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Virtual Mentor

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FROM THE EDITOR

To Treat, Advocate, and Protect

Physicians are trained to ask two key questions of patients with mental illness: Do you have plans to harm yourself? Have you thought about hurting anyone else? An affirmative answer compels the doctor to play a protective role, sometimes keeping a patient in the hospital against his will to prevent self-harm or violence. In one sense, the physician is preventing the terrible consequence of a disease process. But suicide and homicide are also crimes, so in another sense the physician is stopping her patient from breaking the law.

This is just one example of the many situations in which physicians—particularly primary care doctors and psychiatrists—must balance competing responsibilities: putting the patient’s interests first and alerting others to possible harms that a patient may (or may not) inflict. Treatment decisions, too, become ethically complex when a patient is compelled by law to agree to the plan. People with mental illness, especially those who have broken laws, often find their autonomy, privacy, and right to refuse treatment curtailed. Physicians must understand their legal and moral obligations to such patients. The October issue of *Virtual Mentor* examines the ethical issues that arise at this intersection of mental health and the justice system.

Two clinical cases address the conundrum a physician faces with a potentially dangerous patient. In the first, a doctor contemplates whether or not to commit a patient who abuses alcohol to inpatient treatment against his will. Jeffrey C. Eisen, MD, MBA, provides commentary on the complex process of involuntary commitment for substance abuse. In the second case, a physician suspects that his patient with pedophilic fantasies may be a threat to a specific child. Fabian M. Saleh, MD, and H. Martin Malin, PhD, MA, LMFT, discuss the challenging question of when to report a patient to the authorities.

Two other pieces explore further the duty to protect. In his policy forum piece, Corey Rayburn Yung, JD, looks at the situation of those convicted of sex crimes in the justice system. To keep them from reoffending, many are held indefinitely under civil commitment laws. Yung critiques the murky legal and medical reasoning behind such policies. In his piece on the history of deinstitutionalization, Daniel Yohanna, MD, asks whether our desire to respect patient autonomy has left those who are most severely mentally ill without protection and argues that there may still be a place for mental asylums.

Two articles examine the conflicts of interest that arise when physicians are asked to submit legal testimony. Charles Dike, MD, discusses the dilemma of a psychiatrist who is asked to provide expert opinion for his patient’s worker’s compensation

application. In their law and medicine piece, Susan Buratto, MD, and Stephen H. Dinwiddie, MD, explain the critical distinction between being a treating physician and being a testifying physician. In both pieces, a physician's duty to advocate for patients comes in conflict with the duty to provide an objective, professional opinion for use by the justice system.

A third clinical ethics case explores another example of the use of a physician's expert opinion: a pediatrician offering public commentary on the psyche of a young man accused of murder. In his commentary, John Henning Schumann, MD, examines the responsibilities and restraints physicians must exercise when commenting in the public sphere.

Another set of articles explores notions of culpability of those with mental illness who have committed crimes. Daniel Yohanna, MD, and Maxwell R. Rovner, JD, MD, discuss a journal article on the use of posttraumatic stress disorder (PTSD) as a criminal defense. Eric Trupin, PhD, and his coauthors, Sarah Cusworth Walker, PhD, Hathaway Burden, and Mary Helen Roberts, look at the effectiveness of courts that divert young offenders with mental disorders to treatment centers rather than to jails.

While diagnosing a patient can be the important first step toward treatment, it can also burden that patient with a label and its associated connotations. In no area of medicine is this truer than in mental health, where a diagnosis can permanently stigmatize a patient. Carl Bell, MD, examines efforts to update the concept of personality disorders for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. How we conceptualize an illness is critically important to how we explain and treat it, he writes. Labels can have even broader implications in how individuals with a mental illness are treated by the legal system. In an op-ed, Howard Zonana, MD, explains how registries of patients with mental disorders often violate their rights without effectively protecting the public. In his medicine and society piece, Michael L. Perlin, JD, exposes society's—and the law's—discrimination against those who are labeled insane.

Treatment is, of course, the goal of medicine. Fred Friedman, JD, challenges us to be ambitious and collaborative in our treatment goals for those with mental illness. Health and justice can only be reached, he argues, by working in a true partnership with patients.

Laura M. Blinkhorn, MD
PGY-1
Swedish Family Medicine Residency-First Hill
University of Washington
Seattle, Washington

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ETHICS CASE

Speculating on a Public Figure's Mental Health

Commentary by John Henning Schumann, MD

Dr. Garcia was a pediatrician in private practice specializing in adolescent patients. Her hobby was writing, which she hoped to make a larger part of her career. To that end, she had been keeping a blog on medical issues and local politics. More recently, she had been invited to contribute commentary to the local public radio station.

Tragedy struck in the suburb where she practices. In a scenario that has become all too familiar, a 16-year-old tenth grader named John went to school with a gun, killed two classmates, and injured several others before surrendering to the police. One of Dr. Garcia's own patients had been shot. In the days following the violence, a few details emerged about John in the media. He was the only child of divorced parents. His father was a drug addict who had cut off contact with his son. Now John lived with his mother. Though he was a good student, he didn't seem to have many friends at school and had been the brunt of teasing. Classmates were quoted as saying he was "weird" and "a loner." An English teacher recalled a disturbingly violent short story he had written in a creative writing class the year before. A neighbor described seeing John through the window of his bedroom playing video games at all hours of the day and night. In video footage as he was led to the courthouse, John looked disheveled and was muttering to himself.

Like everyone else in town, Dr. Garcia was shocked and riveted. She was devastated by the shooting and longed to understand what had motivated John to act in this way. Moreover, she had long thought that there was insufficient mental health counseling at the local high school. She followed the media coverage intently and talked of little else with colleagues and friends.

Dr. Garcia believed that video games could desensitize some players to violence. By piecing bits of information together, she had begun to develop a theory about what had led John to such a desperate act. She surmised that he had had a troubled childhood and little support at home or school and was struggling with an emerging mental illness.

A reporter from the local radio station called to ask Dr. Garcia for an on-air interview about the shooting. As an expert on adolescence, Dr. Garcia could add insight into John's motivations, he said. Dr. Garcia eagerly agreed.

On air, Dr. Garcia said that information coming to light about John from his teachers' and classmates' descriptions unfortunately suggested a picture much like

that of several other young school shooters in the past few years. She said she suspected that most of them had clinical psychiatric problems that, if the schools had put enough resources into mental health services, could have been identified. It seemed possible, she said, that John had a severe mental illness, such as schizophrenia, and that he carried out the crime while he was psychotic. She went on to say that she had noticed in her pediatric practice that teens who felt ostracized and friendless often turned to videogames in their free time and that their playing only isolated them further. And, yes, she believed that violent videogames could desensitize some habitual players to real violence. The sad case of John illustrated why action needs to be taken on these fronts, Dr. Garcia argued.

The next day at work a senior doctor in her practice, Dr. Humphrey, mentioned that he had heard her on the radio. Dr. Garcia smiled and asked him what he thought.

“To be honest, I was pretty shocked. How could you make such suggestions about a young man you haven’t even met? He’ll be tried in this town. Your opinion carries weight because you’re a doctor. Did you ever think you’d be influencing a jury?”

Dr. Garcia was chastened. When she went home, she read through comments on the online version of her story. Some people endorsed her opinion and others disagreed. But it was true, she realized, that none of them knew what was going on with John. A lot of people disagreed with the policy changes she recommended. A few accused her of using the town’s tragedy to promote her own social agenda.

Commentary

Newtown. The Boston Marathon. Columbine. Oklahoma City. Fort Hood. 9/11.

These are but a few of the places and events that have become tragic pages in American history. Is the price of liberty that we must all learn to acclimate to instances of mass murder?

The sheer number of calamitous events we have seen in recent years has the potential to inure us to violence, lest we become emotionally involved in each horrible occurrence. These events flash through the news cycle like so much grist for the mill; even those that have fundamentally changed our culture eventually fade into memory.

When tragedies affect us, whether personally or at a distance, we grope for explanations as to why perpetrators see fit to harm innocents. We seek to interpret the uninterpretable.

The school shooting in her community personally and professionally affected Dr. Garcia. One of her patients was a victim. Therefore, on a personal level, it’s completely understandable that she became emotionally invested in the shooting. She was grieving injury to or loss of a patient, the loss to the community, a loss of “innocence.”

To mix metaphors, Dr. Garcia was socked in the solar plexus by the tragedy. But as a physician specializing in adolescence, her groping to explain the unexplainable fell right into her wheelhouse.

As a physician-blogger-cum-radio-personality with a growing platform, Dr. Garcia would be looked upon by community members to weigh in on the matter. The fact that she was personally invested in the tragedy would only add to her credibility.

When she appeared on local radio and speculated about the (presumed) killer's motives, Dr. Garcia had ample data on which to base her assessment: news reports and opinions from friends and work colleagues, mixed with her own theories about adolescent mental health and video games—all creating a narrative that would be of great interest to the radio audience. But her statements raise many ethical questions, as highlighted by both her colleague Dr. Humphrey's response to her appearance and the differing viewpoints in the comments section of the story's web version. How should Dr. Garcia have appropriately weighed her duty as a citizen against her duty as a physician in commenting on this case? Was it appropriate of her to use a mass medium to expound on what amounts to a set of her beliefs and opinions, in the absence of direct evidence? How much authority do Dr. Garcia's public comments carry?

Dr. Garcia is a pediatrician, not a psychiatrist. Therefore, her description of the suspect's motives or emotional milieu should be given only with a serious disclaimer, explaining that a psychiatric assessment is beyond what she can professionally offer. Her error is in omitting a disclaimer that her opinions are just that—and she should specify that they are in no way more meaningful by virtue of her professional credentials and proximity to the case.

However, as a concerned citizen and member of a caregiving profession (and perhaps as a parent—we are not told), she's perfectly within bounds to speculate on motives. From the radio station's perspective, she is a local expert. But she is ethically obligated to inform the station and listeners as to her biases and professional qualifications and limitations.

In fact, the American Psychiatric Association proscribes its members from commenting on the mental health of public figures under a nonbinding rule known as “the Goldwater Rule” [1], which originated after a 1964 magazine article that surveyed more than a thousand psychiatrists about Barry Goldwater's emotional suitability for holding the office of president. (Goldwater later sued for libel and won a monetary settlement [2].) The fact that many mental health professionals routinely violate the Goldwater Rule does not invalidate it. Those of us in the health professions who are solicited for comments about public events would be wise to heed its rationale, regardless of our specialty [3].

In trying to help the public (and herself) understand an atrocious act of violence, Dr. Garcia is trying to help herself, her patients, and her community. When called upon

by the news media for help in understanding the tragedy, Dr. Garcia is seeking to fulfill an obligation to the public to provide reliable, valid medical information [4]. However, in overstepping the bounds of her specialty and offering only conjecture based on hearsay and her own opinions, she is not living up to these societal or ethical expectations.

Dr. Garcia's foray into radio psychology in the case of the mass shooting potentially alters the mechanics and outcome of the community's response and law enforcement's handling of the case. In offering her opinion over a mass medium, she has potentially tainted the jury pool in her community, those neighbors and listeners who are supposed to consider the suspect innocent until proven guilty. Even if she turns out to be correct, by assuming the suspect guilty and speculating about his emotional state she has used her station adversely—despite the solace it may provide to both listeners and herself—because it may influence the trial's outcome unfairly.

Even if Dr. Garcia had contextualized her comments by stating she was attempting to understand John's motivations and offering only personal views, she would still have been veering into unethical territory. Physicians' opinions on matters of medicine, science, and policy are given extra credence by our educational attainment and trusted social role, whether deserved or not. I can think of only one instance in which psychoanalyzing public figures is part of the job description: working as a profiler for a law enforcement agency [5]. Dr. Garcia, though free as a citizen to speak her mind, should have upheld the profession's and nation's values by not putting forth speculations that may be given more weight than they deserve, even if events conformed to her professional hypotheses.

As physicians, we are imbued with society's tacit permission to delve into the personal and private. However, we must constrain ourselves from prurient speculation. As Voltaire wrote, "with great power comes great responsibility."

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John Henning Schumann, MD, is an associate professor of medicine and the director of the internal medicine residency program at the University of Oklahoma School of Community Medicine in Tulsa. He has written widely about patient experience and physician-patient communication, on topics ranging from the ethics of hospital discharges “against medical advice” to the “non-ethics” of nonindicated commercial screening tests. His blog and radio work can be found at glasshospital.com.

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ETHICS CASE

Pedophilia: Is There a Duty to Report?

Commentary by Fabian M. Saleh, MD, and H. Martin Malin, PhD, MA, LMFT

Dr. Gregory is a third-year psychiatry resident at a large academic medical center. Several months ago, Mr. Green was assigned to his care. A taciturn, overweight, 59-year-old janitor, Mr. Green was admitted to the emergency room with acute alcohol poisoning. He arrived at the hospital after having made a scene at a bar. When he sobered up, Mr. Green explained that he wasn't a regular drinker, but had tried getting drunk because he was so miserable.

Dr. Gregory had a particular interest in dynamic psychotherapy and had been hoping for patients open to that approach. Before discharge, Mr. Green agreed to return to Dr. Gregory's outpatient clinic for help.

Mr. Green was a responsive patient. He pledged never to touch alcohol again and readily admitted that he needed help for depression. In addition to prescribing medication, Dr. Gregory began weekly counseling sessions with Mr. Green. As Dr. Gregory began to earn his trust, Mr. Green shared some intimate details of his past. He had grown up with alcoholic, neglectful parents and had been molested by a family friend when he was a young boy. As an adult, he had no friends and had not had an intimate relationship for more than 2 decades. Dr. Gregory encouraged Mr. Green to be open and trusting. "This is a safe space," he assured him.

Several months into treatment, Mr. Green admitted that he was sexually attracted to little girls. He quickly added that he had never acted on these fantasies. Dr. Gregory reminded him that it was illegal to download pornographic images of children from the Internet. They both acknowledged that it would be catastrophic to act on the fantasies.

Dr. Gregory's acceptance seemed to embolden Mr. Green. Week after week, the conversation was dominated by descriptions of his pedophilic fantasies. More disturbing still, the fantasies all began to revolve around a little girl Mr. Green called "A." Though he spoke about her if she were a real girl, he insisted that she was purely a figment of his imagination.

Despite Mr. Green's insistence that this was fantasy, the specificity of the descriptions and explicit nature of his fantasies caused Dr. Gregory concern that "A" was not a fantasy but a real little girl whom Mr. Green had been watching. But if "A" were indeed an actual child, Dr. Gregory had no idea who she was. A relative? A neighbor? A co-worker's daughter?

Dr. Gregory was unsure what to do about Mr. Green. On the one hand, he had encouraged Mr. Green to be open about his feelings and private thoughts. He had assured him that he was safe. And, as far as Dr. Gregory knew, Mr. Green had never hurt a child. Everyone is entitled to a private fantasy life, Dr. Gregory thought. On the other hand, Dr. Gregory worried that Mr. Green might be a current or potential child molester. Mr. Green was starting to seem obsessed with the idea of “A.” If she were a real little girl, she could be in imminent danger.

Commentary

Dr. Gregory finds himself faced with an increasingly common ethical dilemma in psychiatric practice: how to balance the duty to protect the confidentiality promised to patients with the duty to protect children from a patient he increasingly believes may represent a significant threat.

Reporting

Opinion 5.05 of the American Medical Association’s *Code of Medical Ethics*, recognizing that physicians are impeded in providing appropriate treatment if their patients do not feel safe in disclosing personal information, holds that “information disclosed to a physician by a patient should be held in confidence...subject to certain exceptions which are ethically justified because of overriding considerations” [1]. Such exceptions include threats to inflict “serious physical harm” on the self or others with a “reasonable probability that the patient may carry out the threat” [1]. In such instances, the physician should take “reasonable precautions” to protect the intended victim, including notifying law enforcement. Physicians are further admonished to “disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law” when the law is contrary to the best interests of patients [2].

It would be hard to overstate the importance of the *Tarasoff* decisions with respect to medical ethics in general and confidentiality in particular [3]. The essence of the *Tarasoff* decisions is the dictum that, in conflicts between patient-therapist confidentiality and serious danger to reasonably identifiable others, protection trumps privilege. In his alliterative distillation of this dictum, California Supreme Court Justice Mathew O. Tobriner, for the majority, wrote: “The protective privilege ends where the public peril begins” [4]. It is important to note, however, that, while *Tarasoff* triggered a rash of “duty-to-warn” or “duty-to-protect” statutes nationwide, 16 states have adopted a discretionary approach to those duties and four states currently have no duty-to-warn or -protect statutes [5].

There is considerable congruence between the *Tarasoff* mandate to breach confidentiality in instances of serious threat of physical violence to a reasonably identifiable person and the American Medical Association’s *Code of Medical Ethics* opinion on confidentiality. Ken Kipnis has pointed out, however, that it is an error to infer that because some action is legally required, it is ethically required. Additionally, he warns against “the conflation of personal morality and professional ethics” [6].

Even if Dr. Gregory practices in a state with a Tarasoff-like duty-to-protect statute, it is arguable that not much of Tarasoff applies in Mr. Green's case. There is no reasonably identifiable victim and no serious threat of physical violence as anticipated by the Tarasoff criteria.

While Mr. Green's case currently does not appear to trigger the duty to protect mandated by Tarasoff, Dr. Gregory may have a duty or an ethical obligation to report Mr. Green to a state child welfare or law enforcement agency. In most states, he must make a report if he has a "reasonable suspicion" of child abuse. But what exactly will he report and to whom? He will be unable to identify a child who he believes has been or will be abused by Mr. Green. And while in most jurisdictions reporting in good faith carries with it immunity from suit for breach of confidentiality, Dr. Gregory will want to be certain that he is operating from a standard of practice embraced by his peers.

It seems, therefore, that Dr. Gregory cannot ethically report his fears about Mr. Green to law enforcement. This does not mean, however, that he should simply put his concerns aside. It is important for Dr. Gregory to discuss Mr. Green's case with his direct supervisor, who might suggest consulting with the medical center's risk managers and corporate counsel. It is likely that Dr. Gregory will have signed a document attesting to his awareness of his responsibilities as a mandated reporter as part of his employment agreement with the institution. Furthermore, licensing boards may have required similar attestations. The risk to Dr. Gregory is significant if he fails to honor those agreements.

There is much Dr. Gregory can do to ensure that his professional interactions with Mr. Green remain ethical and responsible.

Clarifying Confidentiality and Privilege

By promising Mr. Green that "this is a safe place," Dr. Gregory has inadvertently misled him. Dr. Gregory must make clear the limits of confidentiality in a psychotherapeutic relationship, including his obligations to protect Mr. Green and others in the event of a credible threat of harm and his special mandate to report suspected child abuse. Ethical practice requires that properly informed consent includes a clear disclosure of the limitations on confidentiality that might apply in Dr. Gregory's state. Mr. Green is entitled to be informed about the risks he incurs should he disclose reportable behavior even though Dr. Gregory assures him that it is safe to tell his story.

Treatment

Once clear boundaries around reporting have been established, it will be important for Dr. Gregory to explore his concern that "A" is an actual child and not just a figment of Mr. Green's imagination as the patient insists. It is not uncommon for clinicians to be so concerned with the legal requirements of mandated reporting that they neglect to question the patient carefully in therapy. Mr. Green's presentation strongly suggests a diagnosis of pedophilia, and denying illegal behaviors is not atypical patient behavior, at least early in therapy. Dr. Gregory will want to continue

scrutinizing the patient's story in the face of his clinical experience and other content in his patient's presentation, such as his detailed description of "A," that suggest that Mr. Green may not be disclosing completely. It will be important for Dr. Gregory to sharpen his interviewing focus and continue to explore discrepancies even if Mr. Green's initial responses are "no."

Dr. Gregory might also consult with or refer the patient to a colleague who specializes in the treatment of paraphilic disorders. Deciding not to report Mr. Green is not equivalent to deciding not to address his sexual fantasies and behavior in treatment; that requires training and a particular skill set that many excellent general therapists do not possess. Mr. Green may, indeed, have been an accurate reporter of his feelings and behaviors in therapy. But even patients who acknowledge sexual arousal towards children may be less willing to acknowledge sexual behavior with children. As a general rule, cognitive-behavioral therapies and relapse prevention strategies, including group therapies aimed at confronting and supporting patients as they struggle with denial, cognitive distortions, and social skills deficits, are helpful for patients like Mr. Green [7]. As an expert in dynamic psychotherapy, Dr. Gregory may not have significant experience with these modalities or the "containment" model for working with paraphilic patients who have abused children or are at risk for doing so.

Protection

Dr. Gregory will want to think about appropriate behavioral restrictions with Mr. Green as a condition of continuing to work with him in therapy. Dr. Gregory has made a start by warning Mr. Green of the illegality of viewing and downloading child pornography and obtaining Mr. Green's agreement that the results of doing so would be "catastrophic" [8]. There are other potential dangers that must be addressed in terms of an overall "safety plan" for Mr. Green. For example, if Mr. Green's job as a janitor involves working in schools or other places where children congregate, Dr. Gregory will want to help Mr. Green understand why he should consider changing jobs. If Mr. Green's job involves such ready access to children and if his symptoms were to become even more intense, an argument can possibly be made that he may be endangering children, thus triggering reporting requirements.

Finally, in view of the disclosures Mr. Green has been making about his pedophilic interests, Dr. Gregory should explore with Mr. Green the possibility of adjusting or modifying his medication regimen with the idea of diminishing his symptoms with the use of a serotonergic or testosterone-lowering agent. Informed consent would need to be obtained prior to treatment with either medication.

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Fabian M. Saleh, MD, is a forensic and child and adolescent psychiatrist and assistant clinical professor of psychiatry at Harvard Medical School in Boston. He is the director of the Sexual Violence Prevention and Risk Management Program at Beth Israel Deaconess Medical Center, a teaching hospital of Harvard Medical School. Dr. Saleh's forensic practice focuses on criminal and civil cases, including but not limited to juvenile sexual offending behavior, risk assessment, and risk management.

H. Martin Malin, PhD, MA, LMFT, is a clinical sexologist and licensed marriage and family therapist specializing in the treatment of sexual disorders. He is professor of clinical sexology at the Institute for Advanced Study of Human Sexuality in San Francisco and was formerly manager of the Johns Hopkins Medical School Sexual Disorders Clinic.

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ETHICS CASE

The Treating Psychiatrist and Worker's Compensation Reporting

Commentary by Charles C. Dike, MD, MPH

Stanley Crumb was a train conductor. Starting long before sunrise, he took passengers from distant suburbs into a bustling downtown. One morning, on his first run of the day, he saw a figure flash before the train. He pulled on the brakes, but it was too late. The train had killed a young woman. Mr. Crumb later learned that the woman had been severely depressed and had left a suicide note, but he could not help blaming himself.

Mr. Crumb was shattered by the event. Several weeks after the incident, he still could not sleep because of horrible nightmares. He kept having flashbacks, and in a disturbing variation he imagined jumping in front of a train himself. At the urging of his wife and his supervisor, he went to the employee assistance program and was referred for evaluation for psychiatric hospitalization. It was determined that Mr. Crumb needed to be hospitalized.

Dr. Young was his psychiatrist at the hospital. She diagnosed Mr. Crumb with posttraumatic stress disorder (PTSD). She started him on medication for depression and nightmares and on cognitive behavioral trauma therapy. After discharge, Mr. Crumb continued to see Dr. Young on a weekly basis.

Mr. Crumb was benefitting from psychiatric care, but it became clear to Dr. Young that PTSD was not his only problem. Mr. Crumb had a strong family history of mental illness, and several episodes in his past suggested to her that Mr. Crumb might have bipolar disorder. Dr. Young encouraged Mr. Crumb to continue treatment to better understand the nature of his illness.

One afternoon, Mr. Crumb arrived at her office in great distress. His insurance company was challenging the necessity of his continuing with therapy through his worker's compensation. Worse still, they were disputing payment of Mr. Crumb's hospitalization. Mr. Crumb hired an attorney and asked Dr. Young to provide a written statement about his current mental state and need for hospitalization.

A few days after submitting her statement, Dr. Young received a call from Mr. Crumb's lawyer. He asked her to remove certain sections of the written statement. Specifically, he wanted her to redact the section about her suspicions of preexisting bipolar disorder. It would destroy Mr. Crumb's chances of getting compensation, the lawyer warned.

Dr. Young believed her primary duty was to be an advocate for her patients. But if this went to a hearing, she would be sworn to tell the “whole truth” and that truth was complicated. She believed that Mr. Crumb may well have had a psychiatric illness before the accident, though the woman’s suicide was the defining trauma prior to hospitalization.

Commentary

This case highlights several difficult challenges facing treating clinicians when they are suddenly thrust into the murky waters of the criminal justice system. Specifically, it accents the immense responsibility a psychiatrist has when her patient depends entirely on her formal report to obtain a desired outcome. The involvement of an attorney complicates matters even more. The critical ethics question is whether or not Dr. Young should redact sections of her psychiatric report at the request of her patient’s attorney.

Attorneys and physicians are professionally bound by different sets of ethical obligations. Attorneys are ethically mandated to zealously advocate for the stated desires of their clients. The “win or lose” mentality fostered by our legal system often encourages attorneys to engage whatever mechanism they can without breaking the law in order to “win” for their clients. It is, therefore, understandable that Mr. Crumb’s attorney would ask Dr. Young to redact portions of her report, if he believes it would aid Mr. Crumb in receiving worker’s compensation.

Physicians, on the other hand, are trained to vigorously advocate for what is in the best interest of their patients even if it runs contrary to their patients’ stated desires, an ethical principle often referred to as beneficence. Additionally, physicians are enjoined to comply with the ethical principle of nonmaleficence—avoiding causing harm to their patients. The American Academy of Psychiatry and the Law (AAPL) Ethics Guidelines note that psychiatrists should be bound by ethical principles of respect for persons, honesty, justice, and social responsibility [1]. Hence, it is only natural that the ethical obligations of attorneys will clash in some cases with the ethical obligations of psychiatrists for honesty in their evaluations and reports.

Dr. Young believes that continued therapy is important for Mr. Crumb’s recovery, but she cannot compromise her professional integrity to achieve that end. The AAPL Ethics Guidelines emphasize the observation that “being retained by one side in a civil or criminal matter exposes psychiatrists to the potential of unintended bias and the danger of distortion of their opinions” [1]. Psychiatrists are admonished not to “distort their opinion in the service of the retaining party” [1]. To be honest and objective, psychiatrists must aspire to tell “the whole truth and nothing but the truth” in all areas of their work. Psychiatrists preparing a report for a third party enhance the honesty and objectivity of their work by basing their opinions on all available data. Therefore, drawing a conclusion from limited data or purposely ignoring or deleting data is not only problematic but also unethical.

While nonmaleficence and beneficence are at the core of clinical interactions, they operate less well in a legal or quasilegal setting where psychiatrists must maintain a delicate balance between competing duties to the patient, to a third party, and to their profession. As a result, treating psychiatrists should generally avoid performing evaluations of their own patients for legal purposes. It is recognized, however, that in certain situations such as disability evaluations, worker's compensation proceedings, civil commitment hearings, and the like, treating psychiatrists may be required to generate a psychiatric report for a third party. Psychiatrists completing a report for their patients' eligibility for compensation of any kind should be particularly vigilant and sensitive to the implications of these competing roles—they must be careful not to act as agents of the state and essentially “deny” all requests for compensation by their patients and, by the same token, be careful not to endorse every request for compensation by their patients.

The case presented for discussion demonstrates the complexity of working with an attorney in a clinical context; wearing the hat of a treating psychiatrist while at the same time preparing a psychiatric report for a patient's attorney. It is not uncommon for attorneys to ask for sections of a psychiatric report to be altered in some way to suit the attorney's particular purpose. The question of whether or not the draft of a psychiatric report should be submitted to attorneys for their review and comments has been the subject of a great many debates among forensic psychiatrists [2-4]. Some believe it is helpful because reviews by attorneys may help identify incorrect factual information, which, if not corrected, could be embarrassing and could lead to questions about the validity of the report and credibility of the author [2-4]. Other psychiatrists believe, however, that providing an opportunity for attorneys to comment on a draft report could lead to a conflict, as in the case presented; they opine that only the finished product should be submitted and all requests for alteration of the report should be ignored. To the latter group, maintaining a rigid stance guards against any improper influence. All groups agree that redacting information relevant to a psychiatric report in order to appease an attorney (or a patient for that matter) is unethical [2-4].

Dr. Young should seek clarification from the attorney about the attorney's rationale for requesting a redaction of sections of the report that suggested a preexisting bipolar disorder; even if there were a preexisting mental illness upon which Mr. Crumb now developed a valid PTSD diagnosis, would the concept of the “eggshell or thin skull rule” not apply? This is a legal concept used to explain a defendant's culpability. In sum, it states that a plaintiff's preexisting condition should not mitigate either the punishment or compensation for harm. Applied to this case, the presence of a preexisting bipolar disorder would be irrelevant to Mr. Crumb's claim, given that an identifiable traumatic event led to his subsequent development of symptoms of PTSD (and perhaps, to the worsening of the preexisting condition as well).

While it would be unethical for Dr. Young to alter her psychiatric assessment, it would be permissible for her to better explain her reasoning. Were Dr. Young to

need more clarity regarding diagnosis, she could consider requesting additional investigation through psychological testing in order to paint a more complete picture of her patient. Dr. Young would have to present support for her professional opinion that, despite the presence of an underlying mental illness, the trauma from the accident led the patient to develop PTSD; that, but for the accident, her patient would not have suffered from PTSD; and that the symptoms of PTSD worsened an underlying but hitherto undiagnosed psychiatric condition. Dr. Young would strengthen her case by comparing her patient's level of functioning before and after the accident to indicate the impact of the trauma on him. Furthermore, a preexisting mood disorder, if that were the case, should not preclude Mr. Crumb from being covered for treatment by his insurance company given the "thin skull" theory described above.

In conclusion, with regard to redacting of information, Dr. Young should consider redacting or editing only incorrect factual information provided by the patient or collateral sources, but insist on leaving information relevant to her professional opinion.

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Charles C. Dike, MD, MPH, is an assistant professor of psychiatry and the deputy training director in the Law and Psychiatry Division fellowship program at Yale University Medical School in New Haven, Connecticut. He is also director of the Whiting Forensic Division at Connecticut Valley Hospital in Middletown.

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ETHICS CASE

Civil Commitment for Substance Abuse

Commentary by Jeffrey C. Eisen, MD, MBA

Mr. Robinson arrived at the emergency room in the middle of the night after crashing a car through a glass storefront. Luckily for him, he hadn't been going very fast, but had a large cut on his hand. He was not an easy patient; he swung at a nurse who was cleaning his wound, yelled obscenities at the doctor who was trying to get a history, and urinated in his cubicle. His hand required 20 stitches. His blood alcohol level was 400.

When Mr. Robinson's daughter Margaret arrived at the hospital, she was frantic with worry, not only about the health of her father but also about her own family. The car was hers and she needed it to get to work. She was the single mother of two young children, whom she'd had to leave with a neighbor. Her father had come to live with them in the Boston suburbs a year earlier after going through a messy divorce. He'd struggled with alcohol throughout his life, but had started drinking heavily again soon after moving in with Margaret. This was his third visit to the emergency department for an alcohol-related crisis. Margaret was at her wit's end. She asked to see Dr. Diallo, a psychiatrist who had been called in to interview Mr. Robinson during a previous hospitalization.

"We've tried everything—individual therapy, group therapy, AA, outpatient full-day programs. It just isn't enough for him. He's wonderful when he's sober, but drunk is another story."

Dr. Diallo agreed that Mr. Robinson needed more intensive care to achieve sobriety. He decided to admit Mr. Robinson to the hospital for detoxification and to broach the subject of longer-term inpatient treatment with him that afternoon when he had sobered up and Margaret got out of work.

Mr. Robinson was a completely different person in the afternoon. He gave Margaret a hug when she came in and asked about his grandchildren, but he was less pleased to see Dr. Diallo. "I just got a little too drunk last night," he said impatiently.

Margaret reminded him that they had been through similar episodes three other times. "You're an alcoholic, Dad. You scare me when you're drunk."

Dr. Diallo told him about the advantages of ongoing hospitalization for substance-abuse treatment, but Mr. Robinson shook his head. He wasn't interested. Margaret

begged Dr. Diallo to intervene. “He got into a car in that state! He’s a menace to himself, my family, and the whole community,” she argued.

Unlike many states, Massachusetts allows for involuntary civil commitment for patients with substance use issues if they are at risk of “serious harm” to themselves or others as a result of their use of substances. Though a judge ultimately determines whether or not a patient can be involuntarily committed for substance-abuse treatment, the psychiatrist must make the decision whether or not to petition the court for such an order.

The decision weighed heavily upon Dr. Diallo. On the one hand, Mr. Robinson had come into the ED three times with dangerously high levels of alcohol. On the other hand, infringing someone’s freedom demanded strong justification, especially when that person had, so far, not harmed anyone or been accused of harming anyone. Dr. Diallo wondered if mandating inpatient treatment for substance abuse was in his patient’s best interest.

Commentary

The case of Mr. Robinson describes the complexities associated with treating the substance dependent patient. Dr. Diallo’s desire to motivate this patient to seek treatment, and the worry expressed by his daughter, stand in great opposition to a patient who denies both the problems and consequences of ongoing substance use.

The concerns of Dr. Diallo and Margaret are further heightened by Mr. Robinson’s potential for harm to himself, and others as well, due to his alcohol dependency. He could have injured or killed others when crashing his car. Following this event, he attempted to assault a nurse in the Emergency Department (ED), yet again endangering the life of another.

Mr. Robinson’s actions affect Dr. Diallo and Margaret considerably. Margaret exemplifies the range of conflicting and often confusing emotions felt by family members attempting to reach their substance-abusing loved ones. Margaret expresses worry, frustration, hurt, and, importantly, a sense of helplessness and desperation. Similarly, Dr. Diallo feels compelled to intervene, yet may feel helpless to change a dire situation and frustrated when the patient does not adhere to treatment recommendations.

Given that Mr. Robinson risks significant harm to himself and others due to substance dependence and has not been helped by other treatment modalities, Dr. Diallo ponders an important question, namely if mechanisms exist to mandate substance-abuse treatment against the will of the patient. In the state of Massachusetts, Chapter 123, Section 35 of the Massachusetts General Laws allows spouses, blood relatives, guardians, physicians, and police officers to petition the court to commit substance-dependent patients for up to 90 days of treatment in a locked facility. This suggests that Dr. Diallo or Margaret may petition the court to commit Mr. Robinson to inpatient substance-abuse treatment.

Between 2004 and 2008, up to 5,000 Section 35 civil commitment cases were considered per year in Massachusetts [1]. Nationally, 38 states have laws that permit civil commitment to inpatient or outpatient substance-abuse treatment programs. Of the remaining states, 8 permit some form of involuntary treatment that does not include civil commitment, such as emergency hospitalization due to substance-use concerns. Alabama, Pennsylvania, Virginia, and Wyoming do not offer any legal provision for involuntary treatment [2]. Notably, Massachusetts law authorizes commitment to inpatient programs only and does not include an outpatient option.

Clinicians may express interest in this modality of treatment but are often uncertain about whether or not a particular patient is appropriate for mandated treatment, and many may not even be aware of the existence of such laws. Dr. Diallo seems uncertain in both of these regards—whether or not mandated treatment is even possible and, if so, to what extent Mr. Robinson might meet the criteria for commitment.

Determining which patients are appropriate candidates for mandated substance-abuse treatment remains controversial and complicated. Dr. Diallo must be aware of the criteria for commitment under the Massachusetts law. First, the individual under consideration must be a substance abuser, which is defined in the law by chronic or habitual ingestion, the loss of power of self-control over the use of substance(s), and interference with social and/or occupational functioning. Second, likelihood of “serious harm” as a result of the substance use must exist [3].

In this case, determining the seriousness of harm at time of initial presentation is not particularly difficult, given the dramatic events leading to Mr. Robinson’s arrival in the emergency department and the behavior following it. However, the evidence shifts over time. Once admitted to a detoxification unit and sober, the patient becomes “a completely different person,” described as “wonderful” by his daughter. A clinician evaluating the patient at the time of ED arrival might conclude that the imminence of risk supports civil commitment for substance-abuse treatment, whereas a clinician evaluating the pleasant, sober patient may have less urgent concerns about seriousness of harm. Mr. Robinson’s actions while intoxicated are clearly serious, but, as it pertains to the civil commitment statute, clinicians may interpret the definition, timing, and imminent nature of “serious” differently.

Dr. Diallo’s review of the legal criteria only represents the beginning of this process. Even if Mr. Robinson appears to meet the legal standard for civil commitment, many clinician-, patient- and systems-based factors can affect the commitment process and may limit access to mandated treatment. Dr. Diallo will also consider the efficacy of such treatment and his own ethical framework as he decides whether or not to file a petition.

The complexity involved in pursuing an order for mandated treatment could create a significant barrier for Dr. Diallo or Margaret, who have limited knowledge of the petitioning process. Typically, in my experience, the physician must provide written

documentation in support of the petition, present data at court in front of a presiding judge who will decide the case, and otherwise coordinate patient discharge, among other tasks, all of which are time consuming and take away from time with other, perhaps more urgent, patient needs. As this case continues, Dr. Diallo will have to determine whether the time and effort involved in the process is prohibitive, given the many responsibilities involved in managing a multitude of complicated patients on his detoxification unit. In essence, Dr. Diallo must feel compelled enough to take the time away from other responsibilities to focus on this endeavor.

Patients with medical or psychiatric comorbidities can be challenging for substance-abuse commitment facilities, which may not have staff with the necessary expertise to manage these additional concerns. In some cases, physicians must also assert that the person being committed will remain medically stable throughout the holding and transfer process until reaching a facility. This case does not suggest that Mr. Robinson has acute medical or psychiatric problems that would affect the civil commitment process, but it would be important to consider the possibility that he may experience the physical effects of withdrawal during the holding and transfer period.

The nature of the legal system may also complicate a petitioning effort. In my experience, judges can hold a higher threshold for commitment if a patient has been previously committed. While this has not been documented in the case, it is an important detail not to be overlooked. If a prior commitment is found, Dr. Diallo may need to explain his rationale for pursuing this treatment modality, given that prior commitment did not result in ongoing sobriety.

The timing of the petition requires consideration as well. In Massachusetts, petitions for civil commitment for substance abuse are filed and heard by judges only when the court is open [4]. If Mr. Robinson arrived in the emergency department on the weekend or overnight, for example, clinicians would be limited in their ability to pursue the petition when the need and evidence for containment was greatest. The petition would originate from Mr. Robinson's location in the detoxification unit, which allows more time to prepare the petition, allows Mr. Robinson to detox safely, and reduces the risk of his going through a withdrawal event during the process. Nonetheless, the petitioning effort should still begin at the start of the business day so that the petition and the patient arrive at court early enough for the case to be heard.

As Dr. Diallo evaluates this case, he will certainly ask whether mandated treatment for substance abuse works. A review of 30 years of research into the efficacy of coerced substance-abuse treatment reveals an inconsistent and inconclusive pattern of results [5]. Several of the studies cited in this review found that treatment outcomes for mandated and nonmandated clients did not differ. While certain studies found that voluntary clients had better treatment outcomes, others asserted that legal pressure was negatively related to treatment outcomes. Similarly, studies of the sobriety retention rates of mandated and nonmandated clients reflected mixed

outcomes [5-9]. A number of factors account for the varied conclusions, including small sample sizes, the lack of group differences at baseline, the challenge in comparing mandated to nonmandated treatment programs and differences in outcome measures [5].

A clinician's interpretation of the appropriate outcome measures associated with substance-abuse treatment by civil commitment complicates the decision-making process. If basic survival for 90 days represents a successful outcome because risk of imminent harm or death is averted during the commitment period, then a clinician may support pursuing civil commitment as a treatment option. Other clinicians may assign a period of postcommitment sobriety as the appropriate measure of success.

With scant data to support or refute the efficacy of mandated substance-abuse treatment, the decision will fall to Dr. Diallo's clinical judgment, which incorporates the factors associated with this specific case and his own ethical framework. Ethical considerations weigh significantly in the decision to commit a patient for substance-abuse treatment [5]. A review of 850 papers related to coerced substance-abuse treatment noted that 81 percent were nonempirical in nature, reflecting that the discussion of civil commitment for substance abuse emphasizes the significant ethical, legal, and policy issues involved in such treatment [5]. Dr. Diallo must consider the extent to which society should curtail the liberty of substance users and, as such, if he should take away Mr. Robinson's freedom to protect his life and the well-being of the greater community.

Despite agreement between Dr. Diallo and Margaret that that Mr. Robinson often places himself in serious risk of harm to himself and others as a result of ongoing substance use, the question remains whether or not civil commitment for substance-abuse treatment is appropriate for him, particularly when taking into account the multifaceted commitment process and the lack of clarity from the perspectives of efficacy and ethics. As is common in such cases, Dr. Diallo will likely to continue the discourse and debate with his peers, with the family of Mr. Robinson, and with the patient himself.

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Further Reading

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Jeffrey C. Eisen, MD, MBA, is a supervisor and instructor in psychiatry at Harvard Medical School and the Cambridge Health Alliance and is the 2013-2014 fellow in forensic psychiatry at the University of Massachusetts Medical School. His interests include ethics and efficacy in civil commitment for substance-abuse treatment and performance improvement in behavioral health. He also implemented the integration of psychiatric services into a primary care clinic serving the homeless population of Cambridge and its surrounding communities.

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THE CODE SAYS

AMA Code of Medical Ethics' Opinions on Discussing Patients with Third Parties

Opinion 5.04 - Communications Media: Standards of Professional Responsibility

Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients. When information concerning a specific patient is requested by the media, the physician must obtain the consent of the patient or an authorized representative before releasing such information. The physician may release only the authorized information or that which is public knowledge. The patient-physician relationship and its confidential nature must be maintained.

With these considerations in mind, the physician may assist the representatives of the media in every way possible. When the patient or authorized representative consents to the release of information, physicians should cooperate with the press to ensure that medical news is available more promptly and more accurately than would be possible without their assistance. Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason, prognosis will be given only by the attending physician or at the attending physician's direction.

Statements regarding the circumstances surrounding shootings, knifings, and poisonings are properly police matters, and questions whether they were accidental should be referred to the appropriate authorities.

Certain news that is part of the public record, such as deaths, may be made available without the consent of the patient or authorized representative.

Issued prior to April 1977; updated June 1996

Opinion 5.05 - Confidentiality

The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations.

When a patient threatens to inflict serious physical harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notification of law enforcement authorities.

When the disclosure of confidential information is required by law or court order, physicians generally should notify the patient. Physicians should disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law.

Issued December 1983; updated June 2007 based on the report “Opinion E-5.05, ‘Confidentiality’ Amendment.”

Opinion 5.06 - Confidentiality: Attorney-Physician Relation

The patient’s history, diagnosis, treatment, and prognosis may be discussed with the patient’s lawyer with the consent of the patient or the patient’s lawful representative.

A physician may testify in court or before a worker’s compensation board or the like in any personal injury or related case.

Issued prior to April 1977

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JOURNAL DISCUSSION

The Evolving Definition of Posttraumatic Stress Disorder: Legal Ramifications

Daniel Yohanna, MD, and Maxwell R. Rovner, MD, JD

Berger O, McNeil DE, Binder RL. PTSD as a criminal defense: a review of case law. *J Am Acad Psychiatry Law*. 2012;40(4):509-521.

I was flying back to San Francisco to get a flight to the East Coast and I had a nightmare. The motion of the plane brought me back, and I woke up shouting. Everyone on the plane moved away and there was a big empty spot around me on the plane. After that, it was very bizarre and jarring.
John Kerry [1]

In this article, Drs. Berger, McNeil, and Binder have reviewed case law from appellate courts around the country and in the District of Columbia regarding the use of posttraumatic stress disorder (PTSD) as a criminal defense [2]. This review is especially important to forensic psychiatrists because as it establishes and outlines how PTSD can be used at the trial level and how it is viewed at the appellate level when the trial court decision has been appealed.

Defining PTSD

When John Kerry returned from Vietnam in April of 1969, he suffered a flashback and dissociation due to his combat experience [1]. The reaction of his fellow passengers—regarded by Vietnam veterans as characteristic of the era—was misunderstanding and revulsion. However, largely as a result of media coverage of the plight of returning Iraq and Afghanistan War veterans, PTSD has become part of the common lexicon. Twelve to 13 percent of returning veterans of the Iraq war [3] and a lesser number from the Afghanistan war [4] have been diagnosed with PTSD. Other sources of public exposure to the diagnosis of PTSD include reporting on children and adults who have been abused or who have been repeatedly exposed to acts of violence in our inner cities and who go on to develop the condition.

Even the new *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*), has recognized the changes in our understanding and perhaps acceptance of PTSD by placing it and reactive attachment disorder, disinhibited social engagement disorder, acute stress disorder, and adjustment disorder in a separate chapter on trauma- and stressor-related disorders. The *DSM-5* also expanded the definition of the criterion of the traumatic event, known as criterion A, to include *learning* that a traumatic event befell a close family member or friend. The list of symptoms has been expanded to include intrusive symptoms, avoidance of stimuli

associated with the traumatic event, and alterations in arousal and reactivity, which means negative thoughts and emotions associated with the traumatic event [5].

This redefinition may prove legally significant, inasmuch as exaggerated negative beliefs about oneself and the world, a phenomena also known as hostile attribution or intent, may increase the likelihood of a person's committing an aggressive act [6]. For example, possessing, after a traumatic event, the distorted idea that the whole world is a dangerous place or that certain groups of people cannot be trusted may increase the risk that a person will react aggressively to what would otherwise have been viewed as a benign situation. So, for instance, if a person has been assaulted by someone in a baseball cap and bomber jacket, he or she might use mace more readily on the next similarly attired individual who brushes past her. The new criteria are likely to expand the number of people diagnosed with PTSD and increase the likelihood that it will be used as a defense in criminal cases.

PTSD in Criminal Defenses

The review paper examines recent cases brought on appeal in which PTSD was offered as a basis for a criminal defense. It includes claims that the defendant is not guilty by reason of insanity (NGRI), cases in which unconsciousness was used as a defense, self-defense justifications, and cases involving diminished capacity and mitigating circumstances in sentencing.

Using the legal database LexisNexis, Berger et al. reviewed 194 federal and state appellate court cases in which PTSD was used as a defense through 2010. Of those cases, 47 involved a criminal defense based on a diagnosis of PTSD. In 39 of the cases, there was a PTSD defense that was addressed by the appellate court and they became the subject of authors' review; in 8, the issue appealed was not related to PTSD, so the appellate court decided the case on other grounds. Also included in the review were three unpublished trial cases in which PTSD had been raised successfully as a defense. It is likely that there are numerous similar cases, but such trials are generally not published and are therefore unavailable for review.

Several important conclusions can be drawn from this review for forensic psychiatrists. First and foremost, expert testimony regarding PTSD meets criteria for admissibility in court. It meets what is known as the *Daubert* test of admissibility decided in the 1993 U.S. Supreme Court case of *Daubert v. Merrell Dow Pharmaceuticals* [7]. Following the court's decision in that case, diagnosis is admissible if it is provided by an expert, i.e., one who uses reliable criteria to make the diagnosis, and if there is support for the diagnosis in the literature and general acceptance of the diagnosis in the field.

PTSD has been the basis for successful insanity defenses since 1979. Berger and his colleagues concluded from the small number of jury trials reviewed that PTSD has been a successful insanity defense at trial, particularly and perhaps only, when the phenomenon of dissociation has been involved.

PTSD has received mixed treatment as an insanity defense at the appeal level. This is especially true since the widespread reform of insanity statutes around the country following the NGRI trial of John Hinckley Jr., who shot President Reagan in 1981. In many state and federal laws, statutes were amended to require that a defendant have a *severe* mental illness or defect [8], and insanity became an affirmative defense, i.e., one that required proof that the defendant was insane and met the strict M’Naghten requirement that he or she lacked the capacity to understand the nature and quality or wrongfulness of his or her conduct—sometimes summarized as “knowing right from wrong” [8]. The affirmative defense was a response to the less restrictive criteria of the American Legal Institute (ALI), which some states still retain and which allow an insanity claim to be made if the defendant was incapable of conforming his or her conduct to the requirement of the law at the time of the crime [9].

Dissociation. Berger concludes that dissociation would likely be the only PTSD-related phenomenon that would meet the M’Naghten standard in jurisdictions where a “clear and convincing” standard of proof is applied. Dissociation is defined by the American Psychiatric Association as “a disruption of consciousness, memory, identity or perception” and is associated with several psychiatric diagnoses other than PTSD [5]. Dissociation following a traumatic event is strongly correlated to the development of PTSD [10] but is generally responsive to treatment [11]. Proving that dissociation has occurred and continues to be a symptom in defendants with PTSD is a challenge for forensic experts, especially when the defendant in question has undergone treatment.

Unconsciousness. The dissociation symptom of PTSD has also been used successfully to argue in favor of the defendant’s unconsciousness during a criminal act. If it can be demonstrated that a defendant was not conscious of his surroundings when he committed a criminal act, that is, in itself, grounds for acquittal. Although it is not known what weight juries have given this defense in acquittals, courts have determined that juries can be instructed by the judge during a trial about the nature of this defense and may consider it in their deliberations and that expert testimony about it can be given.

Self-defense. The authors have also cited cases in which battered-spouse syndrome has been classified as a form of PTSD and used as a defense. Courts have deemed PTSD relevant in cases in which abuse victims have harmed their abusers [2]. Given the expanded *DSM -5* criteria that include negative alterations of cognition, it is likely that PTSD may be used more often as a component of self-defense arguments.

Appellate courts have also ruled that it is an error for trial courts to exclude expert testimony in cases where PTSD has been introduced to refute the requisite state of mind (or *mens rea*) in jurisdictions where expert testimony typically is allowed to refute *mens rea*. The *mens rea* standard requires that the person had a specific intent to commit a crime and committed it purposely and knowingly [12]. These rulings

confirm that PTSD is relevant in trials where diminished capacity or a related *mens rea* defense is offered.

The authors conclude that PTSD can also play a role in establishing a mitigating circumstance during the sentencing phase of trial. They cite hyperarousal symptoms, impaired impulse control, overestimation of danger and dissociative phenomena as likely elements to be used as a mitigating circumstance in federal and in some state cases, but a connection between the PTSD and the offense must be established.

Conclusion

In conclusion, forensic psychiatrists will need to be familiar with the use of PTSD as a legitimate and proper defense in criminal cases, especially given the changes in the *DSM-5* and greater public awareness of PTSD. Careful screening for PTSD, review of ongoing symptoms, changes in symptoms over time, with or without treatment, and relevance to the offense will be crucial elements of expert testimony.

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Daniel Yohanna, MD, is the vice chair and an associate professor in the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago Pritzker School of Medicine. His interests are in community psychiatry and forensic psychiatry, as well as the development of systems of care for people with mental illness.

Maxwell R. Rovner, MD, JD, is a fourth-year psychiatry resident at the University of Chicago Medical Center. He is a graduate of Harvard Law School and the University of Chicago Pritzker School of Medicine. Before going to medical school, he was a law clerk for U.S. District Judge Harry D. Leinenweber, a policy assistant to Chicago Mayor Richard M. Daley, and the chief speechwriter to Mayor Daley and U.S. Senator Carol Moseley-Braun. He is interested in outpatient and forensic psychiatry.

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STATE OF THE ART AND SCIENCE

Dynamic Descriptions of Personality Disorder in the *DSM-5*

Carl C. Bell, MD

The practice of psychiatry, like the practice of all medicine, is an intellectual, emotional, moral, spiritual, and ethical vocation; it is a serious undertaking because people's lives and well-being depend on the accuracy of the models, science, and art that determine outcomes. With this in mind, the American Psychiatric Association's Board of Trustees appointed a work group to draft the section on personality disorders for the latest version of the *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM-5* [1], and I was a member of that work group.

Much research had been done on personality disorders since publication of the *DSM-IV* in 1994 [2]. According to the *DSM-IV*, there were two ways to classify personality disorders—the categorical approach, which contends that personality disorders are distinct clinical syndromes—and the dimensional approach, which posits that personality disorders “are maladaptive variants of personality traits that merge imperceptibly into normality and into one another” [3]. Since 1994, a wealth of research had been directed toward determining the value of a dimensional versus a categorical model for personality disorders, and, after lengthy discussions about the merits of each, the work group decided to strike a balance between the two approaches, developing a hybrid model with features of both.

The APA's Board of Trustees decided that the work group's model was too difficult for the field to use and put the product of our work in Section III of the personality disorder chapter, the section called “Emerging Measures and Models—Alternative *DSM-5* Model for Personality Disorders.” Section II, “Diagnostic Criteria and Codes for Personality Disorder,” in the *DSM-5* remains the same as it was in the *DSM-IV*. Section III, containing the work group's efforts, notes that personality disorders are characterized by impairments in personality functioning and pathological personality traits [4]. With this conceptualization, the *DSM-5* takes a decided turn to being psychodynamic as well as descriptive, where the *DSM-IV* was descriptive only.

In the Section III model, the functioning of personality is assessed in the domains of the self and interpersonal relations—decidedly psychodynamic concepts—and by personality traits—which are descriptive. The latter, the descriptive personality trait aspects that remain in Section II of the *DSM-5*, are unchanged from the *DSM-IV*. They describe Cluster A (paranoid, schizoid, and schizotypal) personality disorders; Cluster B (antisocial, borderline, histrionic, and narcissistic) personality disorders; and Cluster C (avoidant, dependent, and obsessive-compulsive) personality disorders [4].

Functioning of Personality in Domains of Self and Interpersonal Relations

The Section III addition outlines the characteristics of normal or healthy personality functioning in the domains of self and interpersonal relations. At the level of *self*-functioning, the healthy personality has two components:

1. Identity: characterized by an “ongoing awareness of a unique self; maintenance of role-appropriate boundaries; consistent and self-regulated positive self-esteem, with accurate self-appraisal; and the capacity of experiencing, tolerating, and regulating a full range of emotions” [5], and
2. Self-direction: exemplified in a person who “sets and aspires to reasonable goals based on realistic assessment of personal capacities; utilizes appropriate standards of behavior, attaining fulfillment in multiple realms, and can reflect on, and make constructive meaning of, interpersonal experience” [6].

Likewise, at the level of *interpersonal* functioning, a healthy personality is determined by the quality of two aspects of interpersonal relationships, empathy for others and intimacy with others.

1. Empathy: a person has healthy empathy for others if he or she is: “capable of accurately understanding others’ experiences and motivations in most situations; comprehends and appreciates others’ perspectives, even if disagreeing, and is aware of the effect of [his or her]...actions on others” [6].
2. Intimacy: intimate aspects of a personality are normal if the person is capable of: “maintaining multiple satisfying and enduring relationships in personal and community life; desiring and engaging in a number of caring, close, and reciprocal relationships; and striving for cooperation and mutual benefit and flexibly responds to a range of others’ ideas, emotions, and behaviors” [6].

This contribution provides a major breakthrough; by defining characteristics of a healthy personality, it establishes a normative reference point for interpersonal functioning in life that adds clarity to the assessment and diagnosis of the people we seek to serve and help.

As we begin to use the *DSM-5*, the ethical issues associated with the personality disorder descriptions will surface. For example, because carrying a diagnosis borderline or narcissistic personality disorder is quite damaging to patients, the *DSM-IV* categorical personality diagnostic approach perpetuates stigma, whereas a dimensional approach would break that stigma. Because the dimensional model has a more psychodynamic base, it is, for now, less stigmatizing, and has greater capacity for recognizing that personality traits are not everlasting and thus can be altered with early childhood social and emotional skills training [7]. Regarding the impact on patients in the criminal justice system, although the *DSM-5* has the customary “Cautionary Statement for Forensic Use” [8], a diagnosis of antisocial personality is associated with a dangerous, criminally prone person who is likely to be stuck in that mode for the rest of his or her life. Accordingly, using the dimensional personality model may mean that fewer people will be demonized by psychiatric personality diagnosis.

With electronic technology, the *DSM-5* will be easier to revise than its predecessors, and, as more solid evidence accumulates, it is possible that the psychodynamic, hybrid personality disorder model of Section III will be integrated into the diagnostic criteria and codes section of the *DSM-5* before another 19 or 20 years elapses.

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Carl C. Bell, MD, is director of the Institute for Juvenile Research (the birthplace of child psychiatry) and professor of psychiatry and public health in the Department of Psychiatry at the University of Illinois College of Medicine at Chicago. He has been practicing medicine for more than 40 years and has 450 publications.

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HEALTH LAW

Juvenile Forensic Psychiatric Evaluations

Susan Buratto, MD, and Stephen H. Dinwiddie, MD

The first juvenile court was established in Cook County, Illinois, in 1899 [1]. Based on the legal principle of *parens patriae* (which emphasizes the state's responsibility—and hence power—to act in the best interests of individuals who are unable to protect themselves), juvenile courts traditionally have emphasized rehabilitation rather than (as in traditional courts) punishment of the offender [1]. Legal matters typically addressed in juvenile and family courts include delinquency, child abuse, and custody. Because juvenile courts since their inception have emphasized treatment and rehabilitation rather than punishment, mental health professionals have played an especially important role in juvenile courts [2]. This discussion will focus particularly on evaluations of minors involved in the juvenile justice system, since in criminal matters juvenile courts may need to address such matters as the minor's competence to understand his or her Miranda rights, fitness to stand trial or be sentenced, and eventual disposition (i.e., detention or treatment).

Expert mental health evaluations—forensic psychiatric evaluations—can be of great assistance to the legal system, but collaborating with the court requires a clear understanding on the expert's part of his or her role and limitations. The American Academy of Psychiatry and the Law defines forensic psychiatry as a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, correctional, regulatory, or legislative matters and in specialized clinical consultations in such areas as risk assessment or employment [3]. Some important considerations in child and adolescent forensic practice are explored below.

Clarifying the Role of the Forensic Psychiatrist

It is important to distinguish between a psychiatrist who treats patients in a correctional setting and a psychiatrist who functions as a forensic evaluator. The former has a therapeutic relationship with and a duty to the patient. In contrast, no therapeutic relationship is established between the forensic evaluator and the minor being evaluated; the forensic evaluator's primary duty is to serve as an objective expert to the court. In that role, the expert's opinion may harm the minor's interests—for example if he or she opines that the juvenile defendant is fit to stand trial and thus will be forced to face the legal consequences of his or her acts.

Therefore, in the initial encounter with the minor, parent, or both, the evaluator should assess their understanding of the forensic evaluation, who requested it, and why. He or she should inform all parties that no therapeutic or treatment relationship

will be established following the evaluation and make every effort to ensure they understand this distinction. Circumstances unique to the forensic evaluation and personal characteristics of the evaluator may obscure this distinction and thus should be considered:

- Children and adolescents may be less able than adults to understand these differences in a doctor's role;
- The multiple interviews and history taking involved in forensic evaluation may mimic a treating relationship, lending themselves to misinterpretation; and
- Child and adolescent psychiatrists often interact differently with minors than many other adults do—adopting a more relaxed or friendly tone, using colloquial language, and addressing minors by their first names—particularly when minors are evaluated in detention facilities. This casual conversational tone and friendly demeanor increases the likelihood that minors will presume an ongoing relationship is being developed with the evaluator.

In summary, although the forensic evaluator has a unique duty to serve as an objective expert to the court, special circumstances in juvenile forensic evaluations may foster confusion between the roles of forensic evaluator and treating psychiatrist. Ensuring minors and parents understand these differences is key to preserving any ongoing or future treatment relationships between the minor and mental health care professionals.

It is worth pointing out that treating psychiatrists may, at times, be asked to perform in a forensic role, and to the extent possible should resist doing so. As outlined above, the differences between the roles and purposes of forensic and treating clinicians can present critical challenges to someone who is functioning in a dual capacity. If the service request comes from the patient or parent, the treating psychiatrist should educate the patient or parent about the disadvantages of having the same psychiatrist serve in a dual capacity. Alternately, if the treating psychiatrist is subpoenaed or court-ordered to testify, he or she is always obliged to respond and should seek legal counsel before taking further action [4].

Legal and Ethical Responsibilities of the Evaluator

Even if the minor and parent both understand and accept the differences between the roles of clinical and forensic psychiatrists, the forensic evaluator may struggle to accommodate the obligations of forensic practice. The absence of a treatment relationship may prove especially challenging for the trainee accustomed to evaluating patients for the purposes of deciding upon treatment. In medical school and residency training, new doctors are encouraged to accept symptoms as reported by their patients, but, in the justice system setting, the evaluatee may have a strong motivation to mislead the expert. Because the forensic psychiatrist has a primary duty to be an objective reporter rather than an advocate, an investigative, comprehensive approach is used to thoroughly delineate and substantiate reported symptoms and to interpret and assess the minor's behavior during the interviews. This entails that the expert:

- Thoroughly investigate reported symptoms.
 - Question minors about reported symptoms when they suggest a diagnosis that may impair fitness to stand trial or be sentenced; and
 - Explore alternate explanations or causes for reported symptoms, for example medical illness, sleep disturbance, alcohol or drug abuse, maltreatment, or neglect.
- Wherever possible, verify all information received from or about the minor.
 - Review all available pertinent prior psychiatric and medical records. If possible, arrange a telephone call with current mental health or medical care professionals; and
 - Seek information from collateral sources including parents, other family members, teachers or coaches, school personnel, babysitters, child protection workers, probation officers, case managers, and so on.

The forensic evaluator must be alert to the potential for deliberate deception on the part of the minor or parent. Minors or parents might “fake good” or “fake bad” for any number of reasons, including:

- To avoid perceived stigma against being diagnosed with a psychiatric illness;
- To rapidly resolve or “move on” from legal conflicts;
- To avoid revealing information (e.g., drug or alcohol abuse, child maltreatment or neglect, previously unreported medical or psychiatric symptoms) perceived as being damaging or embarrassing;
- A belief that being found unfit to stand trial will result in charges being dismissed;
- Confusion about the evaluator’s role or the evaluation process; and
- Distrust of the “system” and limited willingness to engage with an evaluator who may be perceived as “against” the minor.

Over the course of the evaluation, the forensic psychiatrist may identify previously undiagnosed psychiatric disorders or may dismiss as invalid current or previous diagnoses. For example, he or she may find that the minor needs immediate or at least rapid medical intervention when:

- The minor or parent reports new symptoms or demonstrates signs of illness that cause clinical impairment;
- The minor or parent reports that current medications are no longer providing effective symptom management;
- The evaluator identifies a potential for significant risk associated with treatment, including potential drug-drug interactions, suboptimal dosing, and higher-risk treatment without sufficient clinical justification;
- The minor or parent reports a new or worsening pattern of drug or alcohol use; and
- The minor reports she is pregnant but has not discussed this with her parent or guardian.

Likewise, the forensic psychiatrist may determine, over the course of the evaluation, that the minor requires immediate or at least rapid social or educational intervention if:

- The minor reports being the victim of bullying or intimate partner violence;
- The minor reports being pressured into gang involvement, pressured to engage in illicit activities, or pressured to make certain decisions or take certain actions relative to his or her legal case;
- The minor or parent reports a significant change in the minor's academic progress or functioning; and
- The forensic evaluator determines that the minor needs educational testing or enhanced educational services not currently provided. This may be especially important if psychological testing done as part of a forensic evaluation identified previously unaddressed learning disabilities or cognitive deficits.

Although the forensic psychiatrist has a primary duty as an objective expert, forensic practitioners should nonetheless “be bound by the underlying ethical principles of respect for persons, honesty, justice and social responsibility” [3]. When confronted with such conflicts, trainees are encouraged to seek the support of supervisors to identify appropriate interventions utilizing parents or guardians, health care providers, school administrators, teachers or coaches, social workers, probation officers, or other community resource people who can meet the minor's needs.

Confidentiality

With minors and parents. In treatment settings, physicians have an ethical and legal obligation to preserve patient confidentiality and to protect the right of the patient to hold information private. Conversely, the juvenile court seeks a forensic psychiatric evaluation for the purpose of obtaining information about the minor. Because the practice of forensic psychiatry presents such significant obstacles to the maintenance of confidentiality, the forensic evaluator should inform minors and parents of the limits of confidentiality at the start of each interview, clearly communicating the following:

- The nature and purpose of the forensic evaluation;
- The absence of confidentiality. Special effort must be made to ensure all parties understand that information disclosed during the forensic evaluation may appear in a written report. For minors involved with the juvenile courts, the forensic report will most likely be provided to the judge, the state's attorney, and the attorney representing the minor;
- The evaluator's obligation as a mandatory reporter. Minors, parents, and other parties should be informed of the conditions and circumstances necessitating mandatory reporting;
- The right of the minor to refuse to participate in the evaluation overall or to refrain from answering specific questions. This is particularly important when answering would negatively impact the minor's legal case; and
- If collateral information will be sought from outside parties, both the minor and parent should always be asked to authorize third parties to release

information. However, when a forensic evaluation is requested by the court, a court order may preclude a refusal by the minor or parent to release information. If either the minor or parent refuses to allow the release of information, the evaluator should consider whether or not to inform the minor or parent that the information will be sought without his or her consent.

After the limits of confidentiality are reviewed in the initial forensic psychiatric evaluation, to ensure that the minor has adequately grasped the situation, he or she should be asked to:

- Explain the nature and purpose of the evaluation;
- Restate his or her understanding of confidentiality and the limits of confidentiality in the forensic evaluation;
- Describe how information provided may be used and to whom this information will be made available;
- Identify matters necessitating mandatory reporting; and
- Acknowledge his or her right not to participate in the evaluation.

Minors should be reminded of these limits at the start of every subsequent forensic interview, and their ongoing understanding of these considerations should be assessed.

Collateral contacts. In most instances, communication with collateral contacts takes place over the telephone. When interviewing collateral contacts, the forensic psychiatrist should:

- Identify his/her role and the nature and purpose of the evaluation;
- Emphasize the absence of confidentiality. Collateral contacts should be told that any information provided may appear in a written report provided to the court;
- Consider whether or not to inform the third party of the minor's or parent's consent or refusal to allow information to be released. If release was refused, the forensic evaluator can explain information is being sought pursuant to a court order;
- Understand information the collateral contact reports as "fact" and distinguish this from the contact's stated opinions; and
- Protect confidential information. Although any information obtained in the course of a forensic evaluation could appear in the written report, the forensic psychiatrist should take care not to disclose confidential information to collateral contacts. The forensic evaluator might anticipate polite, deflecting responses to direct questions from a collateral contact.

Conclusion

In the practice of medicine there is an implicit promise that the doctor's role is first and foremost to act in the patient's best interest. As an expert witness, the role of the forensic psychiatrist is substantively different. If not explicitly informed of the nature of this role, juvenile evaluatees, parents, and collateral contacts may understandably

feel betrayed when the expectations of a patient-physician relationship—that the physician will treat or advocate for “the patient”—is not met. Court personnel may similarly misconstrue the forensic evaluator’s role and presume an overarching intent to advocate for the evaluatee. Fairness to all parties demands a thorough evaluation and reporting of pertinent data, even when doing so may be seen as less than advantageous to either or even both parties in a legal matter. In concentrating on the duty to serve as an expert witness, the forensic examiner is best positioned to navigate the overlapping challenges presented by this interesting work.

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Susan Buratto, MD, is a fellow in forensic psychiatry in the Department of Psychiatry and Behavioral Sciences at Northwestern University’s McGaw Medical Center in Chicago.

Stephen H. Dinwiddie, MD, is a professor of psychiatry in the Department of Psychiatry and Behavioral Sciences at Northwestern University’s McGaw Medical Center in Chicago.

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POLICY FORUM

Court Diversion for Juveniles with Mental Health Disorders

Eric Trupin, PhD, Sarah Cusworth Walker, PhD, Hathaway Burden, and Mary Helen Roberts

The high rates of diagnosable mental health disorders among youth involved in the juvenile justice system has prompted calls to action from congressional representatives [1], administrators within federal justice agencies [2], federal commissions [3], and the Council of State Governments [4]. In addition, the federal Mentally Ill Offender Treatment and Crime Reduction Act [5] provides grant funding for collaborations between mental health and justice systems, and recent legislation in Washington State directly addresses the diversion of juvenile offenders with mental health disorders through expanding diversion options and strengthening connections with mental health treatment [6].

The focus on this area reflects the fact that approximately 70 percent of youth involved with the justice system face at least one mental health challenge [7, 8] compared to only 22 percent of youth in the general population. Nearly 30 percent of justice-involved youth have a disorder that seriously disrupts functioning and requires immediate treatment. Often, the mental health conditions of justice-involved youth are complex and involve more than one diagnosis. Approximately 60 percent of youth in the justice system have at least three diagnosable disorders at one time; the most common disorders being disruptive disorders, anxiety disorders and substance use disorders [8].

Explanations for this state of affairs are complex and include family system and neighborhood factors. Since the 1970s the mental health system has shifted towards community-based, outpatient care with decreased reliance on institutional treatment. While the goals of deinstitutionalization were laudable, it had the effect of reducing residential options for both adults and youth with serious mental health disorders and resulted in the increased use of the justice system to manage mental health crises [9]. In 2003, the federal General Accountability Office estimated that 12,700 parents voluntarily relinquished custodial rights to their children to the child welfare and juvenile justice system so their children could receive mental health services that were otherwise unavailable in their communities [1]. If parents had to go to these lengths to secure treatment for their child's diabetes or cancer, it would be deemed a public health catastrophe and a national disgrace.

While mental health disorder can clearly be a driving factor in a youth's involvement in the justice system, in other cases the presence of a mental health challenge is less central to a youth's offending behavior. A number of recent studies indicate that the

presence of a mental health disorder may not, on its own, predict subsequent reoffending for youth who are already involved in the justice system. Rather, substance use disorders and mental health disorders that co-occur with substance use disorders are stronger predictions of recidivism [10, 11]. Youth involved in the justice system often come from disorganized neighborhoods with high rates of poverty and violence that put them at high risk for developing mental health vulnerabilities [12]. These same neighborhood factors are also risk factors for involvement in the justice system, but the presence of a mental health disorder may simply co-occur, rather than drive, juvenile offending. At the same time, providing mental health treatment to youth with complex risks can prevent juvenile offending [13].

Diversion from formal court processing has a long history in juvenile justice and is receiving more attention as a strategy to reduce the consequences of court involvement for youth with mental health disorders. The use of diversion aligns with the juvenile court's stated mission to rehabilitate youth, and diversion can minimize the potentially harmful and costly effects of a formal adjudication process [13, 14]. There is significant variability among diversion program protocols. Typically, though, when a juvenile offender with a mental health diagnosis comes before the juvenile court judge, the judge uses the youth's prior history, psychological testing, and mental status evaluations in determining that diversion is the better alternative. Diversion involves an agreement between the youth and the juvenile court, often involving the family as well, that specifies a course of treatment or other activity. When the youth has satisfied the conditions of the diversion agreement, the matter is considered resolved without further court involvement. This often—but not always—prevents the creation of a criminal record for the youth.

The potential effectiveness of diversion as a court strategy is thought to occur through a minimization or avoidance of negative labeling wherein the youth, through court processing, may begin to think of himself or herself as “bad” or be exposed to youth who have more criminally oriented thinking [15, 16]. Further, diversion programs are thought to increase access to mental health treatment that is likely to be effective in reducing problematic behaviors.

A 2010 review of all diversion programs for juvenile offenders found that youth who were diverted from formal court processing had lower rates of recidivism (return to the justice system) than youth who were formally processed. Further, the same study found that diverting youth to treatment further reduced offending (including offenses that do not reach the justice system) [17]. This review, however, was not specific to mental health diversion programs. The literature on mental health diversion for juveniles is still new and fairly sparse. In a retrospective evaluation of a multicounty diversion program operating in Texas, Cuellar and colleagues found that participating youth had a reduced rate of offending (49.5 percent) than a waitlist control group (68.2 percent) [13]. A multicounty study of New York's Mental Health Juvenile Justice Diversion Project [18] identified significant variation in

effectiveness among counties due to availability of services but found that some counties significantly reduced recidivism for youth enrolled in the program.

Given the nascent stage of research on mental health diversion with juvenile courts, the adult literature on mental health diversion provides a useful comparison. Adult studies show that mental health diversion (often through specialty mental health courts) is effective in linking offenders to treatment [19, 20]. Further, some programs achieve sustained reductions in recidivism [21] with some mixed effects across studies [22]. A meta-analysis of adult mental health courts found moderate impact on recidivism with some effects on improved GAF (global assessment of functioning) score and reduced number of days spent in inpatient treatment [23]. This finding is likely to be highly related to both the functioning of the mental health court teams and the quality of services obtained [23].

The quality of services obtained through a mental health diversion is paramount but, as yet, not typically a principal concern of diversion programs; emerging systems are primarily focused on the identification of need and setting up referral protocols [24, 25]. However, decades of research on effective treatment for justice-involved youth as well as meta-analyses of effective treatment components demonstrate that the quality of treatment is essential for achieving desired outcomes [26-29]. Further, the significant role that substance use disorders play in increasing risk for recidivism suggests that treatment for these disorders should be paramount.

A few other considerations are important for future programming and research in mental health diversion for juveniles. First, the notorious instability of mental health diagnostic categories for juveniles suggests that eligibility for mental health diversion programs should be based on functioning rather than specific types of disorder. While the traditional view of child mental health disorder largely conceptualizes youth symptoms as precursors to adult categories of disorder, alternative approaches to psychiatric disorders in youth argue that disorders are contextually based, depending on age and developmental stages, and that psychiatric symptoms in children represent distinct classes of disorders rather than emerging adult disorders. Consequently, while diagnostic labels are useful in understanding the general types of symptoms youth may be exhibiting, caution should be taken, particularly in the absence of well-specified juvenile-specific diagnoses, in relying on diagnosis when identifying need within juvenile populations. Existing screening tools that focus on symptom-type or functioning are good options for this purpose (e.g., Massachusetts Youth Screening Inventory [30]; Child and Adolescent Functional Assessment Scale [31]).

Another concern, voiced more in the adult diversion literature but still relevant for juveniles, is the potential for coercion in mandating mental health treatment through the justice system. Coercion is problematic from an ethical perspective but also has implications for successful engagement [23]. Most diversion programs are voluntary, but care should be taken to ensure that youth and families understand their options

and that the consequences of not participating in a diversion program are not so punitive as to effectively compel participation.

Finally, the risk of providing treatment services within the justice system is that white youth typically have higher enrollment in these programs than youth of color. White youth are more likely to be identified as needing treatment, while youth of color are identified as needing punishment for the same crimes. This is already a problem for mental health strategies in adult court where the significant majority of mental health court participants are white males and females [32]. The use of culturally sensitive screening tools as well as system attention to culturally sensitive engagement of youth and families is critical in reducing the risk of worsening the disproportionate treatment of communities of color in the justice system.

In sum, mental health diversion programs show great promise in effectively addressing the treatment needs of scores of youth with mental health and substance use disorders who come in contact with the justice system. The further development of these programs and careful attention to treatment quality, treatment eligibility, and cultural sensitivity will increase the capacity of this system approach to fulfill the rehabilitative mission of the juvenile justice system.

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Eric Trupin, PhD, is a professor, vice chair of the Department of Psychiatry and Behavioral Sciences, and director of the Division of Public Behavioral Health and Justice Policy at the University of Washington School of Medicine in Seattle. He is a child psychologist and directed the Division of Child and Adolescent Psychiatry at Children's Hospital and Medical Center for 12 years. He directs clinical and systems research programs supported by NIDA, The MacArthur Foundation, and Paul Allen Foundation.

Sarah Cusworth Walker, PhD, is a research assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine in Seattle. Her work focuses on the intersection of policy and research in juvenile justice and allied public systems for youth.

Hathaway Burden is a project manager at the Center for Children and Youth Justice in Seattle. She manages the center's mental health reform efforts in the juvenile justice and child welfare systems.

Mary Helen Roberts has served as a representative in the Washington State Legislature since 2004. She is the vice chair of the Public Safety Committee.

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POLICY FORUM

Civil Commitment for Sex Offenders

Corey Rayburn Yung, JD

The use of civil commitment for postprison confinement of sex offenders represents a quintessential example of a poorly conceived scheme designed to unify concepts from the fields of law and medicine. Legislators supporting such programs attempted to utilize the authority of mental health professionals to lend credence to legal regimes on shaky doctrinal ground. The result has been a set of programs that fail from both a medical and legal standpoint. These laws also place lawyers and medical practitioners in difficult ethical positions when they become involved in sex offender commitment cases. Among the many ethical, moral, and legal complications of civil commitment of sex offenders are the co-optation of medical authority to legitimate commitment based upon nonmedical classifications, *ex post facto* application of civil commitment statutes to offenders who committed crimes decades earlier, admissibility of treatment records during a civil commitment hearing, and the likelihood of lifetime commitment that results from a finding of future dangerousness.

Background

In the late 1980s and early 1990s, Washington and Minnesota began a national trend when they became the first states to enact statutes to allow civil commitment of sex offenders after their release from prison [1]. In contrast to criminal imprisonment, civil commitment is considered by the Supreme Court of the United States to be nonpunitive, and a person subject to it is held in a civil facility for an indefinite duration. The law authorizing civil confinement utilized the frightening and seemingly authoritative phrase “sexually violent predators” (SVPs) to designate offenders set to be diverted to civil facilities [2, 3]. The definitions of SVP vary by jurisdiction but generally entail a finding—with involvement of a mental health professional—that an offender has a high risk of reoffending and some mental disorder. In 1997, the Supreme Court legally sanctified the new SVP laws when it issued its decision in *Kansas v. Hendricks* upholding the constitutionality of the Kansas civil commitment statute [4].

It was not until 2006 that the federal government, as part of the Adam Walsh Child Protection and Safety Act (AWA), joined the states in establishing its SVP civil commitment program [5]. Although certain viable legal challenges to the AWA civil commitment scheme were not considered, the Supreme Court upheld the federal government’s program in 2010 in *United States v. Comstock* [6]. With the federal government’s involvement in civilly committing sex offenders, it is likely that the number of detained persons will increase substantially in the coming years [7].

According to the federal and state SVP laws, government officials, usually in the prison system or prosecutor's office, initiate the process by which offenders are subject to SVP determination. Next, the assigned prosecutor offers to the alleged SVP a civil hearing before a judge to consider the government's case for civil commitment. Until the completion of the hearing and any appeals, the offender typically remains in custody despite having completed his or her prison sentence [8]. At the hearing, the offender is afforded some due process and other constitutional protections including the right to have counsel, cross-examine witnesses, testify, and subpoena witnesses [9]. Nonetheless, the process differs from a criminal proceeding in numerous significant respects. Primarily, the burden of proof on the prosecution is typically lower; "clear and convincing" instead of "beyond a reasonable doubt" at the federal level [10]. There should be no illusion that the civil commitment is for temporary treatment of offenders. In reality, civil commitment of sex offenders has overwhelmingly led to lifetime detention [11].

Medical/Legal Quandaries

Medical professionals often find themselves involved in SVP cases that push them beyond their ethical comfort zones. When called to consult or to testify at SVP hearings, medical professionals are asked to shoehorn medical diagnoses into ill-fitting legal language. Because of the importance of deciding whether an offender is a "sexually violent predator," the primary task of medical professionals involved in SVP cases is adapting recognized medical terminology to that label. Unfortunately, interpreting the meaning of that invented phrase is well beyond the expertise of the medical (and possibly any other) community.

Consider how a mental health expert must assess an offender's status in a typical SVP case. Initially, the practitioner is asked to determine with reasonable precision the future risk that an offender will commit another "sexually violent" crime. Because of the relative certainty sought, judges often show a preference for hard data and disinterest in seemingly subjective clinical assessments. Notably, the only objective diagnostic tool fitting that description that is available to medical professionals to evaluate future sex offender recidivism risk is STATIC-99 (and its revisions). STATIC-99 is a ten-item questionnaire developed by R. Karl Hanson and David Thornton that uses actuarial data to assess risk of future sex offenses [12].

Although STATIC-99 is useful for certain tasks, in SVP cases it might actually be counterproductive. Notably, STATIC-99 does not indicate whether an offender is a "sexually violent predator," but instead uses actuarial data to classify recidivism risks [12]. The simple ten-question diagnostic tool makes it remarkably easy for an individual young male offender to be classified as medium-high or high-risk purely on the basis of his age and sex, rather than on more useful data such as his criminal record [13]. If the tool merely remains in the province of medical professionals, that shortcoming could be addressed when it is effectively integrated into an overall assessment of an offender. However, despite universal belief among trained mental health professionals that STATIC-99 should only be used by licensed practitioners as part of an overall diagnostic profile [12, 14], statutes and courts have come to

directly rely on STATIC-99 without caveats or context [15, 16]. Further, there is increasing skepticism among mental health professionals about the reliability and efficacy of the STATIC-99 test, which makes its use even more problematic [17, 18].

Knowing how STATIC-99 results are likely to be (mis)used, how should a responsible mental health professional act? Failing to perform the test would be a professional failure because it is the only accepted diagnostic tool applicable in such cases, and the diagnostic value of a mental health professional's clinical judgment would be undermined if he or she did not submit the STATIC-99 results. But, once the tool is used, the results and resultant risk category become part of the permanent record of the case and can be misused by any judge involved in the matter.

The use of STATIC-99 is just one example of the potential pitfalls for mental health professionals in SVP cases. Other problems emerge in applying psychiatric diagnoses to other critical legal terms such as an offender's having "serious difficulty" in avoiding the commission of other sex crimes [19] or being "likely to engage in future sexual predatory acts" [20]. Those phrases, and similar language used in other statutes, assume a degree of exactitude that is often unachievable by medical practice. Because of court rulings regarding admissible evidence at civil commitment hearings, practitioners are asked to take the questionable step of evaluating the contents of offenders' treatment sessions that the offenders often believed would be kept confidential [21]. Also of note, the mental health professional's only role is making a diagnosis; the so-called treatment options (usually lifetime confinement) are decided entirely by those with solely legal training. Finally, because the SVP laws have been applied to sex offenders who committed crimes before the enactment of authorizing statutes, such offenders were not notified of the risk that they could be subject to lifetime civil commitment after their criminal sentences were completed [22].

Lawyers and mental health professionals are confronted with new, challenging roles in SVP cases. The laws that necessarily involve those with legal and medical training were unfortunately poorly designed to integrate the two fields because of the political backdrop against which such legislation is adopted. Americans overwhelmingly support restrictions on sex offenders, and collateral restrictions on that population are typically passed unanimously with no debate [23]. It should not be surprising, then, that SVP statutes seeking to unite law and medicine have failed to accomplish the basic requirements of either field.

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Corey Rayburn Yung, JD, is an associate professor at the University of Kansas School of Law in Lawrence who specializes in sexual violence law and whose scholarship has been used by courts across the country, including the Supreme Court of the United States.

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MEDICINE AND SOCIETY

Sanism and the Law

Michael L. Perlin, JD

“Sanism,” an irrational prejudice against people with mental illness, is of the same quality and character as other irrational prejudices such as racism, sexism, homophobia, and ethnic bigotry that cause (and are reflected in) prevailing social attitudes [1, 2]. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition, and deindividuation and is sustained and perpetuated by our use of alleged “ordinary common sense” (OCS) and heuristic reasoning in irrational responses to events in both everyday life and the legal process [3, 4].

I have written extensively about the roots of the assumptions that are made by the legal system about persons with mental disabilities. These mistaken assumptions include: that people with mental illness are erratic, deviant, sexually uncontrollable, emotionally unstable, superstitious, lazy, and ignorant; that they demonstrate a primitive morality; they are invariably more dangerous than persons without mental illness, and such dangerousness is easily and accurately identified by experts; that for a person in treatment for mental illness to decline to take prescribed antipsychotic medication is an excellent predictor of (1) future dangerousness and (2) need for involuntary institutionalization; that people with mental illness should be segregated in large, distant institutions because their presence threatens the economic and social stability of residential communities; that they give in too easily to their basest instincts and do not exercise appropriate self-restraint [5].

These assumptions—which reflect societal fears and apprehensions about mental disability, persons with mental disabilities, and the possibility that any individual may become mentally disabled—ignore the most important question of all—why do we feel the way we do about people with mental disabilities [6, 7]? One explanation may lay in history. Thousands of years ago, it was commonly believed that sickness was “a punishment sent by God” [8]. Historian Judith Neaman has concluded that “demonic possession remains the simplest, the most dramatic, and secretly, the most attractive of all explanations of insanity in the Middle Ages” [9, 10]. Society saw madness as a condition “in which a person was ‘possessed, controlled, or affected by some supernatural power or being,’ and this connection has remained ‘extremely resilient in western culture’” [11].

Any attempt to place mental disability jurisprudence in context results in confrontation with a discordant reality: social science data that refutes these

assumptions is rarely a coherent influence on mental disability law doctrine [12-14]. Rather, the legal system selectively—teleologically—accepts or rejects social science data depending on whether or not the use of that data meets the *a priori* needs of the legal system [15, 16]. In other words, social science data is privileged when it supports the conclusion the fact finder wishes to reach, but it is subordinated when it questions that conclusion [17].

By way of example, as Susan Stefan has perceptively noted, courts routinely find mentally disabled women to lack sufficient competence to engage knowingly and voluntarily in sexual intercourse but just as routinely find them competent to consent to give their children up for adoption. In one startling case, a court made both of these findings simultaneously about the same woman [18].

Thus, it is no surprise that courts selectively accept stereotypes to exert social control—engaging in gross stereotyping about the impact of mental illness on behavior when sentencing persons convicted of crime or deciding on involuntary civil commitment and rejecting the stereotypes when acknowledging them might lead to a socially undesirable result, such as an insanity acquittal [19].

This stereotyping of the effects of mental illness also flows from the meretricious impact of a false “ordinary common sense” (“OCS”) and the pernicious impact of heuristic thinking on judicial decision making. OCS is self-referential and non-reflective (“I see it that way, therefore everyone sees it that way; I see it that way, therefore that’s the way it is”). Not surprisingly, many of the greatest areas of OCS-caused dissonance emerge in cases involving family relationships (“If Joe was that bad...why didn’t the defendant divorce him? Why didn’t she just leave him?”), sexual assault (“Look at the way she was dressed; she was asking for it”), and mental illness (“If he had just tried harder, he really could have gotten better”). Areas such as these are treasure troves of self-righteousness, narrow thinking, and “atrophied moral development” [20].

Heuristics are “simplifying cognitive devices that frequently lead to...systematically erroneous decisions through ignoring or misusing rationally useful information” [21-23]. The vividness heuristic, for example, is a cognitive simplifying device through which a “single vivid, memorable case overwhelms mountains of abstract, colorless data upon which rational choices should be made” [24]. So, because most high-profile cases involving the insanity defense are the focus of exaggerated media attention, the illusion is created that they are reflective of the entire universe of insanity cases, or even the entire universe of all cases [25].

The law’s use and misuse of social science and OCS nurture sanism. Decision making in mental disability law cases is inspired by (and reflects) the same kinds of irrational, unconscious, bias-driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic, and religiously and ethnically bigoted decision making. Sanist decision making infects all branches of mental disability law and distorts mental disability jurisprudence by, for instance, relying vividly on the heuristic of

the statistically exceptional but graphically compelling case of the person with a major mental disorder who is randomly violent [26].

Paradoxically, while sanist decisions are frequently justified as being therapeutically based, sanism customarily results in antitherapeutic outcomes [27-29]. This happens in a wide array of decisions, ranging from those that commit insanity acquittees charged with misdemeanors to maximum-security facilities for many years longer than the maximum sentence they would have received if found guilty [30] to those that ignore a Supreme Court decision limiting the indefinite commitment of persons found permanently incompetent to stand trial [31] to those that mandate medication over objection even where there is a strong likelihood that neurological side effects may result [32].

Judges are not immune to sanism. “Embedded in the cultural presuppositions that engulf us all,” judges also take deeper refuge in heuristic thinking and flawed, non-reflective “ordinary common sense” [33]. They reflect and project the conventional morality of the community, and judicial decisions in all areas of civil and criminal mental disability law continue to reflect and perpetuate sanist stereotypes [34]. Thus, a trial judge responding to a National Center for State Courts’ survey indicated that, in his mind, defendants who were incompetent to stand trial *could have* communicated with and understood their attorneys “if they [had] only wanted” [35]. Judges are not the only sanist actors. Lawyers, legislators, jurors, and witnesses (both lay and expert) all exhibit sanist traits and characteristics [36].

Sanist attitudes also lead to pretextual decisions. “Pretextuality” refers to the fact that courts regularly accept (either implicitly or explicitly) testimonial dishonesty, countenance liberty deprivations in disingenuous ways that bear little or no relationship to case law or to statutes, and engage in dishonest (and frequently meretricious) decision making, specifically when witnesses, especially expert witnesses, show a “high propensity to purposely distort their testimony in order to achieve desired ends” [37]. The failure of more than half the states to implement the Supreme Court’s 1972 decision in *Jackson v. Indiana* [38] (limiting the length of time one can be kept in a maximum security forensic psychiatric facility solely because of incompetence to stand trial) is a textbook example of pretextuality [39]. As I have written elsewhere, “the political decision making in insanity acquittal cases—best exemplified by a National Institute of Mental Health Report conceding that individual release decisions are made in accordance with political dictates in ‘controversial cases’—demonstrates that pretextuality drives this area of jurisprudence” [39]. Pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious or corrupt testifying.

Pretextual devices such as condoning perjured testimony, distorting appellate readings of trial testimony, subordinating statistically significant social science data, and enacting purportedly prophylactic civil rights laws that have little or no “real-

world” impact dominate the mental disability law landscape [40]. A few examples are illustrative. Although the District of Columbia Code contains a provision that patients can seek either periodic review of their commitment or an independent psychiatric evaluation, in the first 22 years following the law’s passage not a single patient exercised this right to statutory review [41]. While former attorney general William French Smith told Congress that the insanity defense “allows *so many persons* to commit crimes of violence,” one of his top aides candidly told a federal judicial conference that the number of insanity defense cases was, statistically, “probably insignificant” [42]. When a state enacts a new statutory scheme to “treat” sex offenders, but fails to hire any professionals experienced in the provision of such treatment, that new statute is pretextual [43, 44].

In other circumstances, courts simply “rewrite” factual records to avoid having to deal with social science data that controverts their view of how the world “ought to be” [45]. The classic example is Chief Justice Burger’s opinion for the court in *Parham v. J.R.* (1979) [46], approving more relaxed involuntary civil commitment procedures for juveniles than for adults. Gail Perry and Gary Melton accurately characterized the *Parham* case in this way:

The *Parham* case is an example of the Supreme Court’s taking advantage of the free rein on social facts to promulgate a dozen or so of its own by employing one tentacle of the judicial notice doctrine. The Court’s opinion is filled with social facts of questionable veracity, accompanied by the authority to propel these facts into subsequent case law and, therefore, a spiral of less than rational legal policy making [47].

Even when courts do acknowledge the existence and possible validity of studies that take a position contrary to their decisions, this acknowledgement is frequently little more than mere “lip service.” Involuntary civil commitment and periodic review hearings, for example, rarely make vigorous and authentic inquiries into the restrictivity of confinement and the availability of community treatment, both of which they are mandated to do by an array of court decisions [48], and refusal-of-treatment hearings rarely take seriously the autonomy-privileging language of cases such as *Rivers v. Katz* [49, 50].

Until system “players” confront the ways that sanist biases inspire the selective incorporation or misuse of social science data and such pretextual decision making, mental disability jurisprudence will remain incoherent. Behaviorists, medical researchers, social scientists, and legal scholars must begin to develop research agendas to (1) determine and assess the ultimate impact of sanism, (2) better understand how social science data is manipulated to serve sanist ends, and (3) formulate normative and instrumental strategies that can be used to rebut sanist pretextuality in the legal system. Practicing lawyers need to articulate the existence and dominance of sanism and of pretextual legal behavior in their briefs and oral arguments so as to sensitize judges to the underlying issues.

A rare example of judicial understanding of the ravages of sanism and pretextual thinking is *In re the mental health of K.G.F.* [51], a decision by the Montana Supreme Court that focused specifically on sanism as a factor in assessing effectiveness of counsel in involuntary civil commitment hearings. Underscored the court:

The use of such stereotypical labels [to describe people with mental illness, e.g., “idiots” and “lunatics”]—which, as numerous commentators point out, helps create and reinforce an inferior second-class of citizens—is emblematic of the benign prejudice individuals with mental illnesses face, and which are, we conclude, repugnant to our state constitution. *See generally* Michael L. Perlin, *On “Sanism,”* 46 *Smu L. Rev.* 373, 374 (1992) (identifying prejudice toward the mentally ill among “well-meaning citizens” as the same “quality and character of other prevailing prejudices such as racism, sexism, heterosexism and ethnic bigotry,” which in turn is reflected in our legal system) [and Bruce Winick’s 1999 article “Therapeutic Jurisprudence and the Civil Commitment Hearing” in the *Journal of Contemporary Legal Issues*] (stating that because people with a mental illness “already have been marginalized and stigmatized by a variety of social mechanisms, self-respect and their sense of their value as members of society are of special importance to them” throughout legal proceedings) [52].

“Sanism” is well known in the legal community. A recent search of the WESTLAW database reveals that it has been referred to in 272 law review articles between 1992 and 2013. It is, sadly, much less well-known in the medical community. It is vital that physicians begin to confront its scope and its significance.

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Michael L. Perlin, JD, is a professor of law, director of the International Mental Disability Law Reform Project, and director of the Online Mental Disability Law Program at New York Law School.

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HISTORY OF MEDICINE

Deinstitutionalization of People with Mental Illness: Causes and Consequences

Daniel Yohanna, MD

In ancient Greece and Rome, asylum was a place where those who were persecuted could seek sanctuary and refuge. Those persons included debtors, criminals, mistreated slaves, and inhabitants of other states [1].

Is there a group of American citizens more deserving of safety and refuge than people with severe mental illness (SMI) who have traded one level of confinement in state mental hospitals for another in our nursing homes, intermediate care facilities, jails, and prisons—or, worse, become homeless? This paper reviews trends in the transinstitutionalization of people with SMI and proposes that it is time we offer asylum, in the best sense of the word, to the most vulnerable of the people with severe mental illness.

According to the National Institute of Mental Health (NIMH), 6.3 percent of the population suffers from severe mental illness [2], defined as longstanding mental illnesses, typically psychosis, that cause moderate-to-severe disability of prolonged duration [3]. Given that the number of adults 18 and over in the United States in 2010 was estimated to be roughly 234,564,000 [4], approximately 14.8 million people have severe mental illness. Experts polled by the Treatment Advocacy Center estimated that about 50 beds per 100,000 people would meet needs for acute and long-term care, but in some states the number of available beds is as low as 5 per 100,000 people [5]. Thus, many who need residential treatment cannot obtain it.

The changes that led to this lack of space, as well as changes to the institutionalization process, have made it impossible for people with severe mental illness to find appropriate care and shelter, resulting in homelessness or “housing” in the criminal justice system’s jails and prisons [6]. The percentage of people with severe mental illness in prisons and jails is generally estimated to be 16 percent of the total population [6]. Given that the population in U.S. prisons and jails totaled 2,361,123 in 2010 [7], it would appear that nearly 378,000 incarcerated persons have severe mental illness [7].

How Did We Get Here?

Deinstitutionalization as a policy for state hospitals began in the period of the civil rights movement when many groups were being incorporated into mainstream society. Three forces drove the movement of people with severe mental illness from hospitals into the community: the belief that mental hospitals were cruel and inhumane; the hope that new antipsychotic medications offered a cure; and the desire

to save money [8]. It has not worked out as well as expected on any of the three fronts. People with severe mental illness can still be found in deplorable environments, medications have not successfully improved function in all patients even when they improve symptoms, and the institutional closings have deluged underfunded community services with new populations they were ill-equipped to handle.

Historically, state hospitals fulfilled many needs for people with severe mental illness which included therapy, medication, medical treatment, work and vocational training, and a sense of community. Prior to 1950s, it was not uncommon for state hospitals to provide a work environment. There were often workshops and farms to make or grow some of their own needs. This was particularly true at the end of the nineteenth century [9] before entrepreneurs realized there was a profit to be made in the state hospital system and slowly began selling goods and services to the hospitals, reducing “the amount of work and increasing the amount of idleness in the system” [9].

Legal limits on institutionalization. As patients were being discharged into the community, a series of legal decisions also had an impact on whether one could be readmitted or stay in a hospital setting. As early as 1866, after E.P.W. Packard was committed by her husband to an Illinois state mental institution, efforts to “reform” the system were under way. In her account of the episode, two physicians came to her home, took her pulse, and declared her insane [9]. She was confined for 3 years and, upon her release, led a successful campaign across the country to change the laws to safeguard people’s rights in the hospitalization process [9, 10]. Today every state has civil commitment laws outlining the requirements necessary to hospitalize someone with SMI.

Over time, several court cases have further defined the legal requirements for admission to or retention in a hospital setting. In *Lake v. Cameron*, a 1966 D.C. Court of Appeals case, the concept of “least restrictive setting” was introduced, requiring hospitals to discharge patients to an environment less restrictive than a hospital if at all possible [11]. In the 1975 case of *O’Connor .v Donaldson*, the U.S. Supreme Court declared that a person had to be a danger to him- or herself or to others for confinement to be constitutional [12]. The 1999 U.S. Supreme Court decision in *Olmstead v. L.C.* stated that mental illness was a disability and covered under the Americans with Disabilities Act. All governmental agencies, not just the state hospitals, were be required thereafter to make “reasonable accommodations” to move people with mental illness into community-based treatment to end unnecessary institutionalization [13].

These court decisions have certainly limited the ability of state facilities to confine people in hospitals against their will and created conflict between laws that are intended to preserve liberty and prevent wrongful hospitalization, on the one hand, and the need to identify and treat people early in their diseases, on the other. Although preserving the rights of people with severe mental illness to be treated in

the least restrictive settings is noble, it has allowed many people with SMI to “fall through the cracks” in the system or be rehospitalized in what has been termed the “revolving door” of acute hospital admissions [8]. An even more egregious situation occurs when difficulty being admitted to a hospital leads to the homelessness of people with severe mental illness, who wander the streets in major cities, being arrested or dying. The term “dying with one’s rights on” was coined by Darold Treffert in 1973 to describe how the laws have gone too far in protecting the rights of individuals at the expense of their safety and well-being [14].

Reduced beds in state facilities. Changing federal laws have also contributed significantly to reducing the number of available beds in state facilities. The passage of the 1963 Community Mental Health Construction Act, which made federal grants available to states for establishing local community mental health centers, was intended to provide treatment in the community in anticipation of the release of patients from state hospitals [9]. Laws providing income subsidies through the Aid to the Disabled Program (latter called Supplemental Security Income or SSI), food stamps, and housing subsidies has made it ostensibly possible for people with SMI to live in the community, although many still cannot survive in any dignified or independent manner given that the subsidies are below the poverty level of \$11,490 for an individual [15] (current 2013 federal SSI payment is \$8,529.32 per year for an individual [16]).

Perhaps the most important change in federal law was the introduction of Medicaid, which shifted funding for people with SMI in state hospitals from the states’ responsibility to a shared partnership with the federal government [17]. This created an incentive for states to close the facilities they funded on their own and move patients into community hospitals and nursing homes partially paid for by Medicaid and the federal government. With the Omnibus Budget Reconciliation Act of 1981, the federal government ended direct federal funding for community-based nursing homes that primarily treated patients with mental health problems and required the screening of patients entering nursing homes to assure they had legitimate medical illness [18]. It required states to return to funding non-nursing homes for the long-term care of people with SMI in the community [18], basically segregating many people with SMI into large, underfunded facilities. These facilities were often for profit and privately owned, creating an incentive to reduce costs and care in the name of profits. The perils of this were aptly illustrated in a series of articles by Clifford Levy in the *New York Times* in 2002 [19].

Structural social and economic factors. Why are so many people with severe mental illness placed inappropriately in our jails and prisons? Davis argues that the current decentralized mental health system has benefited middle-class people with less severe disorders preferentially [20], leaving the majority of people with SMI who are either poor or have more severe illness with inadequate services and a more difficult time integrating into a community. Factors such as high arrest rates for drug offenders, lack of affordable housing, and underfunded community treatments might better explain the high rate of arrests of people with severe mental illness [21].

Emergency rooms are crowded with the acutely ill patients with long psychiatric histories but no plausible dispositions. Patients who are violent, have criminal histories, are chronically suicidal, have history of damage to property, or are dependent on drugs cannot be easily placed. They are often discharged back to the streets where they started.

In many states, state hospitals will not even consider admitting patients on Medicaid, expecting the private sector to care for them. But private hospitals have difficulty using the court system to commit people with SMI to the hospital because of the cost of transportation to the court, which is usually off-site, use of personnel, and the lack of reimbursement for psychiatrists who testify in court. It is a time-consuming process that often takes up to half a day.

What Is Needed?

State hospitals must return to their traditional role of the hospital of last resort. They must function as entry points to the mental health system for most people with severe mental illness who otherwise will wind up in a jail or prison. State hospitals are also necessary for involuntary commitment. As a nation, we are working through a series of tragedies involving weapons in the hands of people with severe mental illness—in Colorado, where James Holmes killed or wounded 70 people, Arizona, where Jared Loughner killed or wounded 19 people, and Connecticut, where Adam Lanza killed 28 including children as young as 6 years old. All are thought to have had severe mental illness at the time of their crimes. After we finish the debate about the availability of guns, particularly to those with mental illness, we will certainly have to address the mental health system and lack of services, especially for those in need of treatment but unwilling or unable to seek it. With proper services, including involuntary commitment, many who have the potential for violence can be treated. Just where will those services be initiated, and what will be needed?

Nearly 30 years ago, Gudeman and Shore published an estimate of the number of people who would need long-term care—defined as secure, supportive, indefinite care in specialized facilities—in Massachusetts [22]. Although a rather small study, it is still instructive today. They estimated that 15 persons out of 100,000 in the general population would need long-term care. Trudel and colleagues confirmed this approximation with a study of the long-term need for care among people with the most severe and persistent mental illness in a semi-rural area in Canada, where they estimated a need of 12.4 beds per 100,000 [23]. A consensus of other experts estimates that the total number of state beds required for acute and long-term care would be more like 50 beds per 100,000 in the population [5]. At the peak of availability in 1955, there were 340 beds per 100,000 [5]. In 2010, the number of state beds was 43,318 or 14.1 beds per 100,000 [7].

After the initial treatment in state hospitals, many people will still be in need of long-term treatment, as noted above, in a real asylum such as the ancients imagined. (The exact numbers will need to be reviewed; current studies are too small or not from sufficiently urban areas to be applicable across the country and for every population.)

We cannot depend on our current outpatient facilities to provide the support that is needed to prevent unnecessary homelessness or admissions to jails and prisons among the most vulnerable people with SMI. More housing with various degrees of supervision and facilities with a full-range of services must be brought back into the mental health system, along with revised laws for access to those services, to appropriately care for this population.

New hospitals today look more like luxury hotels than hospitals. They are designed to give a resort-like atmosphere with all its amenities. Certainly we can design facilities that are safe, provide refuge from a difficult world, and offer meaningful activities to improve the lives of the most severely mentally ill. For those who need respite, care, and rehabilitation, the idea of an asylum as idealized by the ancients might be a welcomed alternative.

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Daniel Yohanna, MD, is the vice chair and an associate professor in the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago Pritzker School of Medicine. His interests are in community psychiatry and forensic psychiatry, as well as the development of systems of care for people with mental illness.

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MEDICAL NARRATIVE

Mental Illness, Inside and Out

Fred Friedman, JD, as told to Laura M. Blinkhorn, MD

Fred Friedman, JD, has spent most of his career working at the intersection of mental health and the law. He trained as a lawyer and practiced for many years. He has been an advocate for mental health legislation in the state of Illinois. He educates Chicago police officers in how to interact with patients who are having mental illness crises and medical students on how to better understand the needs of mentally ill patients. Mr. Friedman has struggled with mental illness himself. His narrative as told to Laura Blinkhorn, MD, touches on his experiences as a lawyer, a patient, an advocate, and an educator.

Being a Lawyer

I was always involved in social justice issues, but I was never involved in mental health issues. I never revealed myself as having a severe mental illness. What I would do is I would stop. I would reinvent myself. So when I got out of law school, I worked in a small law firm and I got sick; I attempted suicide. And instead of going back to the law firm, I started my own practice because I was just too ashamed to go back and deal with my former colleagues. After I had started my own practice I had built it into a nationwide practice. I had clients in 22 states and had 5 associates. I was very good and my clients were better off for having me. But I got sick. And again rather than getting better and going back to those clients I just stopped practicing law.

There were two things. One was the shame and the inability to confront, to talk to my clients, and the other was the feeling that I just couldn't practice law and that I would hurt my clients. I certainly didn't want to practice law and hurt my clients.

It's like being a doctor. If you were a doctor and you committed malpractice, part of your worry would be that you'd be guilty of committing malpractice and that you'd have to pay a large fine, but I imagine another part would be that you had committed malpractice and instead of helping your patient you had hurt your patient. It must be a hard thing to bear.

The nature of my illness is that I become dysfunctional. I lie in bed. I've been saying this for a long time now. It is actually more complicated than that. What actually happens is that doing things becomes increasingly difficult, and one of the first things that goes in practicing law is writing briefs or answering the phone or that sort of thing. And then eventually, almost always, it turns into I don't get out of bed. Now if I don't get out of bed then I can't really represent my client. I suppose what I

should have done is told somebody that I was getting sick and have them pick up the slack, but I just never did. Because I was just ashamed. So it would generally develop into a disaster. A brief wouldn't be filed when it should have been or there would be a court date I wouldn't show up at. And then for a long time I would attempt suicide. Or something else similar to that.

So I get sick, I get better, I get sick again. Eventually the symptoms always leave and when they leave I am able to reinvent myself. That comes from lots of support. I'm very lucky. I had a lot of support and I am well educated. I was able to reinvent myself. Most people, many people can't. Once they fall they can never reinvent themselves. For 25 years I had my wife to support me. And when I stopped having my wife to support me I went into the nursing home where I spent 3 years trying to reinvent myself.

Work provides a lot of services. It provides money. I would certainly be a lot better off if I had worked all my life, for the last 40 years. I would be better off, I would have a different, if not better, sense of community.

Being a Patient

I admitted myself voluntarily to the Institute for Mental Disease (IMD), which is a kind of nursing home that serves people with mental illness. In the nursing home, they had no expectation that I would get better. In fact they made it almost impossible for me to get better. One way was the sort of joke therapy. Art therapy class, for example, consisted of coloring books. I don't know what that was supposed to do, but it didn't do anything for me. Another was a current events session that consisted of reading the newspaper out loud. Again, that didn't do anything for me. There was a session on teaching me how to live in the community, which consisted of taking me on a walk around the block.

I had a case worker and every once in a while I would go to see her and she would have me sign something. I later found out that what she had me sign were my goals. She didn't ask me what my goals were. She didn't even tell me what my goals were. And it turned out that the goal that she gave me was losing weight because I was obese. Out of all my set of problems—I'd lost my house, I'd lost my wife, I'd lost my job—being overweight was not the problem that I wanted to work on. And since they fed me, it seemed particularly atrocious. And they gave me a med—I didn't know this at the time—Depakote, which frequently has the side effect of weight gain.

So they were perfectly happy for me to not get better. And they put roadblocks in the way to getting better, apart from the \$30 a month spending money, which of course makes it impossible. How can you look for a job or even go out for a cup of coffee on \$30 a month? A ridiculously small amount of money. So I spent \$12 a month going to see a therapist at Jewish Family Services who was more supportive of my work. My case manager never talked about my getting a job or moving out of the nursing home. The clearest example of this was when I told them that I wanted to

move out and they said, “You signed a contract that said you have to give us 30 days’ notice.” Now, as a lawyer, I can’t imagine how I could be crazy enough to need a nursing home but sane enough to sign a contract that would bind me. But putting that aside, when I said I wanted to leave, I talked to the director of services and he said, “You know, Fred, if you wanted more help, you should have asked. You should take more responsibility.” And I thought, “I checked into a nursing home. You’re telling me I should have done more?” It’s as if I went to the emergency room with a broken leg but didn’t walk up to the orthopedist.

They put all sorts of barriers in my way so I couldn’t leave. They gave me tests. It may just be classist. Among other things they tested my ability to tell time. So they would tell me it was three o’clock and have me write the hands on a clock. Or count change. And what I liked best was they asked me if I was going to prepare a spaghetti dinner what would I need? And I told them. And I failed this test because I didn’t propose a green salad. Now in the real world, I’ve made lots of spaghetti dinners. And sometimes I’ve had a green salad and sometimes I haven’t. And they got paid for keeping me there, not for getting me better. They had no incentive for me to get better.

I was scheduled to leave when my father got sick. I had arranged to move out of the nursing home and into a homeless shelter because it was a better place to live than the IMD. I had given them 30 days’ notice and I was waiting for the 30 days to disappear. And they had given me all these reasons not to go. And my uncle called. The stigma of mental illness was so strong, no one had told him I was in an institution. My parents, my wife, we just never told anyone that I was sick. When he told me, “Your father is very sick; you have to come see him,” and I said, “Well I’m not sure that I can,” he was very confused, and he said “What do you mean?” He said “I’ll pay for it if that’s the issue.” And I said that it wasn’t really the issue though it was part of the issue. Mostly it was that I needed permission to leave. And they, in fact, gave me permission to leave and my uncle paid for my trip to Florida and I was lucky to get there when I did because my father died the next day. And at the same time my sister was in the hospital. So I decided to stay in Florida until she got out of the hospital.

I told the nursing home that I had lost my space in the homeless shelter I was going to go into because they don’t hold those spaces very long. So I stayed for a few weeks. And buried my father, took care of my sister, lived on my own. After 2 weeks, the meds ran out. One would think that was a sign that I could live on my own. Instead, when I got back to the nursing home, I went back to my room and they had plugged my lock—putting something in the lock so the key doesn’t work. And the whole purpose of eviction law is to prevent landlords from doing that, so that you have to go to courts, you don’t just evict somebody.

And as I was standing there thinking about it, someone came up to me and said, “The ambulance is coming to take you away.” And I said, “What do you mean?” And he said, “We called the ambulance.” And I said, “Why?” And he said, “Because you

were without meds for a couple of weeks.” And I tried to figure out what to do. I had a few hundred dollars in my pocket that I’d gotten from my father. But that wouldn’t last very long. The ambulance came, they tied me up, put me on the gurney, and restrained me. And I remember the guy asked me if I knew what the date was. Now I’m not very good at remembering what the date is because normally I look at something that tells me what the date is. Since I didn’t know the date, he said I was disoriented.

I went to the hospital and they started interviewing me. And I said, in my legal opinion, not taking my meds is not grounds for putting me in the hospital. And they said, “Well that may or may not be true, but if you’re wrong you’ll end up at Elgin and you really won’t like Elgin.” (Elgin is the big public psychiatric hospital).

Since I had only a few hundred dollars in my pocket— probably less than \$200—and wasn’t sure I’d win that fight, I signed a voluntary commitment and stayed there. I just turned my head to the wall and gave up. My father was dead, one of the two people who talked to me who wasn’t paid to talk to me. I had no place to live. And was behind a locked door, which I really really really hate. So I suppose from their perspective I was displaying symptoms. I stayed there for 4 weeks. Why did I stay there for 4 weeks? Because Medicaid pays for 4 weeks of hospital care. So as soon as Medicaid stopped paying for it, I got well. And they told me to leave. I don’t know what they could have done for me in 4 weeks except give me meds. And that was very scary. There were people who were actively psychotic. It was just very scary. I don’t like forced treatment. I don’t trust their motivations for forced treatment. Indeed, when I asked them at the nursing home why they did it, they said that they had to protect themselves—“we have to cover our ass”—which doesn’t really strike me as a good reason.

Being an Advocate

After being in the nursing home, I went to a homeless shelter. While I was in the homeless shelter I went to visit the director of the program who had actually by coincidence been a friend of mine many years ago when I was a law student. And we were chatting and I told her I was thinking of getting involved. And she reached into the trash basket and pulled out a flyer about a meeting about Continuum of Care meeting in Chicago and a new model that they were proposing called “housing first.” And I went to it.

At that time, and in some cases still, the prevailing model for offering housing to people who are homeless was “housing-ready.” The housing-ready model says, “We will give you a home when you’re ready for it. And if you’re not ready for it, then we won’t give you a home.” So the emphasis was on fixing the homeless person rather than providing a home. “Housing first” says first you give someone a home and then you try to fix whatever is wrong with them. Housing-ready is sort of like saying, “We’ll give you insulin if you get your blood sugar under control.” It strikes me as silly. And now almost everyone agrees that housing first is the correct model.

When I was in the nursing home I was never going to get a house because I was never going to be ready. When I was in the homeless shelter, I was never going to get a place because I would never be ready. So housing first was a very exciting concept. And then I became very involved both because I had nothing better to do and because I started attending a lot of the meetings and eventually wanted to join the board of Continuum of Care. And they said, “You can’t.” And I said, “What do you mean I can’t?” And they said, “Well, you’re homeless. We can’t have homeless people on this board, that’s a conflict of interest.” That doesn’t make any sense. And I said, “Show me”—at that point I was better—and I said, “Show me where it says that.” And of course it didn’t say that. It said homeless people should be involved in the process. So I became the first person on the board who acknowledged the lived experience of being homeless, and, by the time I left, 25 percent of the board were homeless or had the lived experience of being homeless. And for years the head of the board was a homeless person, which I believed was a remarkable experience, and still do. But then people started saying, well you’re not really homeless.

The reason I wear the “I’m one of those people” t-shirt is that I was in one of those meetings arguing about housing first and one of the providers said, “You guys don’t understand this. Homeless people are like wild animals. They need to be housebroken before you can let them inside.” So I raised my hand and said, “You’re talking about me.” And they said, “Of course, you’re different.” So I thought it would just be easier to get a t-shirt.

I formed Next Steps with two other people to empower homeless people in Continuum of Care. One of them died and the other decided that he needed to support his kids, so I found myself alone. I decided to conduct a fairly large survey. I personally interviewed 30 people and talked about what Next Steps should do or become and the conclusion of that discussion was that, since I identified more as someone who has a severe mental illness than someone who is homeless, I should at least work on mental health issues. So the mission of Next Steps expanded into empowering people with mental illness to become involved in the system. A couple of years ago we got a grant that asked us to become statewide. We became statewide and focus on mental health issues.

Being an Educator

I teach and so I guess I believe that with appropriate supports people with severe mental illness can do work. (Even though there are many times when I doubt it.)

There are three takeaway messages from any talk I give:

1. Anyone can get seriously mentally ill.
2. Getting seriously mentally ill can have disastrous consequences.
3. No matter how bad the symptoms are, people can get better. They can recover. It’s our obligation to create a system that helps people to recover. So now I’m struggling to find out what those appropriate supports would be.

In addition to that, I teach an 8-week recovery class in which people who have lost everything—or perhaps never had anything—how to recover. How they can get a job, find a place to live, form an intimate relationship. Part of it, especially in the beginning, is heartbreaking. Many of them have been taught that it is a bad idea to want anything. So if you want a job, you just don't understand how serious your symptoms are. If you want an intimate relationship, you just don't understand how serious your symptoms are. If you want a better place to live, you should be grateful for whatever hovel you're living in. Now often, this advice is not given by bad people. Often these are people who believe that if you try and fail then you'll feel bad. And of course that's true. Try and fail, then you will feel bad. But if you don't try, you're gonna fail. The beginning step is to help people visualize what they want. Then help them make that more concrete. "I want a better place to live"—What does that mean? "I want a job." What does that mean? And then help them set up paths to achieving it.

Fred Friedman, JD, is a co-founder and member of Next Steps, NFP, a community of people who are mentally ill or at risk for homelessness or both. He serves on the board of the National Alliance on Mental Illness of Greater Chicago, the Depression and Bipolar Support Alliance of Greater Chicago, Thresholds, and Equip for Equality. He regularly lectures to Chicago police officers, Cook County jail officers, and medical students on how to manage and care for people with mental illness. He also teaches an 8-week course on recovery to people who have "lost everything."

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OP-ED

Registries, Violence, and Threats of Harm

Howard Zonana, MD

Physicians have become accustomed to and appreciate the value provided by the availability of organ donor registries, cancer registries, and other disease registries. However, applying the registry concept in the mental health and corrections arenas raises questions about its ultimate effectiveness. The rationale for such registries is that they protect the public in several ways: by restricting the actions of those considered dangerous (e.g., by limiting the access to guns of people in mental health treatment or where sex offenders can live and work) and by making the government or the public aware of the presence of those considered dangerous (as in registries of sex offenders or mandated reporting of threats of harm). But these registries increase the stigmatization of those listed on them, and, because of their focus on those with mental illness, they distort and magnify the role of mental illness in violence.

Gun Restrictions

In the wake of the December 2012 Newtown shootings of children and teachers by a young man who allegedly had Asperger syndrome, the Connecticut legislature enacted a series of bills to restrict firearms and size of ammunition magazines and to provide mental health services to schools [1].

The legislature also added gun restrictions for people who voluntarily admit themselves to mental hospitals. The new law restricts gun possession for any person who voluntarily admits himself or herself to a psychiatric hospital on or after October 1, 2013, for reasons other than drug or alcohol addiction. Anyone who has been so admitted will not be able to receive a permit or eligibility certificate or to possess a firearm for 6 months thereafter [1]. This means that the Connecticut Department of Mental Health and Addiction Services will now have to report all voluntary admissions to public and private psychiatric facilities (including names and other identifying data) to the Department of Emergency Services and Public Protection.

The legislature, however, left a significant gap in the reporting statute. Patients who were involuntarily committed by a court to a psychiatric hospital within the past 5 years were restricted from acquiring guns [1] (lengthening the previous restriction, which only restricted gun access within 1 year of court-ordered commitment [2]), but there are no restrictions on gun ownership for the mentally ill who have been involuntarily hospitalized by a single physician using a physician's emergency certificate. This certification permits detention in a psychiatric facility for up to 15 days without a full court hearing for those who are deemed mentally ill and

dangerous or gravely disabled [3]. This is the most commonly used mechanism for involuntary confinement, and those so hospitalized face no restrictions on the ability to purchase or own a gun.

The underlying assumptions must be that those who voluntarily seek treatment in mental hospitals are more likely to be dangerous than those who do not and, since those with alcohol or drug problems were excluded from the statute, that the latter group are less likely to be dangerous than people with mental illness. Both assumptions are questionable. It is inappropriate to select voluntary patients as the target group for the legislation. A significant number of people with mental illness are admitted because they are “gravely disabled” rather than being dangerous. Furthermore, the exception for those in alcohol or drug treatment is wrongheaded, since this group has a much higher violence rate than those with mental illness alone [4].

Another problem with this section of the new law is that it means hospitals will have to inform potential voluntary patients of these restrictions before they are admitted, which may deter people from seeking treatment. Thus, the law may not only discourage voluntary admissions, it will also increase the stigmatization of mental illness and will unfairly affect patients who are not dangerous. Overall, people with mental illness have been shown to commit only about 4 percent of the total violence in this country [5].

Unlike bans on semiautomatic weapons, mental health laws get bipartisan support. Gun advocacy groups have conceded to gun regulation that applies to people with mental illness. In response to Newtown, the National Rifle Association (NRA) argued that mental illness, not guns, was the root cause of the shooting spree. Restricting possession of weapons only by those with mental illness is not a solution to the larger problem of gun violence, and broad statutes aimed at people with mental illness seeking treatment make the situation worse, rather than better.

Threats of Harm

The headlines from recent mass shootings have focused on the mental illnesses of the perpetrators and have precipitated some reactive laws that legislators hope will decrease the likelihood of recurrences. These laws are not likely to be effective, given our lack of ability to predict which people with mental illness will become violent and when they will have violent exacerbations. Following the Tarasoff rulings of the mid-1970s, most states enacted legislation that requires mental health professionals to report to police or take steps (e.g., hospitalization) to prevent harm when they have concluded that a patient represents a danger to an identifiable victim or specific class of victims [6].

New York, also following the Newtown shooting, passed a law that requires mental health professionals to report to authorities when a patient is “likely to engage in conduct that would result in serious harm to self or others” so that that person’s access to firearms can be restricted [7].

This new statute is vague and will be difficult to apply. How “likely” does an event have to be before a report is required? Many patients express suicidal feelings or ideation during treatment or express anger towards others. Generally patients expect their comments to mental health professionals to be confidential. Confidentiality is not absolute in these treatment relationships due to other statutes that specify reporting of child abuse, elder abuse, and credible threats of harm to specific people. New York’s law introduces yet another warning that will have to be made in advance to patients. It will further erode the patient-physician relationship and will be more difficult to explain. The pressure to report will be high: many professionals will be concerned that not doing so will result in liability. So, once again, the provision could cause people to avoid treatment.

In the 3 months after New York’s mental health professionals were required to report potentially dangerous mentally ill patients to the state database that screens gun-permit holders and applicants, approximately 6,000 names were submitted to the state—but fewer than a dozen resulted in any action to remove weapons [8]. The major problem is overidentification. Reporting will always include many who do not pose a significant risk and will have a chilling effect on help seeking by people concerned about state intrusions.

Sex Offender Registration

Sex offenders are subject to stigmatizing restrictions that don’t protect would-be victims. Indeed, the management of sex offenders has been controversial for more than 75 years. From the 1940s to the 1970s it was hoped that mental health treatment would provide some solution, so offenders were transferred to treatment facilities in lieu of long-term prison sentences [9]. Even when longer sentences were imposed in the 1980s, offenders still had to be released after serving them. Some, of course, reoffended. In 1990 new legislation proposed indeterminate mandatory civil commitments to mental health facilities for sex offenders after they had served their entire criminal sentences, to protect the public [10]. About 20 states have enacted these “sexual predator statutes” since 1990 [11]. These were challenged but upheld by the Supreme Court in 1997 [12].

Then registration for released sex offenders was proposed. The federal government provided incentives for states to adopt them by tying federal funding for law enforcement to the enactment of these statutes. These statutes were named for victims, usually children. The Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act of 1994 required states to establish registries for sex offenders for at least 10 years after their release from prison [13]. In 2006, the Adam Walsh Child Protection and Safety Act expanded the crimes covered by the registries, made failure to register a federal crime, and mandated reporting to a national database [14].

The number of registered sex offenders in the U.S. in 2012 was 747,408 [15]. Keeping track of this data is difficult. California acknowledged losing track of an estimated 33,000 offenders [16]. Many also require community notification, which

was in response to the 1996 Megan's Law, later expanded to mandate that states place information on web sites available to the general public [17].

Many states have enacted more stringent statutes requiring lifelong registration and adding restrictions concerning where offenders may live [18]. Child molesters are barred from living within specified distances (usually 1,000 to 2,500 feet) from schools, child care centers, and playgrounds. There are, however a number of studies that suggest that this restriction is not particularly effective. Zandbergen, Levinson, and Hart [19] compared residential locations for a group of sex offenders who reoffended over a 2-year period with those of offenders who did not offend again. Recidivists were not more likely to live within the buffer zone around schools or day care facilities. Nonrecidivist sex offenders were, in fact, significantly more likely to live within a 2,500-foot radius around at least one school.

In a Minnesota study, the Department of Corrections examined the relationship between residential proximity to areas with high concentrations of children and sexual recidivism. The study found that residence restriction laws, had they been in place, would have been unlikely to deter any of the 224 registered offenders they studied [20]. The fact that 93 percent of sexually molested boys and 80 percent of sexually molested girls know their offenders before the attack [16] highlights the importance of personal relationships rather than residential proximity.

Several authors have argued that forcing offenders to live at a distance from family, friends, and resources can result in social isolation and make reintegrating more difficult [21]. The location restrictions tend to push offenders toward more nonurban areas where jobs may be harder to find and prices for housing can be higher [22]. The public's easy access to registries also makes it harder for released offenders to find jobs. Furthermore, studies have tended to indicate that a high percentage of offenders do not obey location restrictions and that these laws are not strictly enforced [23].

A particularly severe housing restriction statute in Georgia was overturned by the Georgia Supreme Court in 2007 [24]. Georgia's restrictions include a prohibition on loitering where children congregate, including school bus stops. The plaintiff, who purchased a home and established a business in locations away from any schools and child care centers, was then asked to change his residence when new child care centers opened up near his home and business. The Georgia Supreme Court found the restriction around his residence, but not the one around his business, to be unconstitutional. The court's sensible point was that a registered offender could possibly have to move repeatedly if he or she relocated to a less developed area that subsequently became built up with schools, day care centers, and the like.

Conclusion

Tracking of those with mental illness has become so heterogeneous that it is not easily classified. Registries range from those for criminals with mental disorders that may or may not relate to violent behavior to those for people seeking treatment for

mental illness who would not be considered dangerous. In the legislature's rush to "do something" following a tragic event, policy makers are less open to consultation and more prone to sweep with a broad brush where a more nuanced approach is necessary. While some people with severe mental illness do commit heinous crimes, there is no easy way to predict who or when or where the next such event will occur. Since the role played by those with mental illness in our national violence problem is small, they should not be scapegoated.

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Howard Zonana, MD, is a professor of psychiatry, director of the forensic psychiatry residency training program, and an adjunct clinical professor of law at Yale University in New Haven, Connecticut. He is a member of the bioethics committee at Yale-New Haven Hospital and a federal court monitor of standards for mental health care at the women's prison in York, Connecticut. He served as a consultant to the *DSM-5* committee on paraphilic and sexual disorders and in 2012 won the American Psychiatric Association-American Academy of Psychiatry and the Law Isaac Ray award.

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About the Contributors

Theme Issue Editor

Laura M. Blinkhorn, MD, is an intern at Swedish Family Medicine Residency-First Hill in Seattle and a 2013 graduate of the University of Chicago Pritzker School of Medicine. Her professional interests include primary care management of mental illness, cross-cultural medicine, and health care for the homeless.

Contributors

Carl C. Bell, MD, is director of the Institute for Juvenile Research (the birthplace of child psychiatry) and professor of psychiatry and public health in the Department of Psychiatry at the University of Illinois College of Medicine at Chicago. He has been practicing medicine for more than 40 years and has 450 publications.

Susan Buratto, MD, is a fellow in forensic psychiatry in the Department of Psychiatry and Behavioral Sciences at Northwestern University's McGaw Medical Center in Chicago.

Hathaway Burden is a project manager at the Center for Children and Youth Justice in Seattle. She manages the center's mental health reform efforts in the juvenile justice and child welfare systems.

Charles C. Dike, MD, MPH, is an assistant professor of psychiatry and the deputy training director in the Law and Psychiatry Division fellowship program at Yale University Medical School in New Haven, Connecticut. He is also director of the Whiting Forensic Division at Connecticut Valley Hospital in Middletown.

Stephen H. Dinwiddie, MD, is a professor of psychiatry in the Department of Psychiatry and Behavioral Sciences at Northwestern University's McGaw Medical Center in Chicago.

Jeffrey C. Eisen, MD, MBA, is a supervisor and instructor in psychiatry at Harvard Medical School and the Cambridge Health Alliance and is the 2013-2014 fellow in forensic psychiatry at the University of Massachusetts Medical School. His interests include ethics and efficacy in civil commitment for substance-abuse treatment and performance improvement in behavioral health. He also implemented the integration of psychiatric services into a primary care clinic serving the homeless population of Cambridge and its surrounding communities.

Fred Friedman, JD, is a co-founder and member of Next Steps, NFP, a community of people who are mentally ill or risk of homelessness or both. He serves on the board

of the National Alliance on Mental Illness of Greater Chicago, the Depression and Bipolar Support Alliance of Greater Chicago, Thresholds, and Equip for Equality. He regularly lectures to Chicago police officers, Cook County jail officers, and medical students on how to manage and care for people with mental illness. He also teaches an 8-week course on recovery to people who have “lost everything.”

H. Martin Malin, PhD, MA, LMFT, is a clinical sexologist and licensed marriage and family therapist specializing in the treatment of sexual disorders. He is professor of clinical sexology at the Institute for Advanced Study of Human Sexuality in San Francisco and was formerly manager of the Johns Hopkins Medical School Sexual Disorders Clinic.

Michael L. Perlin, JD, is a professor of law, director of the International Mental Disability Law Reform Project, and director of the Online Mental Disability Law Program at New York Law School.

Mary Helen Roberts has served as a representative in the Washington State Legislature since 2004. She is the vice chair of the Public Safety Committee.

Maxwell R. Rovner, MD, JD, is a fourth-year psychiatry resident at the University of Chicago Medical Center. He is a graduate of Harvard Law School and the University of Chicago Pritzker School of Medicine. Before going to medical school, he was a law clerk for U.S. District Judge Harry D. Leinenweber, a policy assistant to Chicago Mayor Richard M. Daley, and the chief speechwriter to Mayor Daley and U.S. Senator Carol Moseley-Braun. He is interested in outpatient and forensic psychiatry.

Fabian M. Saleh, MD, is a forensic and child and adolescent psychiatrist and assistant clinical professor of psychiatry at Harvard Medical School in Boston. He is the director of the Sexual Violence Prevention and Risk Management Program at Beth Israel Deaconess Medical Center, a teaching hospital of Harvard Medical School. Dr. Saleh’s forensic practice focuses on criminal and civil cases, including but juvenile sexual offending behavior, risk assessment, and risk management.

John Henning Schumann, MD, is an associate professor of medicine and the director of the internal medicine residency program at the University of Oklahoma School of Community Medicine in Tulsa. He has written widely about patient experience and physician-patient communication, on topics ranging from the ethics of hospital discharges “against medical advice” to the “non-ethics” of nonindicated commercial screening tests. His blog and radio work can be found at glasshospital.com.

Eric Trupin, PhD, is a professor, vice chair of the Department of Psychiatry and Behavioral Sciences, and director of the Division of Public Behavioral Health and Justice Policy at the University of Washington School of Medicine in Seattle. He is a child psychologist and directed the Division of Child and Adolescent Psychiatry at Children’s Hospital and Medical Center for 12 years. He directs clinical and systems

research programs supported by NIDA, The MacArthur Foundation, and Paul Allen Foundation.

Sarah Cusworth Walker, PhD, is a research assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine in Seattle. Her work focuses on the intersection of policy and research in juvenile justice and allied public systems for youth.

Daniel Yohanna, MD, is the vice chair and an associate professor in the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago Pritzker School of Medicine. His interests are in community psychiatry and forensic psychiatry, as well as the development of systems of care for people with mental illness.

Corey Rayburn Yung, JD, is an associate professor at the University of Kansas School of Law in Lawrence who specializes in sexual violence law and whose scholarship has been used by courts across the country, including the Supreme Court of the United States.

Howard Zonana, MD, is a professor of psychiatry, director of the forensic psychiatry residency training program, and an adjunct clinical professor of law at Yale University in New Haven, Connecticut. He is a member of the bioethics committee at Yale-New Haven Hospital and a federal court monitor of standards for mental health care at the women's prison in York, Connecticut. He served as a consultant to the *DSM-5* committee on paraphilic and sexual disorders and in 2012 won the American Psychiatric Association-American Academy of Psychiatry and the Law Isaac Ray award.

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