 BULL. AM. ACAD. PSYCHIATRY & L. 200 (1977).

16. Dixon v. Att'y Gen. of Pa., 325 F. Supp. 966 (M.D. Pa. 1971).

had been hospitalized because clinicians had found them to be dangerous based on unstructured risk assessments. Yet a four-year follow-up found that only 14% of the predicted-violent patients later committed a violent act in the community.[17]

The fourth study examined risk assessments among defendants in Canada undergoing court-ordered pre-trial evaluations for competence to stand trial. The research concluded that 39% the defendants found through clinicians' unstructured risk assessment to have a "medium" or "high" likelihood of being violent to others committed a violent act during a two-year follow-up, compared to 26% of the defendants predicted to have a "low" likelihood of violence.[18]

In the most recent study, researchers took as their subjects male and female patients being examined in the acute psychiatric emergency room of a large civil hospital.[19] Psychiatrists and nurses were asked to assess the risk of patient violence to others over the next six-month period. Patients who elicited professional concern regarding future violence were moderately more likely to be violent after discharge (53%) than were patients who had not elicited such concern (36%). In other words, of the patients predicted to be violent by the clinicians, one-in-two later committed a violent act, while of the patients predicted to be safe by the clinicians, one-in-three later committed a violent act. The accuracy of predicting violence was statistically significant for male patients, but not for female patients.[20]

Overall, as Douglas Mossman has stated, the research supports the conclusion that "clinicians are able to distinguish violent from nonviolent patients with a modest, better-than-chance level of accuracy."[21] Despite the existence of only "modest" empirical support, courts repeatedly have held that clinical predictions of violence are

17. TERRANCE THORNBERRY & JOSEPH JACOBY, THE CRIMINALLY INSANE: A COMMUNITY FOLLOW-UP OF MENTALLY ILL OFFENDERS (1979).

18. Diana Sepejak et al., *Clinical Predictions of Dangerousness: Two Year Follow-up of 408 Pre-Trial Forensic Cases*, 11 BULL. AM. ACAD. PSYCHIATRY & L. 171 (1983).

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

20. *See also* Pamela Robbins et al., *Mental Disorder and Violence: The Moderating Role of Gender*, 27 L. & HUM. BEHAV. 561 (2003).

21. Douglas Mossman, *Assessing Predictions of Violence: Being Accurate About Accuracy*, 62 J. CONSULTING & CLINICAL PSYCHOL. 783, 790 (1994). *See also* Douglas Mossman, *Further Comments on Portraying the Accuracy of Violence Predictions*, 18 L. & HUM. BEHAV. 587 (1994); Douglas Mossman, *Dangerous Decisions: An Essay on the Mathematics of Clinical Violence Prediction and Involuntary hospitalization*, 2 U. CHI. L. SCH. ROUNDTABLE 95 (1995); Douglas Mossman, *Commentary: Assessing the Risk of Violence—Are "Accurate" Predictions Useful?*, 28 J. AM. ACAD. PSYCHIATRY & L. 272 (2000).

sufficiently valid to be admissible as scientific evidence.[22] In recent years, however, the lack of strong empirical support for the validity of unstructured violence risk assessment has motivated clinical researchers to explore an alternative form of risk assessment, one that disaggregates the process of violence risk assessment into its three component parts, and structures one or more those components. Courts[23] as well as legislatures[24] have become remarkably receptive to the introduction of structured risk assessment tools in evidence.

22. *See* 1 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 9-1.0 at 411 (David L. Faigman et al. eds., 2002); John Monahan, *Violence Risk Assessment: Scientific Validity and Evidentiary Admissibility*, 57 WASH. & LEE L. REV. 901, 915–16 (2000). *But see* Erica Beecher-Monas & Edgar Garcia-Rill, *Danger at the Edge of Chaos: Predicting Violent Behavior in a Post-Daubert World*, 24 CARDOZO L. REV. 1845 (2003).

23. Courts are increasingly approving of the use of structured risk assessment instruments when a statute calls for an assessment of violence risk. *See* United States v. Barnette, 211 F.3d 803, 815 (4th Cir. 2000) (Psychopathy Checklist Revised [PCL-R] admissible); Lee v. State, 854 So.2d 709, 711–12 (Fla. Dist. Ct. App. 2003) (Rapid Risk Assessment for Sex Offense Recidivism [RRASOR], Minnesota Sex Offender Screening Tool–Revised [MnSOST–R], PCL-R, Sex Offender Risk Appraisal Guide [SORAG], and Violence Risk Appraisal Guide [VRAG] admissible); *In re* Detention of Walker, 731 N.E.2d 994, 996–98 (Ill. App. Ct. 2000) (RRASOR and PCL-R admissible); State v. Holtz, 653 N.W.2d 613, 616–19 (Iowa Ct. App. 2002) (RRASOR, Static-99, and MnSOST-R admissible); Goddard v. State, 144 S.W.3d 848, 850–53 (Mo. Ct. App. 2004) (Static-99 and MnSOST-R admissible); *In re* Commitment of R.S., 773 A.2d 72, 77, 88 (N.J. Super. Ct. App. Div. 2001) (RRASOR, MnSOST-R, California Actuarial Risk Assessment Tables [CARAT], and Registrant Risk Assessment Scale [RRAS] admissible); Muhammad v. State, 46 S.W.3d 493, 507 (Tex. Crim. App. 2001) (PCL-R admissible); Commonwealth v. Allen, 609 S.E.2d 4, 10–12 (Va. 2005) (RRASOR and Static-99 admissible); State v. Strauss, 20 P.3d 1022, 1027 (Wash. Ct. App. 2001) (MnSOST-R, RRASOR, and VRAG admissible); State v. Kienitz, 597 N.W.2d 712, 715, 718 (Wis. 1999) (VRAG admissible); *see also* David Faigman & John Monahan, *Psychological Evidence at the Dawn of the Law's Scientific Age*, 56 ANN. REV. PSYCHOL. 631 (2005); Bernard E. Harcourt, *From the Ne'er-Do-Well to the Criminal History Category: The Refinement of the Actuarial Model in Criminal Law*, 66 L. & CONTEMP. PROBS. 99 (2003); Eric S. Janus & Robert A. Prentky, *Forensic Use of Actuarial Risk Assessment with Sex Offenders: Accuracy, Admissibility and Accountability*, 40 AM. CRIM. L. REV. 1443 (2003).

24. Virginia became the sixteenth state to enact a sexually violent predator statute, and the first state to incorporate structured risk assessment in a sexually violent predator statute, in April of 2003. 2003 Va. Acts 989. The statute directs the Department of Corrections to identify 10 months before their release all prisoners incarcerated for sexually violent offenses "who receive a score of four or more on the Rapid Risk Assessment for Sexual Offender Recidivism or a like score on a comparable, scientifically validated instrument as designated by the Commissioner." VA. CODE. ANN. § 37.1-70.4(C) (2003). The Rapid Risk Assessment of Sexual Offender Recidivism (RRASOR) is an actuarial instrument consisting of four items: (1) number of prior sex offense convictions or charges (from 1 to 6 or more), (2) age at release (25 or more versus less than 25), (3) victim gender (only females versus any males) and (4) relationship to victim (only related versus any non-related). The latter items within the parentheses are scored higher than the former. A total score of 4 or more on the RRASOR corresponds to a 10-year recidivism rate of 55%. R. KARL HANSON, THE DEVELOPMENT OF A BRIEF ACTUARIAL SCALE FOR SEXUAL OFFENSE RECIDIVISM (1997); *see also* R. Karl Hanson & M.T. Bussière, *Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies*, 66 J. CONSULTING & CLINICAL PSYCHOL. 348 (1998).

B. Structured Violence Risk Assessment

Violence risk assessment might usefully be seen as having three components. In the first component—*selecting and measuring risk factors*—the person performing the assessment decides which risk factors to measure and how to measure them. In unstructured risk assessment, as described above, risk factors are selected and measured based on the mental health professional's theoretical orientation and prior clinical experience, and may vary from case to case, as theory or experience dictate. In contrast, in all forms of structured risk assessment, decisions about which risk factors to measure, and how to measure them, are made in advance, before the risk assessment begins. Explicit rules specify the risk factors' definition and quantification.[25] In structured risk assessment, the mental health professional performing the assessment has no discretion regarding the selection or measurement of risk factors: these decisions are "structured" for him or her in advance by a risk assessment "tool."

The second component of violence risk assessment—*combining risk factors to reach an overall estimate of risk*—involves taking the person's individually-measured risk factors (i.e., his or her "scores" on each of the risk factors), and assembling these risk factors into a single overarching estimate of violence risk. In unstructured risk assessment, as described above, risk factors are assembled in an intuitive manner to generate a clinical opinion about violence risk. In some (but not all) forms of structured risk assessment, risk factors are assembled into an overall estimate of risk by means of a mathematical process specified in advance. That process is usually as simple as adding the scores of the individual risk factors together to yield a total score, but it can involve more complex statistical procedures as well.

In the final component of violence risk assessment—*clinical review of the structured risk estimate*—the mental health professional responsible for the assessment reviews the likelihood of violence produced by the first two components of the risk assessment process in the context of additional information gathered from clinical interviews, significant others, available records, or some combination thereof, and issues his or her final estimate of risk. This final risk estimate offered by the clinician may differ from the risk estimate produced by the first two (structured) components of the risk assessment process. As we shall see, some forms of structured risk assessment allow for this clinical

25. As will be seen, *infra*, either the exact same risk factors can be assessed for all persons being evaluated, or a conditional process can be specified concerning which risk factor is to be assessed next, given a person's score on the previous risk factor.

review, and others preclude it. To illustrate these components of structured risk assessment, I will briefly describe three recently available instruments that partially or fully structure the risk assessment process.

1. The HCR-20

The "HCR-20," first published in 1995 and revised in 1997, consists of a series of ratings addressing *H*istorical, *C*linical, and *R*isk Management factors.[26] In one study, the HCR-20 was completed for civilly committed patients who were followed for approximately two years after discharge into the community. When the scores were divided into five categories, 11% of the patients scoring in the lowest category were found to have committed or threatened a physically violent act, compared to 40% of the patients in the middle category, and 75% of the patients in the highest category.[27]

i. Selecting and Measuring Risk Factors

The 20 factors on this structured risk assessment tool were not derived from a specific empirical research project. Rather, they represent the authors' judgment of which risk factors have emerged most strongly across many empirical studies of violence risk. The ten Historical items on the HCR-20 are (1) previous violence, (2) young age at first violent incident, (3) relationship instability, (4) employment problems, (5) substance use problems, (6) major mental illness, (7) psychopathy, (8) early maladjustment, (9) personality disorder, and (10) prior supervision failure. The five Clinical items are (11) lack of insight, (12) negative attitudes, (13) active symptoms of major mental illness, (14) impulsivity, and (15) unresponsive to treatment. The five Risk Management items are (16) plans lack feasibility, (17) exposure to destabilizers, (18) lack of personal support, (19) noncompliance with remediation attempts, and (20) stress.

Each of the 20 items is measured on a three-point scale, according to the certainty that the risk factor is present: "0" = No—the item is

26. *See* CHRISTOPHER WEBSTER ET AL., HCR-20: ASSESSING RISK FOR VIOLENCE (2d ed. 1997).

27. Kevin Douglas et al., *Assessing Risk for Violence Among Psychiatric Patients: The HCR-20 Violence Risk Assessment Scheme and the Psychopathy Checklist: Screening Version*, 67 J. CONSULTING & CLINICAL PSYCHOL. 917, 925 (1999); *see also* Nicola S. Gray et al., *Prediction of Violence and Self-Harm in Mentally Disordered Offenders: A Prospective Study of the Efficacy of the HCR-20, PCL-R, and Psychiatric Symptomatology*, 71 J. CONSULTING & CLINICAL PSYCHOL. 443 (2003). The most technically appropriate statistic for expressing the accuracy of a violence risk assessment procedure is the Area Under the Curve (AUC) in a Receiver Operating Characteristic (ROC) analysis. *See* Mossman, *supra* note 21, for a thorough description of this technique.

definitely absent or does not apply; "1" = Maybe—the item is possibly present, or is present only to a limited extent; and "2" = Yes—the item definitely is present.

ii. Combining Risk Factors to Reach an Overall Estimate of Risk

The HCR-20 structures the process of selecting and measuring risk factors, but for clinical purposes, it does not structure the process of combining risk factors to reach an overall estimate of risk. As stated in the professional manual for the HCR-20:

> It is not possible to specify a method for reaching a summary or final decision that is appropriate for all situations. For research purposes, it is possible to treat the HCR-20 as an actuarial scale and simply sum the numeric item codes. . .For clinical purposes, it makes little sense to sum the number of risk factors present in a given case, and then use fixed, arbitrary cutoffs to classify the individual as low, moderate, or high risk. As pointed out by others . . . it is both possible and reasonable for an assessor to conclude that an assessee is at high risk for violence based on the presence of a single risk factor—if, for example, that risk factor is 'Active Symptoms of Major Mental Illness' and reflects the assessee's stated intent to commit a homicide, or to act upon the basis of current sexually sadistic fantasies . . . . In sum, at present it may be neither possible nor desirable to develop cutoff scores for the determination of summary or final risk judgments in clinical settings.[28]

iii. Clinical Review of the Structured Risk Estimate

Since for clinical purposes the HCR-20 does not structure the process of combining risk factors to reach an overall estimate of risk, but rather allows the clinician to combine the 20 measured risk factors in an intuitive manner[29] to yield an overall estimate of risk, there is no need for a "clinical review" of a structured risk estimate.

28. WEBSTER ET AL., *supra* note 26, at 21–23.

29. Regarding combining risk factors to reach an overall assessment of risk, the authors of the HCR-20 suggest that, even for clinical purposes, "it is reasonable for assessors to conclude that the more risk factors present in a given case, the higher the risk of violence. Even here, though, assessors must be cautious. The relation between the number of risk factors present and risk for violence is probably distinctly nonlinear; risk likely depends on the specific combination, not just the number, of risk factors present." *Id*. at 22–23.

2. Violence Risk Appraisal Guide

The Violence Risk Appraisal Guide[30] (VRAG), first published in 1993, consists of twelve risk factors designed to predict violence in mentally ill offenders. In a recent prospective study with 467 male forensic patients, the VRAG showed impressive predictive validity. Patients were placed into one of nine categories of violence risk: 11% of the patients who scored in category 1 on the VRAG were later found to commit a new violent act, compared with 42% of the patients in category 5, and 100% of the patients in category 9.[31]

i. Selecting and Measuring Risk Factors

The VRAG was developed from a sample of over 600 men from a maximum-security hospital in Canada. All had been charged with serious criminal offenses. Approximately fifty predictor variables were coded from institutional files. The criteria used to develop the instrument were any new criminal charge for a violent offense, or return to the institution for an act that otherwise would have resulted in a criminal charge for a violent offense, over an average time at risk in the community of approximately seven years after discharge. A series of analyses identified twelve variables for inclusion in the instrument.[32] The variables were (1) score on the Psychopathy Checklist, (2) separation from parents under age 16, (3) victim injury in index offense, (4) diagnosis of schizophrenia, (5) never married, (6) elementary school maladjustment, (7) female victim-index, (8) failure on prior conditional release, (9) property offense history, (10) age at index offense, (11) alcohol abuse history, and (12) diagnosis of personality disorder.[33]

30. Grant T. Harris et al., *Violent Recidivism of Mentally Disordered Offenders: The Development of a Statistical Prediction Instrument*, 20 CRIM. JUST. & BEHAV. 315, 317 (1993); VERNON QUINSEY ET AL., VIOLENT OFFENDERS: APPRAISING AND MANAGING RISK (2d ed. 2006). For updates on studies using the VRAG, see http://www.mhcp-research.com/ragreps.htm (last visited Jan. 9, 2006).

31. Grant T. Harris et al., *Prospective Replication of the* Violence Risk Appraisal Guide *in Predicting Violent Recidivism Among Forensic Patients*, 26 L. & HUM. BEHAV. 377, 385 (2002).

32. Harris, *supra* note 30, at 323.

33. *Id*. at 324. For all variables except numbers 3, 4, 7, and 10 the nature of the relationship to subsequent violence was positive (that is to say, subjects who injured a victim in the index offense, who were diagnosed as schizophrenic, who chose a female victim for the index offense, or who were older, were significantly *less* likely to be violent recidivists than other subjects.).

ii. Combining Risk Factors to Reach an Overall Estimate of Risk

Each of the twelve risk factors measured by the VRAG are statistically weighted, and the weighted scores are added together to yield an overall estimate of violence risk.

iii. Clinical Review of the Structured Risk Estimate

Importantly, the authors of the VRAG do not allow for any clinical review of the structured risk estimate that this instrument produces:

> What we are advising is not the addition of actuarial methods to existing practice, but rather the replacement of existing practice with actuarial methods. This is a different view than we expressed a decade ago, when we advised the practice of adjusting actuarial estimates of risk by up to 10% when there were compelling circumstances to do so. . . . We no longer think this practice is justifiable: Actuarial methods are too good and clinical judgment is too poor to risk contaminating the former with the latter.[34]

3. The Classification of Violent Risk

The first violence risk assessment software, called the Classification of Violence Risk (COVR™) was published in 2005. COVR is an interactive software program designed to estimate the risk that an acute psychiatric patient will be violent to others over the next several months. Using a laptop or desktop computer, COVR guides the evaluator through a brief chart review and a 10-minute interview with the patient. COVR generates a report that places the patient's violence risk into one of five categories—ranging from a 1% likelihood of violence in the first category to a 76% likelihood of violence in the highest category—including the confidence interval for the given risk estimate.[35]

34. VERNON QUINSEY ET AL., VIOLENT OFFENDERS: APPRAISING AND MANAGING RISK 197 (2d ed. 2006). For a discussion of adjusting actuarial elements of risk, *see* CHRISTOPHER WEBSTER ET AL., THE VIOLENCE PREDICTION SCHEME: ASSESSING DANGEROUSNESS IN HIGH RISK MEN (1994).

35. JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE (2001). More specifically, the rates of violence in the community during the 20 weeks following discharge for each of the five risk categories were 1%, 8%, 26%, 56%, and 76%, respectively. Many more patients were in the lower than in the higher risk categories. For example, 37% of all patients were in the lowest risk category (that is, the category in which 1% of the patients were later violent), and only 7% in the highest risk category (that is, the category in which 76% of the patients were later violent). *Id*. In addition, the newly developed software was administered to independent samples of acute civil inpatients at two sites. Patients classified by the software as high or low risk of violence were followed in the community for 20 weeks after discharge. Expected rates of violence in the low and high risk groups were 1% and 64%, respectively. Observed rates of violence in

i. Selecting and Measuring Risk Factors

This software was constructed from data generated in the MacArthur Violence Risk Assessment Study.[36] In this research, over 1,000 patients in acute civil psychiatric facilities were assessed on a 134 potential risk factors for violent behavior. Patients were followed for 20 weeks[37] in the community after discharge from the hospital, and their violence to others was assessed.[38] The software is capable of assessing those forty risk factors[39] for violence that emerged as most predictive of violence in the original research, but in any given case assesses only those risk factors necessary to classify the patient's violence risk. Among the risk factors assessed most frequently by the COVR are the seriousness and frequency of prior arrests, young age, male gender, being unemployed, the seriousness and frequency of having been abused as a child, a diagnosis of antisocial personality disorder, the lack of a diagnosis of schizophrenia,[40] whether the individual's father used drugs or left the home before the individual was 15 years old, substance abuse, lack of anger control, violent fantasies, loss of consciousness, and involuntary legal status.

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the low and high risk groups were 9% and 35%, respectively, when a strict definition of violence was used, and 9% and 49%, respectively, when a slightly more inclusive definition of violence was used. John Monahan et al., *An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders*, 56 PSYCHIATRIC SERVICES 810 (2005). Note that the author of this article is one of the owners of COVR™.

36. Regarding the MacArthur Violence Risk Assessment Study, which produced the data from which the Classification of Violence Risk software was ultimately developed, *see* Paul S. Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. PSYCHIATRY 566 (2000); Steven Banks et al., *A Multiple-Models Approach to Violence Risk Assessment Among People with Mental Disorder*, 31 CRIM. JUST. & BEHAV. 324 (2004); Thomas Grisso et al., *Violent Thoughts and Violent Behavior Following Hospitalization for Mental Disorder*, 68 J. CONSULTING & CLINICAL PSYCHOL. 388 (2000); John Monahan et al., *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. PSYCHIATRY 312 (2000); Eric Silver et al., *Assessing Violence Risk Among Discharged Psychiatric Patients: Toward an Ecological Approach*, 23 L. & HUM. BEHAV. 235 (1999); Henry Steadman et al., *A Classification Tree Approach to the Development of Actuarial Violence Risk Assessment Tools*, 24 L. & HUM. BEHAV. 83 (2000).

37. *See* MONAHAN ET AL., *supra* note 35 ("We look at the 20 week period immediately after discharge because this represents both the time period during which the patients appear to be at highest risk for violence and clinicians or a mental health system might reasonably take steps to reduce the likelihood of violence after discharge.") *Id.* at 35.

38. Measures of violence to others included official police and hospital records, patient self-report (under a Federal Confidentiality Certificate), and the report of a collateral (most often, a family member) who knew the patient best in the community.

39. Listed in MONAHAN, *supra* note 37, at Table 6.3.

40. Note that a diagnosis of schizophrenia was associated with a *lower* risk of violence than other diagnoses (primarily depression and personality disorder).

ii. Combining Risk Factors to Reach an Overall Estimate of Risk

To combine risk factors into an overall estimate of risk, the COVR relies on "classification tree" methodology. This approach allows many different combinations of risk factors to classify a person as high or low risk. Based on a sequence established by the classification tree, a first question is asked of all persons being assessed. Contingent on the answer to that question, one or another second question is posed, and so on. The classification tree process is repeated until each person is classified into a final risk category.[41]

iii. Clinical Review of the Structured Risk Estimate

In the view of its authors, the COVR software is useful for informing, but not replacing, clinical decision making regarding risk assessment. The authors recommend a two-phased violence risk assessment procedure in which a patient is first administered the COVR, and then the risk estimate generated by the COVR is reviewed by the clinician ultimately responsible for making the risk assessment in the context of additional information believed to be relevant and gathered from clinical interviews, significant others, and/or available records. Although clinical review would not revise or "adjust" the structured risk estimate produced by the COVR, and could in principle either improve or lessen predictive accuracy as compared to relying solely on an unreviewed COVR score, the authors of the COVR believed it essential to allow for such a review, both because of possible limits on the generalizeability of the validity of the software[42] and because of the possible presence of rare risk or protective factors.[43]

41. This "interaction" contrasts with the more typical "main effects" approach to structured risk assessment, such as used by the VRAG (see above), in which a common set of questions is asked of everyone being assessed and every answer is weighted and summed to produce a score that can be used for purposes of obtaining an overall estimate of risk.

42. For example, is the predictive validity of the COVR generalizable to people of Native Americans, or to forensic patients, or to people outside the United States, or to people who are less than 18 years old, or to the emergency room assessments of persons who have not recently been hospitalized? The predictive validity of this instrument may well generalize widely. Yet there comes a point at which the sample to which a structured risk assessment instrument is applied differs so much from the sample on which the instrument was constructed and validated that one would be hard pressed to castigate the evaluator who took the structured risk estimate as advisory rather than conclusive.

43. The second reason given in defense of allowing a clinician the option to review structured risk estimates is that the clinician may note the presence of rare risk or protective factors in a given case, and that these factors—precisely because they are rare—will not have been taken into account in the construction of the structured instrument. In the context of structured instruments for assessing violence risk, the most frequently mentioned rare risk factor is a direct threat, that is, an apparently serious statement of intention to do violence to a named victim (as happened in the *Tarasoff* case. *See supra*

Summary. In unstructured risk assessment, neither the selection nor the measurement of the risk factors used in the assessment is specified in advance. Therefore, there are no risk factor "scores" that can be combined to yield a quantitative estimate of risk, and so no need for a clinical review of such an estimate. The three forms of structured risk assessment described above all specify in advance *at least* which risk factors are to be addressed and how those risk factors are to be measured. The HCR-20 structures *only* the choice and measurement of risk factors. The COVR goes on to *also* structure the manner in which the risk factors are combined to yield an overall estimate of risk. But the COVR allows the clinician to review this structured estimate in the context of other (unstructured) information available to the clinician. The VRAG, in contrast, is what might be called a *completely structured* (i.e., actuarial) risk assessment tool. No clinical review is allowed: the structured risk estimate that is available when the risk factors are combined is the final product of the risk assessment process.[44]

The forms of risk assessment described above are summarized in Table 2 in the Appendix. While the three specific structured risk assessment tools considered here are the most frequently discussed in the literature, it should be emphasized that they are merely illustrative of a larger group of instruments that—like the HCR-20—structure only the choice and measurement of risk factors,[45] or—like the COVR—also structure the manner in which the risk factors are combined to yield an overall estimate of risk, but allow the clinician to review this structured estimate in the context of other available information,[46] or—like the VRAG—stipulate that the structured risk estimate that is available when the risk factors are combined is the final product of the risk assessment process.[47]

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notes 9–10.).

44. I described the use of these three instruments in the manner that their creators recommend that they be used. There is, however, nothing inherent in the instruments themselves that dictates only such "recommended" uses. For example, there is nothing to stop a clinician from combining risk factors on the HCR-20 by adding them together in an actuarial manner, or from clinically reviewing the risk estimate produced by the VRAG, or from failing to clinically review the risk estimate produced by the COVR. In each circumstance, however, the clinician who testified to so doing would likely be asked on cross-examination to defend why he or she behaved contrary to the recommendations of the authors of the very instrument that he or she chose to assess risk.

45. *See* P. Randall Kropp & Stephen Hart, *The Spousal Assault Risk Assessment (SARA) Guide: Reliability and Validity in Adult Male Offenders*, 24 L. & HUM. BEHAV. 101 (2000).

46. *See* R. KARL HANSON, THE DEVELOPMENT OF A BRIEF ACTUARIAL SCALE FOR SEXUAL OFFENSE RECIDIVISM (1997).

47. *See* Grant T. Harris et al., *A Multi-Site Comparison of Actuarial Risk Instruments for Sex Offenders*, 15 PSYCHOL. ASSESSMENT 413 (2003).

If structured violence risk assessment is superior to unstructured violence risk assessment, which specific form of structured risk assessment has the highest predictive validity? Should the clinician structure only one component of the risk assessment process (as the HCR-20 does), two components (as the COVR does), or all three components (as the VRAG does)? On this issue, perhaps because some of these tools are so new, there are many strong opinions, but no "widespread acceptance"[48] of a single view among either researchers or practitioners.

C. The Use of Structured Violence Risk Assessment in Clinical Practice

The post-*Tarasoff* scientific literature is clear that structured risk assessment is superior to unstructured risk assessment in accurately predicting violent behavior. But are mental health professionals heeding the research and using structured risk assessments when assessing violence risk? [49] The literature on the incorporation of structured risk assessment into the clinical practice of predicting violence is thin, but all of it suggests that only a minority of mental health professionals routinely employ structured risk assessment.

Elbogen[50] surveyed 134 mental health professionals and paraprofessionals in Nebraska and asked about the relevance to violence risk assessment of a large number of risk factors. Some of the risk factors were ones found on structured risk assessment instruments such as the VRAG, the HCR-20, and the COVR.[51] Others were not research-

48. Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579 (1993).

. 49. It would be a waste of resources, in my view, to require that every civil patient be administered a structured violence risk assessment tool (although the routine use of structured risk assessment with forensic cases may indeed be appropriate). The great majority of civil patients pose no undue risk of violence. Rather, I believe that all civil patients should be *screened* for violence risk, and only those who score positively on the screen should proceed to a formal structured violence risk assessment. Brief illustrative screening questions would be:

1. Did a violent act or the threat of a violent act precipitate or recently precede the patient's current treatment?

2. Did the patient act violently or threaten to act violently during the current treatment?

3. [If no to both of the above] Does the patient have a documented history of violent acts or threats of violent acts, even though neither has occurred recently?

Answering these questions satisfactorily may require directly questioning the patient and relevant others and obtain reasonably available records of recent prior treatment, as well as carefully reviewing current treatment records. *See* Monahan, *supra* note 5.

50. Eric Elbogen et al., *Perceived Relevance of Factors for Violence Risk Assessment: A Survey of Clinicians*, 1 INT'L J. FORENSIC MENTAL HEALTH 37 (2002).

51. Some of the risk factors studied here were taken from the MacArthur Violence Risk

based, but rather were "behavioral" variables obtained from interviews with clinicians that "involved observable, on-[hospital]-unit behaviors,"[52] such as "impulsive behavior while in care."

> [R]esults show that nearly every clinician perceived dynamic, behavioral variables to be significantly more relevant than research-based factors. . .. Behavioral risk factors were perceived as more relevant than research risk factors from the HCR-20 and the VRAG, and from three of the four domains of the MacArthur Risk Assessment Study.
>
> . . . .
>
> [T]he findings suggest that efforts are needed to disseminate risk assessment research to clinical practice. . .. Results would seem to indicate, though, that clinicians may not be aware of this research.[53]

Tolman and Mullendore[54] surveyed 93 general practitioners of clinical psychology and 71 diplomates of the American Board of Forensic Psychology from Michigan regarding instruments used in conducting violence risk assessments. Forty percent of both groups had performed risk assessments for *Tarasoff* purposes in the past. Tolman and Mullendore found that the VRAG was used in making violence risk assessments by 27% of the diplomates and by 9% of the general practitioners, and the HCR-20 was used by 31% of the diplomates and 2% of the general practitioners. [55] For diplomates, the VRAG and the HCR-20 were among the top five instruments used to assess violence risk, whereas for the general practitioners these structured risk assessment instruments were not among the top five instruments used. Rather, general practitioners tended to rely on all-purpose instruments whose relationship to violence risk is either unsubstantiated, such as the Minnesota Multiphasic Personality Inventory (2D) (MMPI-2),[56] or

Assessment Study, from which the Classification of Violence Risk (COVR) was ultimately derived.

52. Elbogen et al., *supra* note 50, at 39.

53. *Id.* at 43–44 (emphasis removed from original). *See also* Eric Elbogen et al., *Clinical Decision Making About Psychopathy and Violence Risk Assessment in Pubic Sector Mental Health Settings*, 2 PSYCHOL. SERVICES,133, 138 (2005) ("[T]he findings suggest that clinicians in public sector mental health settings may rely on readily available clinical information but at the same time discount less readily available historical and testing information, even though the latter variables have been shown to be most predictive of violence.").

54. Anton Tolman & Kristine Mullendore, *Risk Evaluations for the Courts: Is Service Quality a Function of Specialization?*, 34 PROF. PSYCHOL.: RES. & PRAC. 225 (2003).

55. While the Classification of Violence Risk (COVR) had not been released at the time of this survey, the authors note that when they asked respondents for the "top three" scientific publications on violence risk, "The most frequently cited research by the diplomats was the influential MacArthur Risk for Violence Study . . . ." *Id*. at 229. However, only 11% of general practitioners could provide even one reference to the scientific literature on risk assessment "suggesting that they were largely unfamiliar with this field." *Id.* at 230.

56. For a description of the MMPI-2, s*ee* GARY MELTON ET AL., PSYCHOLOGICAL EVALUATIONS

proven to be invalid, such as the Rorschach.[57]

> [T]he current results indicated . . . that clinicians were interpreting the assessment of dangerousness as a task based solely on well-known diagnostic instruments and methods such as the *DSM-IV*, *MMPI-2*, and clinical interview. . . . [T]his approach to risk evaluation is clearly ignorant of the specialized body of knowledge that has accrued in the past [two] decades and is characteristic of the "unstructured clinical approach" to evaluation that has been criticized repeatedly as a method of insufficient reliability and validity for making important judgments.[58]

Finally, Lally[59] surveyed a national sample of 64 diplomates from the American Board of Forensic Psychology regarding the use of various procedures for assessing violence risk, as well as for several other forensic issues. The VRAG was rated as "Acceptable"—but not as "Recommended"—by more than half of the respondents. The HCR-20 was rated by the majority as somewhere between "Acceptable" and "No Opinion."

I arrive, then, at two conclusions: (1) structured violence risk assessment—of whatever form—is demonstrably superior to unstructured violence risk assessment, and (2) at the current time, only a minority—perhaps only a small minority—of practicing mental health professionals employ structured violence risk assessment when predicting violence. What implications do these two conclusions have for the imposition of *Tarasoff* liability? In most American jurisdictions, the answer seems clear: the second conclusion trumps the first one.

D. The Law of Professional Malpractice

As any student of American tort law knows, in most negligence actions, the defendant's compliance with "industry customs" is one—but only one—factor for the jury to consider when determining liability. "While evidence of applicable customs is admissible, the jury is free to demand more precautions than industry norms require."[60]

FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 45 (2d ed., 1997).

57. Scott Lilienfeld et al., *The Scientific Status of Projective Techniques*, 2 PSYCHOL. SCI. PUB. INT. 27 (2000).

58. Tolman & Mullendore, *supra* note 54, at 230. Criticism of the "'unstructured clinical approach' to evaluation" can be found in W. Grove & Paul Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y & LAW 293 (1996).

59. Stephen Lally, *What Tests are Acceptable for Use in Forensic Evaluations? A Survey of Experts*, 34 PROF. PSYCHOL.: RES. & PRAC. 491 (2003).

60. Philip Peters, *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 917

> Since the late nineteenth century, however, courts have treated physicians [and other health professionals] quite differently. Medical customs are not merely admissible, they define the physician's legal standard of care. In the words of Dean Prosser, the custom-based standard of care 'gives the medical profession. . .the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices.'[61]

In most states, therefore, proving the standard of care means proving only what physicians and other mental health professionals[62] "customarily do under similar circumstances."[63] From the limited amount of research cited above, it seems clear that what mental health professionals do *not* do when they predict violence is rely on any form of structured violence risk assessment. In these states, until it becomes the "custom" of mental health professionals to use structured violence risk assessment, structured violence risk assessment will not be the standard of care against which *Tarasoff* liability is measured.

This situation may be changing, however. Professor Philip Peters argues that "tort law's deference to medical customs is a quaint relic of a simpler time."[64] He notes that a growing minority of states have abandoned the custom-based standard of care. These states "use a reasonable physician standard that assigns the task of standard-setting to the jury rather than to the medical profession."[65] This "reasonable mental health professional" standard of care "provides more protection for innovators and less shelter for those adhering to antiquated customs."[66] In my view, more *Tarasoff* protection for clinical "innovators" who use evidence-based structured violence risk assessment, and less protection for clinicians adhering to the "antiquated custom" of using unstructured risk assessment, is exactly what the future should portend for *Tarasoff* liability.

(2002).

61. *Id.* at 913 (quoting W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 32 (5th ed., 1984)). *See also* William Meadow & Cass Sunstein, *Statistics, Not Experts*, 51 DUKE L.J. 629 (2001).

62. Note that the *Tarasoff* court explicitly joined physicians and other mental health professionals in its ruling: "The role of the psychiatrist, who is indeed a practitioner of medicine, and that of the psychologist who performs an allied function, are like that of the physician who must conform to the standards of the profession." Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976). Subsequently, the decision simply refers to "therapists" or "psychotherapists."

63. Philip Peters, *Empirical Evidence and Malpractice Litigation*, 37 WAKE FOREST L. REV. 757, 758 (2002).

64. Peters, *supra* note 60, at 911. *See also* Philip Peters, *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163 (2000).

65. Peters, *supra* note 63, at 758.

66. Peters, *supra* note 60, at 967.

II. POST-*TARASOFF* DEVELOPMENTS IN MENTAL HEALTH POLICY

Around the time that *Tarasoff* was decided, civil involuntary mental health treatment in the United States was for all intents and purposes carried out in one location: the public mental hospital. This soon changed. "Between 1970 and 1986, the number of inpatient beds in State and county institutions declined from 413,000 to 119,000, and in the 1990s fell well below 100,000. Length-of-stays dropped correspondingly."[67] With the reduction in involuntary *inpatient* treatment, however, came the introduction of involuntary *outpatient* treatment. Mandating adherence to mental health treatment in the community through outpatient commitment has become the most contested issue in mental health law.[68] Although 42 U.S. jurisdictions have statutes that nominally authorize outpatient commitment, until recently few states made substantial use of these laws.[69]

With the 1999 enactment in New York State of "Kendra's Law," however, nationwide interest in outpatient commitment has greatly increased. The law was named in memory of Kendra Webdale, a young woman who died in 1999 after being pushed in front of a New York City subway by a man with a history of mental illness. Kendra's Law mandates adherence to outpatient mental health treatment for a person who meets a number of statutory qualifications, including suffering from

67. Gerald N. Grob, *Deinstitutionalization: The Illusion of Policy*, 9 J. POL'Y HIST. 48 (1997).

68. Outpatient commitment can best be understood in the context of a broad movement to apply whatever "leverage" is available to induce people with serious mental disorder to become engaged in treatment. People with mental disorder are often dependent upon goods and services provided by social welfare agencies, including disability benefits and housing. Their access to these goods and services is often tied to treatment participation. Similarly, people with mental disorder are frequently arrested for criminal offenses. Lenient disposition of their cases may be tied to treatment participation. In each of these contexts, the targeted patients face loss of a valued interest if they fail to comply with prescribed treatment. *See* John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 1198 (2001); John Monahan et al., *Mandated Treatment in the Community for People with Mental Disorders*, 22 HEALTH AFF. 28 (2003); Richard J. Bonnie & John Monahan, *From Coercion to Contract: Reframing the Debate on Mandated Community Treatment for People with Mental Disorders*, 29 L. & HUM. BEHAV. 485 (2005); Jeffrey Swanson et al., *Violence and Leveraged Community Treatment for Persons with Mental Disorder*, AM. J. PSYCHIATRY (forthcoming).

69. There are three types of outpatient commitment. The first is a variant of conditional release from a hospital: a patient is discharged on the condition that he or she continues treatment in the community. The second type is an alternative to hospitalization for people who meet the legal criteria for inpatient treatment: they are essentially given the choice between receiving treatment in the community and receiving treatment in the hospital. The third type of outpatient commitment is preventive: people who do not currently meet the legal criteria for inpatient hospitalization but who are believed to be at risk of decompensation to the point that they will qualify for hospitalization if left untreated are ordered to accept treatment in the community. Joan Gerbasi et al*., Resource Document on Mandatory Outpatient Treatment*, 28 J. AM. ACAD. PSYCH. & L. 127, 129 (2000); Marvin S. Swartz & John Monahan, *Special Section on Involuntary Outpatient Commitment: Introduction*, 52 PSYCH. SERVICES 323 (2001).

mental illness, and who "is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment" and "is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others. . .." [70] Kendra's Law has withstood a number of constitutional challenges in New York State courts[71] and in February 2004 was unanimously upheld by the New York Court of Appeals.[72] The statute has recently been renewed for another five years.[73]

> "Laura's Law," modeled on the New York statute, went into effect in California on January 1, 2003. Florida, Michigan, and West Virginia also amended their civil commitment statutes to allow for outpatient commitment, effective January 1, March 30, and April 9, 2005, respectively.[74]

Since it was enacted in late 1999, 11,856 people in New York State have been evaluated for outpatient commitment under Kendra's Law, of whom 4,742 were committed and another 3,579 were provided "service enhancements," also called "case management and oversight."[75] A recent study of over 1,000 outpatients in mental health treatment at one of five sites across the United States[76] found that across sites between

70. N.Y. MENTAL HYG. LAW § 9.60(5)-(6) (Gould 2002).

71. *See In re* Urcuyo, 714 N.Y.S.2d 862, 873 (2000) ("Kendra's Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness and hospitalization continually repeat itself."). *See also* Ilissa Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1219–27 (2001).

72. *In re* K.L., 806 N.E.2d 480, 482 (N.Y. 2004):

> Studies undertaken in other jurisdictions with AOT laws have found that outpatients subject to court orders had fewer psychiatric admissions, spent fewer days in the hospital and had fewer incidents of violence than outpatients without court orders. Kendra's Law was thus adopted in an effort to "restore patients' dignity, and enable mentally ill persons to lead more productive and satisfying lives." while at the same time reducing the risk of violence posed by mentally ill patients who refuse to comply with necessary treatment.

Id. (internal citations and ellipses omitted).

73. *See* 2006 N.Y. Sess. Laws page no. 158 (McKinney) (extending Kendra's Law until June 30, 2010).

74. John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 U. VA. L. REV. 391, 403 (2006) (citing CAL. WELF. & INST. §§ 5345–49.5 (West Supp. 2005); 2004 Fla. Laws ch. 385; 2004 Mich. Pub. Acts page nos. 496–99; W. VA. CODE ANN. § 27-5-11 (2005)).

75. New York State Office of Mental Health, Statewide AOT Report as of January 1, 2006, http://www.omh.state.ny.us/omhweb/kendra_web/kstatus_rpts/statewide.htm (last visited February 5, 2006).

76. The sites were Chicago, Durham, NC, San Francisco, Tampa, and Worcester, MA . *See* John Monahan et al., *Use of Leverage to Improve Adherence to Psychiatric Treatment in the Community*, 56 PSYCHIATRIC SERVICES 37 (2005).

12% and 20% of all people receiving public-sector outpatient treatment for serious mental disorder reported that they had at some time in the course of their treatment been subject to outpatient commitment or to a related civil court order to adhere to treatment.[77]

Can initiating outpatient commitment be added to the ways in which a clinician can discharge his or her *Tarasoff* "obligation to use reasonable care to protect the intended victim against . . . danger"? There is at least one study that strongly supports such an addition.

In the Duke Mental Health Study, patients who had been involuntarily hospitalized were given a court order for mandatory community treatment after discharge, and were followed in the community. Patients randomly assigned to the control group were released from the court order. For patients randomly assigned to the experimental group, the outpatient commitment order remained in effect for varying periods of time, depending on whether a psychiatrist and the court believed the patient continued to meet legal criteria.[78]

When the data from the experimental group were disaggregated into those patients who were under outpatient commitment for at least 6 months and those patients who were under outpatient commitment for less than 6 months, strong differences emerged. Patients on outpatient commitment for a sustained period had significantly fewer hospital readmissions and hospital days than control subjects. Most pertinent in the current context, however, is the finding that sustained outpatient commitment played a significant role in reducing patient violence:

> The key finding is that extended OPC [Outpatient Commitment] (more than six months) combined with regular out-patient services utilisation (three or more events per month) produced a significant decrease in the incidence of violence. Neither the court order nor services *alone* was effective in reducing violence. However, with regular service use, the presence of extended OPC reduced the probability of violence from 48% to 24%. [79]

Why did outpatient commitment, in combination with outpatient services, halve the risk of patient violence? The answer appears to be because outpatient commitment did two things: it improved medication adherence and it diminished substance abuse.[80]

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77. Marvin Swartz et al., *Use of Outpatient Commitment and Similar Civil Court Treatment Orders in Five United States Communities*, PSYCHIATRIC SERVICES (forthcoming).

78. Marvin Swartz et al., *Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SERVICES 325 (2001).

79. Jeffrey Swanson et al., *Involuntary Outpatient Commitment and Reduction of Violent Behaviour in Persons with Severe Mental Illness*, 176 BRIT. J. PSYCHIATRY 324, 329 (2000).

80. As the authors state:

Summary. Thirty years ago, there were three ways that a therapist could take to discharge his or her "obligation to use reasonable care to protect the intended victim" when a patient was predicted to be violent. The therapist could modify the course of voluntary treatment, or attempt to incapacitate the patient by initiating involuntary inpatient hospitalization, or could warn the victim. The recent development of meaningful outpatient commitment programs now provides therapists with a fourth option for discharging *Tarasoff* duties: the therapist in a growing number of states can petition the patient for commitment as an outpatient. In states with statutes like New York's Kendra's Law, if the person placed on outpatient commitment does not adhere to treatment, he or she can be brought to a hospital by the police for a 72-hour evaluation, and can be committed as an inpatient, should the criteria for inpatient commitment be met. Outpatient commitment, when combined with actual services being made available to the patient, appears, in one major study, to be an effective violence-reduction technique.

III. CONCLUSIONS

Structured violence risk assessment will sometimes be wrong, and adherence to outpatient treatment may fail to forestall a patient's accurately-predicted violence.[81] But as the court in *Tarasoff* said,

> Respondents who received extended OPC with regular out-patient services achieved, on average, the highest positive (improved) change scores on medication adherence and substance use. In turn, those with high change scores in both of these risk factors combined had a significantly reduced incidence of violent behaviour during the year of follow-up. A multivariate model suggests that the benefit of OPC as described is at least partly an indirect effect attributable to change in these intervening clinical risk factors.

Id. at 329. It is important to acknowledge that not all research is in accord on the finding that outpatient commitment can reduce violence. Another randomized controlled trial also followed patients who had been hospitalized and given a court order for mandatory community treatment after discharge at Bellvue Hospital in New York City. A court-ordered outpatient commitment group was contrasted with a control group over a one-year follow-up period. Both experimental and control groups received a package of enhanced services including intensive community treatment. Henry Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330 (2001). No significant differences between the control and experimental groups were found in follow-up hospitalizations, arrests, or other outcomes. A significantly smaller portion of both the experimental and control groups were hospitalized during the year of the follow-up than had been hospitalized during the previous year. The researchers concluded that enhanced services made a positive difference in the post-discharge experiences of both experimental and control groups, but that the court order itself had no discernible added value in producing better outcomes. *See* Paul Appelbaum, *Thinking Carefully About Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 347 (2001); SUSAN RIDGLEY ET AL., THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES (2001).

81. Thirteen years ago, I presented a series of twelve guidelines for how clinicians might lessen their exposure to *Tarasoff* liability. *See* Monahan, *supra* note 5. I based these recommendations on my

"Obviously we do not require that the therapist . . . render a perfect performance; the therapist need only exercise 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.'"[82] In light of the developments that have taken place in the past thirty years in the science of violence risk assessment and in mental health policy regarding outpatient commitment, what counts as "reasonable" in evidence-based practice may be significantly different than it was when *Tarasoff* was decided. Thus the common law is shaped.

experience as an expert witness in a large number of tort cases in which clinicians had been sued for failure to meet their *Tarasoff* duty. Based on the arguments made here regarding structured risk assessment and outpatient commitment, I would now revise two of those guidelines to read as follows. Guideline 1: "Become educated in *structured* risk assessment, stay current with developments in the field, and be conversant with the law of the jurisdiction." Guideline 5: "For cases that raise particular concerns about violence, consider intensified voluntary treatment, *outpatient commitment*, inpatient commitment, or warning the potential victim."

82. *Id.* at 345 (quoting Bardessono v. Michels, 478 P.2d 480, 484 (Cal. 1970)).

APPENDIX

Table 1
Validity Studies of Unstructured Violence Risk Assessment

Study	Percent true positive	Percent false positive	Percent true negative	Percent false negative	Number predicted violent	Number predicted nonviolent	Followup years
Kozol et al. (1972)	34.7	65.3	92.0	8.0	49	386	5
Steadman and Cocozza (1974)	20.0	80.0	—	—	967	—	4
Cocozza and Steadman (1976)	14.0	86.0	84.0	16.0	154	103	3
Steadman (1977)	41.3	58.7	68.8	31.2	46	106	3
Thornberry and Jacoby (1979)	14.0	86.0	—	—	438	—	4
Sepejak et al. (1983)	39.0	61.0	74.0	26.0	262	253	2
Lidz et al. (1993)	53.2	46.8	63.9	36.1	190	167	0.5

Table 2
Unstructured and Structured Approaches to Violence Risk Assessment

	Structured Selection and Measurement of Risk Factors	Structured Combination of Risk Factors to Yield a Risk Estimate	Clinical Review of Structured Risk Estimate
Unstructured Risk Assessment	No	NA	NA
Structured Risk Assessment			
HCR-20	Yes	No	NA
VRAG	Yes	Yes	No
COVR	Yes	Yes	Yes