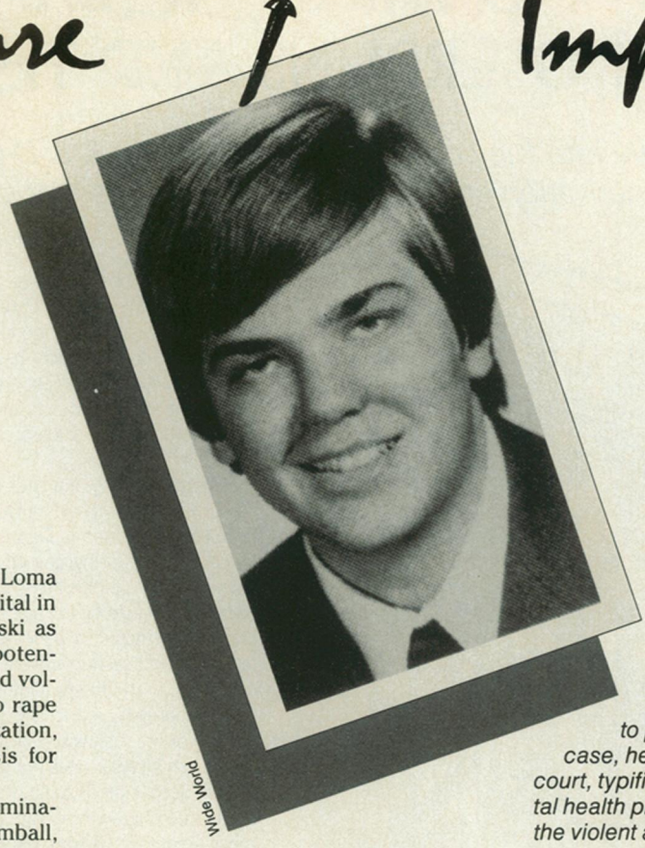
Predicting Future Dangerousness: Imperfect



Should John Hinckley Jr. have been hospitalized before he could carry out his 1981 presidential assassination attempt? His former psychiatrist has been slapped with a lawsuit claiming he should have known Hinckley posed a threat to others and taken steps to protect potential victims. The case, headed for a federal appeals court, typifies recent efforts to hold mental health professionals accountable for the violent acts of their patients.

By BRUCE BOWER

In July 1978, a psychiatrist at the Loma Linda Veterans Administration Hospital in California diagnosed Phillip Jablonski as an "antisocial personality" and "potentially dangerous." Jablonski, who had voluntarily come in after attempting to rape his lover's mother, refused hospitalization, and the psychiatrist found no basis for emergency commitment.

Several days after a second examination, Jablonski's lover, Melinda Kimball, who had just moved out of an apartment they had shared along with their daughter, returned to pick up some belongings. Jablonski murdered her.

Last summer a federal appeals court granted a $282,000 malpractice award to the couple's daughter. Although Jablonski had not specifically threatened Kimball, the court ruled that several VA psychiatrists did not take necessary steps to protect her. If they had checked Jablonski's medical background and police record, the psychiatrists would have realized, the court held, that Kimball was "targeted" by Jablonski.

This case and a number of similar decisions in the past few years raise a great, unanswered question about mental health professionals: Can they accurately predict whether a patient is going to commit a violent act in the near future?

Predicting dangerousness, after all, is a fact of life for many psychiatrists and psychologists. Every discharge and pass for a committed patient in a mental hospital or a general hospital psychiatric unit is based on an estimate of dangerousness; in most states, commitment hinges, by law, on a person's "imminent dangerousness" to self or others; and the Supreme Court, in 1983, ruled that psychiatric predictions of long-term dangerousness are admissible in death penalty cases.

Yet several influential studies conducted in the early 1970s indicate that mental health professionals might as well consult a medium or draw straws when it comes to predicting violent behavior. The research compellingly shows that clinical predictions of violence concerning institutionalized mentally disordered people are, at best, accurate one-third of the time.

But, says psychologist John Monahan of the University of Virginia in Charlottesville, "rarely has research been so uncritically accepted and so facilely generalized by both mental health professionals and lawyers." True, predictions about whether patients who have been in an institution for months or years will ever again be violent are often wrong. On the other hand, short-term predictions using statistical data and made for patients in community settings are largely unexplored. Forecasts of dangerous behavior are probably more accurate in these instances, notes Monahan.

In addition, researchers have not yet taken a detailed look at the criteria mental health professionals use to separate potentially dangerous patients from those they consider to be nonviolent.

There are some indications that clinical workers share a common view of what to look for when trying to assess how dangerous someone is. Paul D. Werner of the California School of Professional Psychology in Berkeley and colleagues report in the February AMERICAN JOURNAL OF PSYCHIATRY that 15 psychiatrists who work at medical facilities in the San Francisco area emphasize the same factors in forecasting violent behavior among patients. After seeing case material for 40 male patients entering a psychiatric intensive care unit, the psychiatrists judged whether each patient would assault someone during the first week after admission. The investigators found, not surprisingly, that patient hostility, agitation, previous assaultiveness and suspiciousness were used by all the psychiatrists to predict violence.

Unfortunately, there was a weak association between their predictions and actual assaults on the ward. Additional studies show the same to be true for 15 psychologists and five social workers who predicted assaults using case material provided by the researchers.

"All of these mental health professionals may share an inaccurate picture of who will be violent," observes Werner. Yet it

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may be just as likely, he adds, that their forecasts were on the mark. The patients they tagged as assaultive may have been similarly identified and quickly treated by hospital staff members before violence could occur.

"This is a real dilemma for researchers," he explains. "You cannot deny immediate treatment to patients who are considered violent in order to see if they actually hurt someone."

Although this ethical consideration limits research approaches, the results of a national survey of psychotherapists presented at the American Psychiatric Association meeting in May are consistent with the smaller California studies. Of 1,223 psychiatrists, psychologists and social workers who were asked how they evaluated a patient's potential for violence, 85 percent said they look for either repeated or recent violent behavior, or verbal threats.

Three out of four therapists were confident that they could predict future assaults accurately and felt other therapists would agree with their forecasts, says survey director Daniel Givelber, a law professor at Northeastern University in Boston. The therapists also reported that only 28 percent of the patients they thought would be violent went on to injure someone. Again, however, early interventions such as hospitalization or a warning to a threatened person make it hard to say whether predictions were off base or led to effective treatment.

There may be less than meets the eye when prediction research is examined, but the demand for accurate forecasts of dangerousness is considerable. Each year, for example, about 20,000 persons charged with or convicted of crimes enter mental institutions. A just-released National Institute of Mental Health (NIMH) survey reports that these people have more frequently been charged with crimes against persons than have inmates in the general prison population.

Several studies indicate that more than one-third of the lawbreakers released from mental hospitals are rearrested. This rate is as high as that for the criminal justice system as a whole.

"Violent psychiatric patients are the most difficult to place in community programs," says psychiatrist A. Michael Rossi of San Francisco General Hospital. They often get caught in a revolving door, he says, going from the hospital to the street and then back to the hospital after being picked up by police.

This does not mean, however, that violence and mental illness walk hand in hand. In an article published last year in *Crime and Justice: An Annual Review of Research* (edited by M. Tonry and N. Morris, University of Chicago Press), Monahan and Henry J. Steadman of the New York State Office of Mental Health conclude that there is no general relationship between crime and mental illness, although there are people who are both criminal and mentally disordered. Prior arrests, not mental illness, are the best predictors for rearrest after release from a state hospital, they note.

Still, the Jablonski case and liability awards in other states serve as a warning to mental health workers. "Clinicians have to develop a repertoire to deal with dangerous patients," says psychiatrist Loren Roth of the University of Pittsburgh. The American Psychiatric Association may eventually issue a statement outlining psychiatrists' duties to protect identified persons from dangerous patients, he adds.

Two University of Minnesota psychiatrists, Jerome Kroll and Thomas B. MacKenzie, suggest that psychiatrists analyze the risk of releasing a patient from the hospital by using a checklist that includes data on medical and criminal history, family environment and job status.

This approach remains to be tested, as does the contention that mental health professionals invariably goof when predicting whether a patient will be violent.

Says Monahan, "A growing number of people are choosing to light small but valid research candles rather than continue to curse the empirical darkness." ☐