Limiting Therapist Exposure to Tarasoff Liability

Guidelines for Risk Containment

John Monahan

The "duty to protect" third parties, first imposed by the Tarasoff case, has concerned and perplexed clinicians. A series of guidelines is offered for reducing therapist exposure to suit, based on expert witness experience in a number of cases raising this form of tort liability. These guidelines concern the assessment and management of risk, the documentation of information and activities, the formulation of written policies, and damage control when risk is realized.

Mention the word law in conversation with practicing psychologists, psychiatrists, and social workers, and they will soon speak of Tarasoff v. Regents of the University of California (1976). No case is better known or evokes stronger feelings. Initially, the subject of vilification by mental health professionals, the California Supreme Court's holding in Tarasoff—that psychotherapists who know or should know of their patient's likelihood of inflicting injury on identifiable third parties have an obligation to take reasonable steps to protect the potential victim—has become a familiar part of the clinical landscape. Although a few state courts have rejected Tarasoff and others have limited its scope, most courts that have addressed the issue have accepted the essence of the "duty to protect," and several have even expanded that duty to include nonidentifiable victims (for reviews, see Appelbaum, 1988; Beck, 1985, 1990; Schopp, 1991; Smith, 1991). In jurisdictions in which appellate courts have not yet ruled on the question, the prudent clinician is well advised to proceed under the assumption that some version of Tarasoff liability will be imposed (Appelbaum, 1985, p. 426). The duty to protect, in short, is now a fact of professional life for nearly all American clinicians and, potentially, for clinical researchers as well (Appelbaum & Rosenbaum, 1989).

I have served as an expert witness in several dozen cases in which the therapist's duty to protect others from a patient's violence was at issue. In each of these cases, someone had been killed or injured by a patient or former patient of a psychologist, psychiatrist, or social worker. The questions put to me were always the same: Would a reasonable therapist, applying the professional standards that existed at the time of the treatment, have assessed the patient's risk of violence as sufficient to justify preventive intervention, and if so, was an appropriate intervention chosen? Initially, given my view (Monahan, 1976) that violence was virtually impossible to validly assess, I was retained solely by defense attorneys. Later, as I came to believe that risk assessment might be feasible and appropriate under some circumstances (Monahan, 1981, 1984), referrals began to come equally from defense and plaintiff's attorneys.

In working on these cases and seeing the obvious emotional, financial, and reputational costs that they placed upon the defendant therapists and their institutions (Brodsky, 1988; Poythress & Brodsky, 1992), I often thought about what the therapist could have done to have foreseen and prevented his or her patient's violence, or at least, when the violence was not foreseeable, to have reduced his or her own exposure to civil liability. In this article, I organize those reflections into a series of guidelines for violence prevention and the reduction of exposure to liability that may be useful to practicing mental health professionals. No jurisdiction currently requires adherence to all, or even to most, of these guidelines in order to meet professional standards of care for dealing with potentially violent patients. Thus failure to act as suggested here does not necessarily mean that liability "ought" to be found by a jury. Each of these guidelines, however, has played a prominent role in at least one "failure to predict" case on which I have been retained. The guidelines cluster in five domains: risk assessment, risk management, documentation, policy, and damage control. They are summarized in the Appendix.

Risk Assessment

Four tasks form the basis of any professionally adequate risk assessment: The clinician must be educated about what information to gather regarding risk, must gather it, must use this information to estimate risk, and, if the clinician is not the ultimate decision maker, must communicate the information and estimate to those who are responsible for making clinical decisions.

Education

The essence of being a "professional" is having "specialized knowledge" not available to the general public. In this context, specialized knowledge consists of both

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knowledge of mental disorder in general (e.g., assessment, diagnosis, and treatment) and knowledge of risk assessment in particular. In addition, one should be thoroughly conversant with the laws of the jurisdiction in which one practices regarding the steps to follow when a positive risk assessment is made.

**Clinical education.** Familiarity with basic concepts in risk assessment (e.g., predictor and criterion variables, true and false positives and negatives, decision rules, and base rates) and with key findings of risk assessment research (e.g., past violence as the single best predictor of future violence) is becoming an important aspect of graduate education in psychology, psychiatry, and social work. For clinicians whose graduate education predated this emphasis or neglected it, many books and articles are readily available (e.g., Appelbaum & Gutheil, 1991; Bednar, Bednar, Lambert, & Waite, 1991; Simon, 1987; Tardiff, 1989). One does not have to commit these works to memory. But I have seen the blood drain from clinicians' faces when a plaintiff's attorney begins a cross-examination by reading a list of well-known titles in the area and asks whether the witness has read them, and the clinician is forced to mumble "no" (see Brodsky, 1991).

It is not enough to learn the basic concepts and classic findings in the field of risk assessment once and consider one's education complete. Research findings evolve and become modified over time, and the conventions of professional practice become more sophisticated. Continuing education in risk assessment through formal programs sponsored by professional or private organizations is one way to keep apprised of developments in the field. Periodically perusing original research journals (e.g., Law and Human Behavior, Behavioral Sciences and the Law, the International Journal of Law and Psychiatry) is another.

In the context of large facilities for assessing and treating mentally disordered people, the most efficient form of risk education may be to charge one person with the responsibility of being a "risk educator." This person's responsibilities might include maintaining a small reference library of literature on risk, keeping abreast of developments in the field, and communicating his or her conclusions to other staff through in-house workshops, reading groups, or occasional memoranda. This person might be an ideal candidate for a local consultant for cases that present difficult risk issues.

**Legal education.** The standards to which clinicians will be held in making judgments on risk are set largely by state law. In the past, these standards were usually articulated by judges who applied common law tort principles to the context of clinical risk assessment. This is what happened in Tarasoff and similar cases in other states. Increasingly, and after intense lobbying by professional mental health organizations, state legislatures are passing statutes to make standards for liability and immunity in this area explicit (Appelbaum, Zanana, Bonnie, & Roth, 1989). These statutes, however, will still require much adjudication to interpret inevitably ambiguous terminology (e.g., what counts as a "serious threat" or a "reasonably identifiable victim" in California's, 1990, statute?). The point here is that there is no national legal standard for what clinicians should do when they assess risk (Givelber, Bowers, & Blich, 1984), and that it behooves clinicians to know precisely what the legal standards in their own jurisdiction are regarding violence prevention. State mental health professional associations ought to have this information readily available.

**Information**

Once a clinician knows what information, in general, may be relevant to assessing risk, he or she must take efforts to gather that information in a given case. Most of the Tarasoff-like cases on which I have worked have faulted clinicians not for making an inaccurate prediction but for failing to gather information that would have made a reasonable effort at prediction possible. There are generally four sources in which relevant information can be found: in the records of past treatment, in the records of current treatment, from interviewing the patient, and from interviewing significant others. In some criminal contexts (e.g., assessments for suitability for release on parole or from insanity commitment) additional records in the form of police and probation reports, arrest records, and trial transcripts may also be available and should be consulted. But in the civil context, these records are generally not available to clinicians.

**Past records.** The only cases in which I have been involved that were, in the words of the defense attorneys, "born dead" were those in which the patient had an extensive history of prior violence that was amply documented in reasonably available treatment records, but those records were never requested. In these cases, the clinician has been forced to acknowledge on the witness stand that if he or she had seen the records, preventive action would have been taken.

The emphasis in the previous paragraph should be on the phrase reasonably available. At one extreme, I served as an expert witness for the defendant in a case in which a patient was hospitalized for a few days and killed a person shortly after being released. One of the arguments of the plaintiff's attorney to support a finding of negligent release was that the treating clinician had not written to the Philippines, where the patient had briefly been hospitalized many years earlier, to obtain the treatment records. This is clearly absurd (i.e., unreasonable), as the patient would in any event have been discharged long before the records had arrived (and had been translated from Tagalog), assuming that they ever would have been sent.

At the other extreme, however, I was the plaintiff's witness in a case in which an outpatient clinic was on the ground floor of a building that housed an affiliated mental hospital. A patient whose hospital records were replete with extreme violence was transferred from the hospital to the outpatient clinic. The hospital did not send the records with the patient, and the outpatient clinic did not request them, at least not until the staff read in the news-
papers that the patient—now their patient—had been arrested for murder.

Somewhere between writing to the Philippines and walking upstairs, a line has to be drawn as to what constitutes a reasonable effort to obtain records of past treatment. I know of no standard operating procedure on this question. "Records" does not have to mean the entire hospital file; a discharge summary may often suffice. More of a priority might be accorded to requesting the records of patients whose hospitalization was precipitated by a violent incident, or who exhibited violence in the hospital, than to requesting the records of other patients. In the context of long-term hospitalization, of course, there will be more opportunity to obtain records from distant facilities than would be the case for short-term treatment (this opportunity to obtain records is also present for patients with repeated short-term hospitalizations). Hospitals in the same geographic area or in the same treatment system (e.g., among public hospitals in the same state or between state hospitals and community mental health centers) might be expected to have established procedures for transferring information. Records of more recent hospitalizations (e.g., within the past five years) may be more probative of risk than may older hospital records. But when indications are that the current hospitalization will be brief and when prior hospitalizations were at distant locations or occurred long ago, it is clearly not standard practice to request records. Nor should it be. It takes time and money to request, locate, copy, transmit, and read treatment records—resources that might more profitably be spent providing treatment.

**Current records.** Reading the chart of the current hospitalization when making risk judgments about hospitalized patients is essential. I am continually amazed, however, at how often clinicians peruse the chart as if it were a magazine in a dentist's waiting room. In particular, nursing notes, in which violent acts and threats are often to be found, are frequently glossed over. Yet, I have seen plaintiff's attorneys introduce exhibits consisting of eight-foot-by-four-foot photographic enlargements of pages from nursing notes containing statements such as, "assaulted several other patients without provocation tonight," and "patient threatening to kill spouse as soon as released." These exhibits certainly concentrated the jury's attention.

**Inquiries of the patient.** Clinicians appear to question patients more often about a history of violence to self or current suicidal ideation, than about a history of violence to others or current violent fantasies. There seems little justification for this inconsistency. Directly asking patients about violent behavior and possible indices of violent behavior (e.g., arrest or hospitalization as "dangerous to others") is surely the easiest and quickest way to obtain this essential information. Open-ended questions such as "What is the most violent thing you have ever done?" or "What is the closest you have ever come to being violent?" may be useful probes, as might "Do you ever worry that you might physically hurt somebody?" The obvious problem, of course, is that patients may lie or distort their history or their current thoughts. This is always a possibility, but often corroborating information will be available from the records (above) or from significant others (below). Quite often, however, patients are remarkably forthcoming about violence. And although there may be reasons to suspect a negative answer in a given case, a positive answer should always be pursued. Unless a question to the patient is ventured, potentially valuable information on risk will not be gained.

**Inquiries of significant others.** Records are often unavailable, and patients are sometimes not reliable informants. A significant other, usually a family member, is frequently available in the case of inpatient hospitalization, however, either in person (accompanying the patient to treatment or seen later in conjunction with the patient's therapy) or at least by telephone. Asking the significant other about any violent behavior or threats in the event that precipitated hospitalization, or in the past, as well as open-ended questions such as "Are you concerned that X might hurt someone?" with appropriate follow-up questions as to the basis for any expressed concern, may yield useful information.

**Estimation**

I have elsewhere suggested a clinical model for estimating a patient's risk of violent behavior (Monahan, 1981). Although the mental health professions have yet to demonstrate that the accuracy of their estimations of risk is high in absolute terms, it is clearly high relative to chance. For example, Kozol, Boucher, and Garofalo (1972), in one of the most cited prediction studies, identified a group of patients, 35% of whom were found to have committed a violent act within five years of release. The base (i.e., chance) rate of violence was 11%. Thirty-five percent is both much lower than 100% and much higher than 11%. Whether these clinical predictions were any more accurate than those that could have been made by nonclinicians (or actuarial tables) using simple demographic variables, however, is unknown. More recent research (e.g., Klassen & O'Connor, 1988) has demonstrated considerably more accurate predictions with narrowly defined groups of high-risk patients.

The obstacles to progress in clinical risk assessment research are formidable. To date, the range of predictor variables that have been used has been narrow, the criterion measures have been weak, the patient samples studied have been constricted, and research efforts have been unsynchronized (Monahan & Steadman, in press). Research attempting to overcome each of these limitations is under way (Steadman et al., in press).

**Communication**

In the individual practice of psychotherapy, the clinician who gathers information on risk is also the clinician who makes decisions based on this information. But in outpatient treatment agencies and in mental hospitals, a division of labor often exists: One person may do the intake, another may be responsible for patient care, a team of
several professionals may provide a variety of assessment and treatment modalities, and one person will have formal responsibility for making or approving discharge decisions. Although this division of labor may be an efficient use of resources, it does raise an issue not present in the solo practitioner context: the communication of relevant information from one mental health professional to another. Here, information must be transferred between or among clinicians, and significant information must be made salient to the person responsible for making the ultimate decisions regarding the patient (Klein, 1986).

Placing all relevant information in the chart, of course, is the primary way of transferring information among treatment professionals. As long as the person ultimately responsible for making the institutionalization or discharge decision reads the entire file, the information is thereby communicated to the person who needs to know it.

In the real world of professional practice, however, information is not always effectively communicated by simply passing on a chart. The ultimate decision maker may be a harried senior staff member whose signature is often a pro forma endorsement of the recommendations of line staff, based only on a brief discharge summary. Or the amount of information in the chart, including information from numerous past hospitalizations, may be literally so voluminous that no final decision maker would be expected to read it verbatim.

For example, I was involved in a case in which a private hospital sought to transfer a chronic patient to a community care facility. The hospital “discharge planner” needed a dolly to move several cartons of records on this patient to the office of the community facility’s intake director. Numerous violent incidents were recorded throughout this massive record, but none of them were mentioned on the hospital’s upbeat discharge summary (the hospital appeared to be trying to sell the patient to the community facility). It was unreasonable, the jury believed, for the hospital to expect the community intake worker to sit down for several days and read the entire record before accepting this patient, especially because the hospital also wanted transfer decisions to be made on a number of other patients by the end of a one-hour meeting.

It is not sufficient to dump undigested information on the desk of the ultimate decision maker and to claim that he or she assumed the risk of liability by taking possession of the file. Rather, information pertinent to risk should explicitly (and in writing, see below) be brought to the attention of the decision maker. Only by making the information salient can one be assured that the decision maker has had the option to make use of it.

From the decision-maker’s vantage point, the implications of information overload are equally clear. When the transfer or discharge summary prepared by others makes no explicit positive or negative reference to risk, one should directly ask what information relevant to risk is in the chart and should record the answer.

Risk Management

For most patients, of course, the gathering of risk information will produce little or nothing of clinical interest (Monahan, 1992). But for some patients—approximately one per month according to a large survey of private practitioners in California (Wise, 1978)—information will be generated to elicit concern. Here, it is essential to develop a plan to manage the observed risk and to monitor patient adherence with that plan.

Planning

This is not the place to recapitulate advice about the clinical management and treatment of potentially violent patients. Excellent guides to this literature exist (Roth, 1987). Whatever treatment modalities are chosen, however, two things should be borne in mind: A range of preventive actions should be considered in deciding how to safely manage the patient’s risk, and consultation with other professionals should be sought in particularly difficult cases.

Choice of a plan. For a patient flagged as high risk, it is important to explicitly consider preventive action. Such actions usually fall into three categories (see Appelbaum, 1985, p. 426). Following the literature on crime prevention, the first category might be called incapacitation, or negating the opportunity for violence in the community by hospitalizing the patient (voluntarily or involuntarily), or if it is hospital violence that is anticipated, negating that opportunity by transferring the patient to a more secure ward until the level of risk is reduced. The second category could be termed target hardening, or warning the potential victim when one can be identified, so that the victim can take precautionary measures. The final category might be called intensified treatment, in which outpatient status is maintained but sessions are scheduled more frequently, medication is initiated or increased, or joint sessions are held with the patient and others significant to the occurrence of violence, possibly including the potential victim (Wexler, 1981). More creative options may also be possible (Dietz, 1990).

The issue here is not that the clinician must necessarily adopt one of these violence-prevention strategies as part of a risk management plan but that the clinician consciously consider such options and make a reasoned and reasonable decision to adopt or not to adopt one of them. If the steps taken to prevent violence are seen as reasonable, the clinician should not be held liable, even if harm occurs.

Second opinions. The problem with choosing a risk management plan, in terms of tort liability, is that because the plan didn’t work (or else there would be no law suit), the plaintiff can often retain another mental health professional as an expert witness to say, with the wisdom of hindsight, that any competent clinician would have known that the plan was defective. The more well thought out the preventive measures taken in a case, the more likely the plaintiff will have in finding a credible witness who can with integrity make such a claim.
One way for a clinician to immunize himself or herself from this kind of Monday morning quarterbacking is for the clinician to initiate it on Friday afternoon, by consulting with a respected colleague about a difficult case before risk management decisions are made (Rachlin & Schwartz, 1986). Getting a second opinion has two advantages. First, the clinician may learn something. He or she may learn that the consulting colleague does not think that the contemplated actions are reasonable. The clinician may have missed a significant risk or protective factor, or may be overreacting to some aspect of the case—we all have blind spots. Or, the planned course of action may be reasonable, but the consultant may have a more creative suggestion.

The second advantage of obtaining a consultation is that it is a concrete way of demonstrating that the clinician took the case seriously and considered a variety of options for violence prevention. If the consultant is an experienced clinician (perhaps the "risk educator" mentioned above), it becomes much more difficult to claim after the fact that "anyone" would have known that the risk management plan was negligent.

There are two clear disadvantages to obtaining consultation, however. The first is that it takes time to familiarize a colleague with a difficult case and to talk through strategy. In many busy practice settings, there is barely enough time to make a reasoned initial decision, much less to review that decision with someone else. The second disadvantage is that in obtaining consultation the clinician may be exposing the chosen consultant to potential liability should the patient commit a violent act (although I emphasize that I know of no cases in which consultants who have not seen the patient have been found to share liability). Perhaps the most equitable ways to obtain consultation are case conferences or grand rounds in which each clinician gets to discuss a difficult case, thereby broadly sharing potential liability with other colleagues, while incurring potential liability from their cases.

**Adherence**

Without doubt, the single largest category of cases on which I have served as an expert witness have involved patient noncompliance with aftercare recommendations. The typical case is one in which a patient is seriously violent when acutely disordered, is treated in a mental hospital until the disorder is under control, and is discharged with the recommendation to continue treatment as an outpatient. The patient comes to few, if any, appointments and then stops showing up altogether. No one on the hospital staff calls to find out what the problem is or to assess the patient's condition. The patient decompensates over the course of a few weeks or months and, while acutely disordered, kills someone. This situation is even more egregious when the patient is known to have a long history of noncompliance with treatment (typically, with psychotropic medication) and is also known from the record to become disordered when off medication and to become violent when disordered. It does not take the jury long to complete the syllogism and to conclude that the clinician or hospital could and should have avoided the tragedy by pursuing the missed appointments and nonadherence to treatment recommendations.

I know how understaffed many mental health facilities are. It is hard enough to see those people who do show up for aftercare treatment, much less to track down those who do not. Furthermore, unless the former patient satisfies the criteria for civil commitment (or outpatient commitment), there may be little the clinician can legally do to force the patient to comply with treatment recommendations (but see Meichenbaum & Turk, 1987, for an excellent account of adherence enhancement). Yet, it is very hard to convince a jury, with the children of the deceased in the front row of the courtroom, that a good faith effort to assure the patient's compliance with treatment was not worth the clinician's time (Klein, 1986).

**Documentation**

It would be an exaggeration to state that in a tort case what is not in the written record does not exist—but not much of an exaggeration. The violent event that gives rise to the suit may occur weeks or months after the patient was last seen. The resolution of the case through settlement or trial will be a minimum of several years from the time of the violent event. Memories fade or become compromised when numerous, or innumerable, other patients are seen in the interval. The record requested by telephone, the questioning of the patient or family member about violence, the hallway conversation with a colleague to communicate information, or the careful consideration of options is unlikely to be retrieved intact from memory; nor would it make much difference if it were. Juries are rightly skeptical of self-interested statements by people who have a lot to lose. "If you did it, why didn't you write it down?" they will reason. "I was busy," is not a credible retort. Unrecorded warnings to a patient's family member that he or she has been threatened with harm are useless when that family member is dead as a result of the threatened violence or is the plaintiff in a suit for damages against the therapist. From the perspective of violence prevention, the suggestions made regarding obtaining and communicating information and developing and monitoring a risk management plan are equally applicable whether or not a record is made. From the perspective of reducing exposure to liability, there is little point in doing any of them unless they are memorialized in ink or on a dated disk (or by a videotaped exit interview; see Poythress, 1990, 1991).

Documenting information received and actions taken, or "building the record," is an essential exposure-limitation technique. When recording information relevant to risk—for example, a statement from a family member that a patient made a violent threat—one should note three things: the source of the information (e.g., the name of the family member), the content of the information (e.g., the nature and circumstances of the threat), and the date on which the information was obtained or communicated. In addition, when noting an action taken
in furtherance of a risk reduction plan (e.g., committing or not committing a patient, warning or not warning a potential victim), it is essential to include a statement, however brief, of the rationale for the action. A comment in the chart or discharge summary—for example, “Called mother on 6/21. She said that she did not take patient’s threats seriously, and that he had always complied with medication in the past”—is worth its weight in gold (perhaps literally) in demonstrating a good faith effort to attend to risk.

**Policy**

The time for a clinician to think through difficult issues regarding risk assessment and management is not when a patient makes a threat or misses a follow-up appointment. Rather, general policy choices should be made and reflected upon before the need for them arises in a given case. These policies or guidelines should be committed to writing and should be reviewed by experienced clinicians and lawyers. Staff should be educated in the use of the guidelines, and their compliance should be audited. Finally, forms should be revised to prompt and record the actions contemplated by the policy statement.

**Written Guidelines**

Memorializing “risk policy” in writing has several virtues (Bennett, Bryant, VandenBos, & Greenwood, 1990). It promotes clarity of thought and thus is conducive to formulating effective procedures, from both the viewpoints of violence prevention and the reduction of exposure to liability. In an organizational context, it allows for consistency of application, so that staff members are not acting at cross purposes (“I thought that it was your responsibility to warn the family!”). And it is efficient in the sense that novice clinicians, or clinicians new to the organization, can more quickly be brought up to the level of practitioners experienced in handling potentially violent patients. The guidelines should periodically (e.g., annually) be reviewed, with an eye to revision in light of developments in research, practice, or state law.

The absolutely essential point here is that the guidelines should reflect the minimal standards necessary for competent professional practice and not the ideals to which an organization would aspire if it had unlimited resources. Stating that “all records of prior treatment shall be obtained” or that “all significant others will be questioned about the patient’s history of violence” are invitations to sue. All prior treatment records often cannot be obtained (recall the case mentioned earlier in which the records were in the Philippines). All significant others can be a large group whom it would be ludicrous to survey in the typical or even the extraordinary case. The rule should be to state as policy only what you actually expect staff to do in the real resource-constrained world of clinical practice.

**External Review**

Experienced clinicians should be the ones to draft risk policy. But the draft should be reviewed by other clinicians from comparable facilities elsewhere (Poythress, 1987). As with securing consultation on difficult cases, discussed earlier, policy consultation serves two purposes. It allows the drafting clinicians to learn from the experience of others and, thus, to substantively improve the quality of their procedures. If the reasonableness of the policies is later impugned in a tort suit, it is very helpful to announce that they received the blessing of the most relevant slice of the professional community before the events that gave rise to the suit. A leadership role can productively be played by state and local professional organizations in drafting model guidelines in this area. Because Tarasoff liability applies to all mental health professions, this task is perhaps uniquely suited to interprofessional cooperation. In addition to review by external clinicians, review by house or retained counsel is also essential to make certain that the policies comport with the statutory and case law of the jurisdiction.

**Staff Education and Compliance**

It is not enough—indeed, it is counterproductive—to draft exemplary guidelines and subject them to clinical and legal review if the guidelines are merely to be filed in some cabinet or entombed in a staff handbook, never to be read. Again, it is much better to have no policies at all than to have policies that are not followed in actual practice. If one has no formal policies regarding risk, one can always try to argue after the fact that there were implied policies or understandings about how high-risk patients were to be handled. This is difficult, but not impossible. On the other hand, when clear and reasonable policies have been formulated and committed to writing by the agency itself, and those policies were violated in the case that gave rise to a tort action, the ballgame is over. It lacks credibility to dispute standards that you yourself have proclaimed. The jury, again with reason, will wonder: “If you didn’t think that this was what the staff should do, then why did you tell them to do it?”

Once the staff have been educated in the use of the guidelines, their compliance should be the subject of periodic “audits.” A senior colleague (perhaps the risk educator mentioned previously) should review files to see whether the guidelines are being followed in practice, whether, for example, records are requested, information is communicated, and all actions are properly documented. Corrective action—including the revision of unworkable policies—should then be taken.

**Useful Forms**

The creation of user friendly forms for documenting actions called for by policy guidelines can both prompt and memorialize appropriate inquiries and responses. I have seen many a case saved for defendants by clinicians having simply checked off “no” to a list of intake questions, including the items “violent history” and “violent ideation.” Expanding that list to incorporate more items contemplated in the risk-policy statement—for example, fill-in-the-blanks for “records requested from _____,” “concerns communicated to ______,” and “attempted to fol-
low-up by _______"—would be very useful both in terms of violence prevention and exposure limitations. Forms should facilitate, rather than impede, gathering necessary information, taking appropriate action, and documenting both information and actions. Here again, state and local professional organizations have a leadership role to play in offering model forms to be adapted in light of an individual agency’s or practitioner’s circumstances.

Damage Control
Risk assessment and risk management involve probabilistic judgments. By definition, these judgments will sometimes be wrong—not wrong in the sense of mistake, but wrong in the sense that low probability events do happen. Often, clinicians learn of their patient’s violence from the evening news or the morning paper. This is followed by calls from the director of the facility or from one’s colleagues, from reporters and, much later perhaps, from a lawyer to arrange the clinician’s deposition. In the context of being a mental health professional, having a patient kill or severely injure another qualifies as a major life event. I am amazed at how often clinicians panic and take actions that are unwise, unethical, and sometimes illegal. The two most prevalent forms of maladaptive clinician reaction to the stress of patient violence and the fear of liability are tampering with the record and making inculpatory public statements.

Tampering With the Record
In several of the cases on which I have served as an expert witness, a treating clinician has learned of his or her patient’s violence from the media and shortly thereafter has gone to the patient’s chart and inserted new material tending to support the reasonableness of the decisions that the clinician had made. In each of these cases, to my knowledge, the new material was factually correct. The clinician was not lying about the events that took place, for example, the questioning of family members about the patient’s violent history or the attempt to follow up on missed aftercare appointments. But the clinician was lying about the date that these events were recorded: The entries were back-dated to appear as if they had been written before the violent act took place. In the most egregious of these cases, a patient had been released from a hospital on January 1 and had killed someone on January 10 (the dates are fictitious). In my capacity as expert witness for the defense, I reviewed the discharge summary. It was a superb document, including a carefully justified risk-management plan and detailed recommendations to the patient and family members regarding adherence to the plan. It was dated January 1, the day of discharge and 10 days prior to the killing. I thought that the case was won: Here was the gun, and there was no smoke. Then I noticed the secretarial inscription at the bottom of the last page. It read, “D: January 11; T: January 12.” My heart sank as I asked my own secretary to confirm my suspicions. The inscription was a secretarial convention for “dictated on January 11 and transcribed on January 12.” The summary had obviously been written on the day after the killing and back-dated to appear as if it had been written before the patient had been discharged. Either through naivete or a desire to avoid becoming an accomplice in fraud, the clinician’s secretary had put the correct dates on the very document containing the manufactured ones. When I informed defense counsel of the ruse, she immediately decided to settle the case—which she had previously thought was eminently winnable—for the amount the plaintiff was asking, rather than risk a trial at which the tainted discharge summary would be placed before the jury.

I want to underscore my belief that everything the clinician wrote in that discharge summary was true: He had indeed developed a careful risk-management plan and communicated to the patient and family exactly as was stated. Nothing was manufactured except the date. I empathize with the plight of overworked clinicians who find it difficult to get all their paperwork (i.e., documentation) completed on time, especially when there are live bodies in the waiting room or in the ward with competing demands for the clinician’s attention. I have many fewer responsibilities in my academic life, and I do not get all my work done on time, either.

Yet it should be clear why tampering with the record is always wrong, even when the intent is to make the record more accurately reflect what actually transpired in a case. It may be legally actionable, and it is strategically catastrophic.

If a suit has not been filed, one can argue that the record does not yet constitute evidence and so changing it is not illegal. But once a suit is filed, changing the record can constitute obstruction of justice. If the clinician is asked under oath whether the records—and the dates of entry are part of the records—are accurate and testifies affirmatively and if the late entries come to light, the clinician is guilty of perjury, a criminal offense.

The most likely outcome of tampering with the record, however, is to completely destroy whatever chances one had of winning the case. Of course, I have no way of knowing how often records were changed and the changes went undiscovered (some clinicians may have secretaries more clever or more loyal than the hapless one in the case I described). But when the late entries do come to light, they are dispositive. The jury will reason, understandably, that if the therapist would lie about the dates of the entries, he or she would also lie about the content of the entries. It is, in short, much better to admit that you didn’t keep good records and hope that the jury believes you when you tell them what happened than to manufacture good records after the fact at the cost of your own integrity and credibility.

Public Confessions
Therapists often feel responsible when a patient commits suicide. It is at least as traumatic for the therapist when a patient kills an innocent third party. Clinicians are not immune from the hindsight effect: Everything seems clear and determined in retrospect (Wexler & Schopp, 1989). Given the nature of their occupation, clinicians will often
want to talk through their feelings of guilt; however, they are strongly advised to resist such public confession. Urges (and might if necessary be advised to go to their own therapist to express their affect in the context of a confidential relationship). Whatever the clinician says can only hurt his or her case if a suit is filed, and, indeed, it may make the filing of a suit more likely.

I was retained on a case in which a patient discharged from a community mental health center later killed a stranger. On the day after the killing made the front page of the local newspaper, the director of the facility wrote numerous comments, in black ink, across the only copy of the discharge summary. These are some of them: "How could we have missed this!" "Somebody should have gotten his records." "Really shoddy work on our part." One can imagine the dollar signs glistening in the plaintiff's attorney's eyes when she saw this subpoenaed document. The case, needless to say, was settled on very generous terms. While unburdening one's conscience and self-flagellation may do wonders for the psyche, they are very hard on the net worth. Indeed, after this case, the mental health center in question was no longer able to buy liability insurance. No one would sell it to them.

Clinicians must learn that when their worst fantasies come true, they should take the time-honored course of defendants in criminal cases: Imitate a potted plant. Say nothing.

Conclusion

Writing of liability is not itself without risk. Clinicians can become so sensitized by the fear of litigation that clinical priorities are distorted and clinical judgment is impaired. The practice of "defensive therapy" is no less socially wasteful than defensive practice in physical medicine. If the import of my remarks is to make clinicians spend their time—and someone's money—tracking down tangentially relevant records or not-so-significant others, or rushing to consult with colleagues every time a young male patient walks in the door, then I have done neither clinicians nor their patients any service. Yet this need not be the outcome. As Richard Bonnie (1988) has written, in most situations, in my opinion, excessive risk avoidance is attributable either to the practitioners' uncertainty about their legal obligations, or to misperceptions about the conduct required to satisfy those obligations. It follows, then, that these negative defensive practices can be reduced by clarifying the specific steps that are sufficient, if undertaken, to discharge one's legal duty. One clear example is the Tarasoff duty. (p. 237)

By offering a set of guidelines to clarify clinicians' legal duty to protect third parties from the violent acts of their patients, I hope to reduce the general sense of anxiety and the occasional resort to excessive precaution that have come to characterize the mental health professions in the post-Tarasoff era.

REFERENCES


A. **Risk Assessment**
   1. Become educated in risk assessment, stay current with developments in the field, and be conversant with the law of the jurisdiction.
   2. Obtain reasonably available records of recent prior treatment and carefully review current treatment records.
   3. Directly question the patient and relevant others about violent acts and ideation.
   4. Communicate information and concerns about violence to the person responsible for making decisions about the patient, and make important items salient.

B. **Risk Management**
   5. For cases that raise particular concerns about violence, consider intensified treatment, incapacitation, or target-hardening.
   6. For especially difficult cases, seek consultation from an experienced colleague.
   7. Follow up on lack of compliance with treatment.

C. **Documentation**
   8. Record the source, content, and date of significant information on risk and the content, rationale, and date of all actions to prevent violence.

D. **Policy**
   9. Develop feasible guidelines for handling risk, and subject these guidelines to clinical and legal review.
   10. Educate staff in the use of the guidelines, and audit compliance.
   11. Revise forms to prompt and document the information and activities contemplated in the guidelines.

E. **Damage Control**
   12. Discourage public statements of responsibility and tampering with the record.