Hospitalization of the Dangerous Patient: Legal Pressures and Clinical Responses

Paul S. Appelbaum, MD

The mental health system is faced with a paradoxical situation relating to the prediction of dangerousness. Never has there been such widespread acknowledgment that mental health professionals lack the tools to make accurate appraisals of patients' future dangerousness.[1] Yet never has the mental health system been called on to predict dangerousness in so many contexts and for such a variety of purposes.[2]

This article addresses one effect of the current focus on dangerousness in the mental health system: the increasing pressure to admit persons thought to be dangerous to others, but who traditionally would not have been considered appropriate for inpatient psychiatric care. After reviewing the legal pressures that have led to this situation, several case examples illustrate problems that have resulted. An attempt is made to examine possible responses of the mental health system to the pressure to admit the dangerous patient and to analyze their likelihood of success.

Legal Pressures for Admission of the Dangerous Patient

Two trends — one in the law of civil commitment and one in the law of torts — have combined to create the current situation in which clinicians often feel compelled to admit dangerous patients who previously might have been refused hospitalization.

Until the late 1960s, the dominant philosophy underlying involuntary hospitalization of the mentally ill could have been described as "paternalistic beneficence." That is, state statutes generally provided for the commitment of those persons who were so ill as to require hospitalization, as a derivative of the state's obligation and desire to provide care for those who were believed to be unable to care adequately for themselves.[3] Although it was not uncommon for dangerous persons to be hospitalized under these statutes, they were not the dominant class of patients hospitalized, and at least theoretically, their dangerousness was significant only as it was a manifestation of their need for care.

Philosophical objections to a "paternalistic" commitment system began to develop strongly in the 1960s as psychiatry's expertise was called into question, the value of hospitalization was challenged, and most important, the mentally ill came to be seen as having rights that precluded beneficent state intervention, except in a small number of circumstances. These exceptions, it was argued,

Dr. Appelbaum at the time this work was performed, was associate professor of psychiatry and law, University of Pittsburgh Schools of Medicine and Law; director, Law and Psychiatry Program, Western Psychiatric Institute and Clinic.
Correspondence: Dr. Appelbaum, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115.

should be limited to situations in which a mentally ill individual presented substantial danger of harm to other persons or to himself or herself.

California was the first state to implement this philosophy of involuntary hospitalization in the 1960s. Other states soon followed, impelled in many cases by court decisions that found the earlier statutes (which based commitment on a patient's need for treatment) to be unconstitutionally vague and overbroad.[4] By the early 1980s, all jurisdictions had accepted dangerousness as the primary basis for commitment of the mentally ill, although a small number of jurisdictions are now experimenting with a return to modified need-for-treatment provisions as additional bases for commitment.[5]

The effect of these changes in commitment statutes has been to focus clinicians' attention increasingly on the question of their patients' potential dangerousness. Although the statutes are in all cases permissive and not mandatory — that is, they allow but do not require the commitment of dangerous persons, presumably enabling other considerations such as treatability to enter into the commitment decision — in practice this distinction is often lost. The public and other governmental agencies (for example, police) often view the mental health system as offering the only opportunity to confine potentially dangerous persons who have not yet committed crimes, and therefore often exert irresistible pressures for the admission of dangerous persons. At least one court, for example, has ordered the continued confinement of a patient, whom psychiatrists testified was no longer mentally ill, on the ground he was still a threat to public safety.[6] As a result of these pressures, and given budgetary imperatives that have led to the exclusion from public mental health facilities of all those who can possibly be allowed to reside in the community, state hospitals in some areas have seen dangerous patients become their primary treatment group, in place of other patients who may have equal or greater need for clinical services.[7,8]

An additional legal development, this time in the area of tort law, has pushed psychiatrists even further in the direction of feeling they have no choice about admitting dangerous persons to their hospitals. The law in question has arisen from two lines of court decisions, the earlier[9] of the two holding psychiatrists responsible for violence committed by former inpatients who were negligently released or allowed to escape; and the more recent line of cases, deriving from the 1976 *Tarasoff* case in California, extending liability to the outpatient situation.[10] *Tarasoff* held that clinicians had an obligation to take reasonable steps to protect identifiable third-party victims of their patients when they know or should have known of their patients' intentions to commit violent acts.

Although *Tarasoff* focused on identifiable victims, and is often associated with the issue of warning such persons, more recent cases have seen a merger of the *Tarasoff* rationale with the reasoning in the earlier escape cases, in which psychiatrists were held liable for harms occurring regardless of whether the victims were identifiable, because the possibility of violence toward *someone* should have been foreseen. Several recent cases have stretched this reasoning to apply a *de facto* standard of strict liability for patients' violent acts.[11,12] Not only have these decisions dispensed with the requirement of an identifiable victim, but also

they have so construed the factual situation as to demand that psychiatrists recognize future dangerousness in almost all circumstances in which violence later occurs. These decisions have had the effect of declaring therapists responsible for any violent act committed by their patients, regardless of their own behavior.[13] The natural response on the part of clinicians has been to feel compelled to commit (or admit voluntarily) *all* dangerous patients, regardless of their suitability for hospitalization. This clinical response to legal pressures is demonstrated in the following case examples.

Case 1 The patient was a 28-year-old man who appeared at the emergency room of a psychiatric hospital late one Saturday night saying he was afraid he would hurt someone. He gave no history of previous psychiatric contact but did have a long history of getting into fights and had been convicted of assaulting his brother-in-law four years previously, for which he spent three years in prison. He was currently on parole. The patient had come to the hospital from a different part of the state, saying that he was too well known there to be comfortable seeking treatment. There was no evidence of psychosis; a diagnosis of antisocial personality disorder was made.

A call to his home catchment area to find out if they would pay the cost of hospitalization revealed that a warrant had been issued for the patient on charges of statutory rape and assault of his own daughter. There was a suggestion that the patient had been warned of these charges prior to his decision to seek hospitalization.

Antisocial personality disorder is not usually considered an appropriate reason for admission to the acute-care facility in question. There are no programs geared to the treatment of such character disorders. In addition, it seemed clear to the emergency room staff that the patient was using his threats in a manipulative way to gain admission, hoping this would mitigate the legal penalties he was likely to face. Nonetheless, given the risk of liability should he be discharged, the decision was made to admit the patient on a voluntary basis. Since his home catchment area refused to pay the costs of out-of-catchment hospitalization, the admitting facility agreed to cover the cost of his care.

Case 2 This patient was a 19-year-old man who had been admitted after his wife left him, claiming he had been having difficulty sleeping and he feared losing control and harming his wife. He said he had access to 15 guns and that, if he did not harm his wife, he probably would hurt himself. There were no psychotic symptoms; his diagnosis was antisocial personality disorder. Two days after admission, the patient denied all symptoms and claimed he had no intent to harm anyone. As his emergency commitment was about to expire, the ward psychiatrist was faced with the decision of whether to seek a longer term commitment.

It was determined that the patient was unlikely to benefit from continued hospitalization. His wife, however, had called the hospital to say she was terrified of him and wanted him committed for her safety. Although the staff did not believe he met the criteria for involuntary commitment, and did not know what they would do with him if he were committed for a longer time, they decided to seek commitment anyway. Their rationale was twofold. First, if the patient com-

mitted a violent act after discharge, the clinicians could not be sued if a court had released him. Second, they remained convinced of his potential for violence and were ethically unwilling to be responsible for placing others at risk.

The patient was found not to meet commitment criteria when his hearing was held. Several days after his release, word was received that he had "beat his father senseless."

Difficulty Formulating an Adequate Clinical Response

Patients who have demonstrated or threatened violent behavior, in the absence of psychosis, usually will qualify for a character disorder diagnosis, often antisocial personality disorder. Traditionally, such persons have been viewed as undesirable patients and have been excluded from most psychiatric inpatient facilities.[14] Even with the new legal pressures for admission, some purists would continue to contend that dangerous persons who may be character disordered but are not psychotic simply should not be admitted to the facility.[15,16] They might claim such patients are not really mentally ill or hospitalization is inappropriate because no therapeutic benefit is likely to accrue. With careful documentation of the reason admission was rejected, this position would continue, psychiatrists could well be immunized from legal liability.

Unfortunately, as appealing as this position might sound, there are several reasons why it is unlikely to be adopted with great frequency. First, when a patient is potentially dangerous to others, it is difficult to convince the public at large that character disorders (which are listed in DSM-III and are often the subject of outpatient psychiatric treatment) do not constitute genuine mental illnesses. Thus, social and political pressures for the admission of such patients are likely to continue to be exerted, and the prospect of liability in the event of harm to a third party — given the progeny of *Tarasoff* described above — remains real.

The second prong of the argument for nonadmission, which rests on the "untreatability" of many dangerous, character-disordered patients, is also open to question. Although most of the literature about the treatment of such patients focuses on long-term, group, and milieu-oriented therapies,[17-19] some authors have pointed to the role that short-term hospitalization in an acute facility might play in the treatment of character disorders. Kalogerakis, for example, noted

> The goals of hospitalization of personality disorders are implicit in the reasons for admission: to get them over a crisis, to help them reconstitute when decompensating, to relieve them of suicidal impulses, to interfere with and free them of assaultive tendencies, occasionally to evaluate and make recommendations. It is important that hospitalization be brief and that the patient be moved on to the setting most appropriate for the achievement of the long range goals.[20]

A third set of factors also mitigates for admission. Many clinicians feel an ethical obligation to protect named or even unnamed potential victims from harm at the hands of their patients. This sensitivity clearly predated the *Tarasoff* decision,[21] but it is probably fair to say that it has been heightened by the attention given to this issue in the wake of *Tarasoff*. Although absurd if carried to an

extreme (psychiatrists cannot roam the streets, detaining all persons who are likely to be dangerous) many people would agree that psychiatrists have some responsibility for those patients who find their way into psychiatric facilities.

It might be argued that this responsibility is best transferred to the criminal justice system: that psychiatrists should turn over dangerous persons to the police. This is appealing in its simplicity but difficult to accomplish.[22] In case 1 above, for example, the emergency room staff clearly had the option of turning the patient over to the police. Yet contacting the police without the patient's permission would have constituted a breach of confidentiality, forbidden by law in many states and something about which mental health clinicians have become quite sensitive. Even more of a deterrent is the reluctance of clinicians to see themselves as part of the criminal justice system, "doing the dirty work" for the police. It is thus much easier and less threatening to the psychiatric self-image to hospitalize such a patient.

Prospects for Resolving the Dilemma

The preceding analysis suggests that without substantial changes in the current legal structure enormous pressures are likely to continue for the hospitalization of dangerous, character-disordered patients. What sorts of legal changes would be required to ameliorate the situation, and what are their prospects of occurring?

A reorientation of the civil commitment system away from dangerousness and toward need for treatment as the basis for commitment might lessen societal pressures for the admission of dangerous persons. Although such shifts in commitment statutes have occurred recently in several states,[5] and do not appear to be precluded by extant court decisions,[4] there are limits to how far this process is likely to proceed. Some jurisdictions already have rejected attempts to broaden the basis for civil commitment.[23] Further, even in those states where changes have occurred, a treatment-oriented standard has been introduced to supplement, not to replace, commitment criteria based on dangerousness. The American Psychiatric Association Model Law on Civil Commitment addresses this problem squarely by requiring that even dangerous persons be incompetent and treatable before commitment can occur,[24] but the intensity of some of the reactions to the Model Law suggests that its provisions are unlikely to be adopted in many states.[25]

Changes in the recent trend to hold psychiatrists liable for their patients' violent acts also might help reduce pressures for otherwise unwarranted admission of dangerous patients. Some courts have evidenced a willingness to move in this direction.[26] Among the changes proposed by courts and commentators have been limiting the *Tarasoff* obligation only to situations in which patients make actual threats[27] or in which therapists determine patients are dangerous, then fail to take appropriate steps to protect intended victims.[28] Even if these reforms were adopted, however, they might not make much of a difference in the emergency room setting, where threats are often overt and problems arise only after a prediction of dangerousness is made.

If the legal situation is unlikely to change dramatically, thus maintaining pressures to admit dangerous patients, one might ask whether hospitals might do more to accommodate themselves to the continuation of this situation. For hospitals with a large enough group of such persons, positive therapeutic programs can be developed. Even when facilities are not prepared to provide such treatment, they might embrace a role of providing asylum at a time of stress, using hospitalization as a form of crisis intervention for the patient who is on the verge of losing control. Implementation of such an approach, however, would require considerable staff education, and in part a reorientation of the therapeutic milieu for these patients.[29]

Conclusion

Recent legal trends have led to strong pressures to admit dangerous, character-disordered patients who previously would not have been thought suitable for inpatient treatment. It seems unlikely that the pressures exerted by the legal system and by society at large for the hospitalization of this group of patients will be easily resisted, at least in the near term, or that significant structural changes in the law's approach will occur. Hospitals therefore may have to prepare to deal with dangerous, character-disordered patients, who previously would not have been admitted, perhaps by the development of specialized treatment approaches that set the stage for later, more prolonged outpatient therapy.

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