Psychiatry and the Law

Basic Principles

Tobias Wasser
Editor

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Preface

The practice of psychiatry is one of the most heavily legally regulated of all medical specialties. Understanding how psychiatry and the law interface provides a foundation upon which to build one's skills and habits through training and beyond. This book can be used to guide or supplement education on the legal regulation of psychiatry, the use of psychiatry to answer legal questions, and the treatment of criminally involved individuals. It is designed to introduce students, trainees, and practicing mental health professionals to core concepts at the intersection of psychiatry and the law, with each chapter focusing on a topic relevant to clinical practice. Authors of each chapter are emerging experts in the field who all completed their forensic training in the Law and Psychiatry Division of the Department of Psychiatry at the Yale University School of Medicine, a nationally recognized training institution for forensic psychiatry and psychology. The authors are well versed in their chapter's particular subject matter, making them ideally suited to identify the most relevant, high-yield topics for students, trainees, and others looking for a brief primer on the topic.

New Haven, CT, USA — Tobias Wasser

About the Editor

Tobias Wasser, MD, was born in New York City as the second of five siblings. He is a fourth generation physician and third generation psychiatrist within his family and currently lives in Connecticut with his wife and two children. Dr. Wasser obtained his undergraduate degree in psychology at Wesleyan University and then completed medical school at the University of Connecticut School of Medicine. He completed all of his psychiatry training at the Yale University School of Medicine—first completing the psychiatry residency program, before completing fellowships in forensic psychiatry and public psychiatry. He is currently an Assistant Professor in the Department of Psychiatry of the Yale University School of Medicine and on faculty in both the Public Psychiatry and Law and Psychiatry Divisions. He is also the Associate Program Director of the Yale Fellowship in Public Psychiatry and works clinically as the Medical Director of the Whiting Forensic Division of Connecticut Valley Hospital. Dr. Wasser is a clinician-educator whose scholarly endeavors focus on the treatment and evaluation of individuals with serious mental illness at the intersection of the mental health and criminal justice systems, with a particular interest in using novel educational approaches to translate this information to students, trainees, and practitioners.

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On a personal note, I would also like to thank my family for their love and support in developing this book. In particular I would like to acknowledge my grandparents, Leonard and Ruth; parents, Lisa and Larry; wife, Marla; and children, Mikayla and Jacob, without whom this work would not have been possible.

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Introduction: Why Understanding the Law Matters

1

Tobias Wasser and Katherine Michaelsen

As a student, trainee, or mental health practitioner, one may already have some inclination that understanding the law matters in the practice of psychiatry. But what is it exactly that makes the law so important? And why in psychiatry in particular?

State and federal laws have a significant impact on the practice of medicine. The practice of psychiatry is particularly affected as it is the most heavily legally regulated of all medical specialties [1]. The reason is relatively simple: far more than any other medical discipline, the law grants psychiatrists the ability to deprive people of their civil liberties. Psychiatrists may force interventions on patients against their will—including hospitalization, medication, or even electroconvulsive therapy (ECT). Further, in a variety of settings, psychiatrists are tasked with determining whether patients lack the capacity to make certain decisions for themselves—including decisions related to medical care, finances, and estate planning—and are in need of surrogate decision-makers. In some states, any physician may enact such privileges; however, in practice, psychiatrists are most often called upon to make these determinations.

Thus, the privilege to override individuals' rights to autonomy is subject to careful legal oversight and protections. So how does the law impact the practice of psychiatry? State and federal laws delineate the limited circumstances within which psychiatrists may deprive patients of their civil liberties. Patient autonomy is generally protected except in cases involving serious concerns about safety or well-being.

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The law also regulates aspects of psychiatric practice that may be frightening or confusing to clinicians because they can lead malpractice claims. For example, the law sets standards of care concerning the confidentiality of a patient's protected health information, a clinician's duties to third parties, and deviations from standards of practice that may lead to liability [2]. Regulations vary significantly by state, so psychiatrists must be familiar with the laws in the states where they practice in order to provide safe, appropriate, and respectful care. A better understanding of psychiatry and the law may also assist psychiatrists with correctly identifying scenarios that fall within the scope of their practice and cases that may benefit from consultation or referral to a specialist.

Understanding the legal regulation of psychiatry and ways that psychiatry is used to answer legal questions have become such complicated and critical practice concerns that a subspecialty has evolved with a focus on this interface: forensic psychiatry. The American Academy of the Psychiatry and the Law (AAPL), the most prominent American professional organization for forensic psychiatrists, is dedicated to excellence in practice, teaching, and research in forensic psychiatry [3]. AAPL defines forensic psychiatry as "a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues" [3].

While a fellowship in forensic psychiatry may provide an avenue to expand a psychiatrist's knowledge and skills at the legal interface, a basic understanding of the law is essential for all psychiatrists, regardless of clinical setting or psychiatric subspecialty (Table 1.1). Further, the increasing number of justice-involved individuals with mental illness creates a need for general psychiatrists to be comfortable treating forensic patients [4, 5]. Even if all forensic psychiatrists dedicated themselves to treating solely incarcerated and/or justice-involved individuals (let alone all the other forensic tasks), there would not be sufficient psychiatrists to address the growing demand [6].

Table 1.1 Impact of the law in various psychiatric subspecialties

Clinical setting	Examples
All	Confidentiality, malpractice, informed consent
Outpatient	Involuntary outpatient commitment, duties to third parties (i.e., Tarasoff warnings)
Inpatient	Civil commitment, involuntary medication
Emergency room	Emergency hold and/or emergency involuntary commitment, suicide risk assessment, violence risk assessment
Subspecialty	
Child and adolescent	Guardianship, termination of parental rights
Geriatric	Testamentary capacity (capacity to write a will), decision-making capacity
Psychosomatic	Decision-making capacity
Addiction	Court-ordered substance abuse treatment

Developing an understanding of the law is particularly important during psychiatry training. Even in the midst of continuing education and professional development, most practitioners continue to practice what they learned through didactics and clinical experience during their training [7]. Currently, there is significant variability in exposure to both forensic teaching and forensic clinical experiences in the USA and Canada [8, 9]. There is also evidence that greater experience with forensics in the classroom and, even more so, in clinical settings is associated with increased comfort and willingness to treat forensic patients [9]. Learning about these concepts during training provides a foundation upon which to build one's skills and habits as one advances through a career. Further, it is important to understand which aspects of psychiatry are regulated at the state vs. federal levels, especially if a psychiatrist goes on to practice in different states.

The Accreditation Council for Graduate Medical Education (ACGME) included a number of legally related requirements in the developmental milestones for psychiatry residents published in 2014 [10]. The ACGME milestones include knowledge, skills, attitudes, and other attributes for each of the ACGME competencies and are organized in a developmental framework from less to more advanced. Each milestone is a descriptor and target for resident performance as he or she progresses from entry into residency through graduation [10]. The six domains of physician competency assessed by the milestones are patient care (PC), medical knowledge (MK), professionalism, systems-based practice (SBP), interpersonal and communication skills (ICS), and practice-based learning and improvement (PBLI). Table 1.2 includes examples of forensic topics described within the milestones.

Table 1.2 Examples of forensic psychiatry related ACGME milestones in residency

Clinical setting	Forensic topics	Milestone
PGY-1		
Inpatient psychiatry	Suicide risk assessment	PC3, MK2
Inpatient psychiatry	Violence risk assessment	PC3, MK2
Inpatient psychiatry	Liability	SBP1
PGY-2		
Emergency psychiatry	Malingering	ICS2
Psychosomatic medicine	Decision-making capacity	MK6, SBP4, PROF1
Psychosomatic medicine	Informed consent	MK6, SBP4, PROF1
Psychosomatic medicine	Substituted judgment	SBP4, PROF1
Psychosomatic medicine	Right to refuse treatment	SBP4
PGY-3		
Outpatient psychiatry	Liability	PROF2
Outpatient psychiatry	Forensic referral and consultation	MK6
Outpatient psychiatry	Patient privacy regulations, HIPPA	MK6
Addiction psychiatry	Drug laws and regulations	MK2

PGY postgraduate year, *ACGME* Accreditation Council of Graduate Medical Education, *PC* patient care, *MK* medical knowledge, *PROF* professionalism, *SBP* systems-based practice, *ICS* interpersonal and communication skills

Connecting the Law to Clinical Work

To highlight the importance of understanding the law in clinical practice, let's review a fairly typical case requiring inpatient admission. As the reader thinks critically about each step in the process, the law's profound impact on practice becomes apparent.

Case Example

Initial Presentation

You are working the psychiatric emergency room of your local area hospital. While on your shift, the nurse comes to you and says there is a new patient, Max, waiting to be seen. The nurse provides you the following information about the patient:

Max is a 22-year-old single male with a history of schizophrenia who was brought into the hospital by the police after an explosive outburst at his outpatient clinic. Max had an appointment with his therapist in the clinic today, but has had difficulty making it in for his appointments, so his case manager picked him up at home and drove him to the clinic. On the ride to the clinic, Max disclosed that he hadn't been taking his prescribed medications for several days. When asked further about this decision, Max stated that he had stopped taking the medication because there were microchips implanted in his pills by his therapist to help the clinic staff track his movement around town. He was very upset about these attempts to monitor him and planned to discuss this with his therapist today at his appointment.

While in the clinic lobby waiting to meet with his therapist, Max suddenly began screaming at his case manager, stating that the case manager was involved in the microchip conspiracy. Max quickly escalated into threatening violence and then attempted to punch his case manager. Fortunately, he did not make physical contact and no injuries were sustained. The clinic staff called 911, and when the police arrived, Max attempted to run away from them. He was ultimately apprehended, arrested by the police for misdemeanor assault, and brought to the emergency room in handcuffs. When they arrived at the hospital, the police released him with a promise to appear in court the following week.

With this background information, you go to interview Max. When you first meet with him, he remains extremely angry with his therapist, who he believed purposefully incited these events so that he would be hospitalized. When you recommend that that he restart his medications, he declines. He says that he does not need to be hospitalized or be given any medications, only to get his therapist "out of the picture." When you ask him what he means by this, he refuses to answer. Overall, his thought processes seem disorganized.

Let's pause for a moment and consider some legal questions that might be important to understand when deciding how best to treat this patient:

Legal Questions to Consider:

- What are the criteria for emergent involuntary hospitalization in your state? Does Max meet these criteria?
- If Max were interested in signing in voluntarily to the hospital, does he have the capacity to make this decision? How would you know?
- Max has made a statement that could be interpreted as a threat of violence against his therapist. Should you report this to his therapist or the police? What are the laws regarding third-party reporting in your state? Are there any other options besides reporting that might fulfill your professional obligation?

Hospital Course

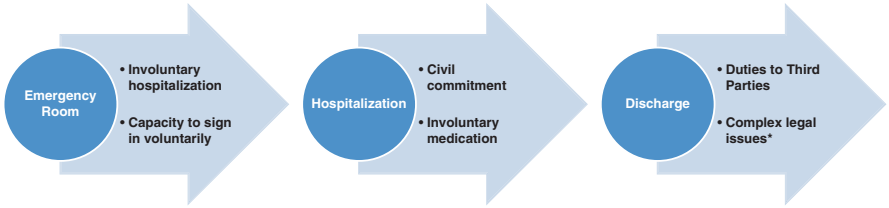
Max was admitted involuntarily to the inpatient psychiatric unit. In the first few days of his hospitalization, he presents with labile affect and disorganized thinking. He perseverates on his discharge and paranoid concerns related to his therapist and medications. When asked about the events leading to his admission, he minimizes the significance of his physical aggression, stating he just "got a little upset." You again recommend that he reconsider taking his medications, but he continues to decline, and he remains in this psychotic state for several days. He begins demanding discharge, especially when he learns that the term of the initial emergency involuntary commitment order ends tomorrow.

Legal Questions to Consider:

- What are the criteria for involuntarily medicating a patient in your state? Does the patient meet these criteria?
- What are the criteria and processes for applying for civil commitment in your state? Does the patient qualify? How does civil commitment differ from an emergency involuntary commitment?

Preparing for Discharge

Max is eventually treated with medications, his symptoms improve, he no longer voices thoughts of harming his therapist, and you determine that he is ready to be discharged. On the day of discharge, you receive a phone call from Max's attorney (public defender) representing him on the misdemeanor assault charges stemming from the incident at the outpatient clinic. The attorney informs you that Max is being charged with assault in the third degree and has a hearing scheduled in court the following week. He wants to know your opinion about whether you think Max is "competent to stand trial" and whether he would qualify for an "insanity defense" because he was clearly suffering from symptoms of mental illness at the time of the incident. You say that you're not sure you are the best person to answer these questions, but he insists that since you have just been treating Max in the hospital, you know his "state of mind" better than anyone else.



*Relevant only in cases in which the patient has incurred legal charges prior to or during hospitalization

Fig. 1.1 Stages of a psychiatric hospitalization and pertinent legal questions

Legal Questions to Consider:

- Now that you're discharging the patient, do you need to call the therapist or the police to warn them about his prior threats? How do the laws in your state regarding duties to third parties apply?
- What does his attorney mean by "competence to stand trial?"
- What is an "insanity defense?" Does your state allow such a legal defense? If so, what are the criteria?
- Does answering the attorney's questions raise any ethical concerns?

While the majority of these questions cannot be answered in the abstract, as they require a thorough understanding of an individual state's laws and statutes, clinical psychiatrists will face many of these questions regardless of the setting (see Fig. 1.1). As this case demonstrates, understanding the law is critical to engaging in safe, appropriate, and recovery-oriented psychiatric practice which is respectful of the rights and civil liberties of both our patients and the public.

How to Make Use of This Book

This book is designed to introduce students, trainees, and practicing mental health professionals to core concepts at the intersection of psychiatry and the law, with each chapter focusing on a different topic area. Chapter authors are emerging experts in the field who are well versed in their chapter's particular subject matter, making them ideally suited to identify the most relevant, high-yield topics for students, trainees, and others looking for a brief primer on the topic.

Most chapters begin with a case vignette synthesized from a historical legal case that places readers in the role of a treater and asks them to consider how they would approach the clinical scenario. The chapters will follow up with details of the actual legal case and the case's historic significance. Finally, each chapter concludes with a discussion of the core principles and concepts of practice

related to each topic. Utilizing this format, we hope to introduce the reader to the most relevant and practical principles of psychiatry and the law in a clinically relevant and succinct format. Given the dynamic and evolving nature of the law, it is not possible to present an up-to-date list of all relevant laws for each individual state. However, chapters provide an overview of national- and state-based regulations for the reviewed topic and guidance regarding where readers can find up-to-date state-specific information.

This text can be used as an educational tool in a variety of ways. In the classroom, for faculty invested in teaching residents or medical students, the book can be used to guide the development of an introductory course in psychiatry and the law, with each chapter or a combination of chapters serving as reading material for each seminar. Chapters can also be used individually for relevant stand-alone classes discussing a particular subject area. For example, in a seminar on suicide risk assessment, an instructor might ask the trainees to read the related chapter in advance and come to class prepared to apply what they've learned to a discussion of challenging risk assessment cases they have seen in the hospital or clinic setting.

Adult learning theory teaches us that applying the information in these chapters in the clinical learning environment is key to integrating the material into the learners' practice [11]. Thus, while rotating on an inpatient unit, attendings may ask residents or students to read one of the several chapters discussing inpatient topics (e.g., involuntary medication or civil commitment) and plan to present what they've learned during team rounds or describe how it applies to a particular patient the team is treating. Further, self-motivated learners facing a complex clinical scenario might read a chapter to help them to better understand the implications of the law in that particular situation. Finally, while this book has been developed with trainees and students in mind, we hope it can also serve as a refresher on these topics for more senior mental health professionals.

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Informed Consent

2

Simha E. Ravven

Clinical Vignette

You are a psychiatrist working as a member of your hospital's ethics committee when you receive a new ethics consult about a female patient who is in a debilitated state. The clinical team has placed an ethics consult because the team has been asked by the patient's parents to terminate the patient's artificial nutrition and hydration (ANH). The team is looking for guidance about how to proceed from the ethics committee. You are asked to serve as the committee's representative and to gather more information about the case.

You begin reviewing the records and learn that the patient is a young woman who suffered an anoxic brain injury 3 years earlier in a motor vehicle accident. It is estimated she had more than 10 min of oxygen deprivation. Neuroimaging has shown cortical atrophy and ventricular enlargement. Neurological assessments have described cerebral cortical atrophy as irreversible, permanent, and progressive.

When you meet her, she has unassisted respiration and circulation. She is unaware of her environment, with the exception of grimacing in response, perhaps in response to sound and painful stimuli. You observe spastic quadriplegia and contractures of her limbs with muscle and tendon damage that has been described as irreversible.

She is not able to swallow food or water to maintain her daily needs. Her medical record notes that this deficit is long-standing and it is believed that she will not be able to recover this ability.

She has had a gastrostomy tube placed to provide hydration and nutrition. This was placed approximately a year prior, with the consent of the family, who, at the time, were hopeful about her prognosis and potential for improvement. She has not had improvement in this time.

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You learn from her family that several years before her motor vehicle accident and resulting injuries, when she was in her mid-20s, your patient had expressed to a roommate that if she were injured or ill, she would not want to live unless she could live at least a "halfway normal" life.

The patient's parents have requested that her medical team terminate artificial nutrition and hydration (ANH). Upon speaking to the team, you learn this would mean certain death for her.

What recommendations would you make to the clinical team? You consider the multiple ethical duties of a physician, including the duty as a physician of non-maleficence or the Hippocratic duty to "First, do no harm." Your patient does not have a written directive and in her current state is not able to give meaningful informed consent for withdrawal of life-prolonging treatment. Would withdrawal of life-prolonging treatment be considered harm?

Is continuation of ANH, thus continuing life in a state the patient had expressed at one time that she would not want to live in, a harm imposed on her? Is harm done in prolonging a state where she may be suffering?

You consider what the team should do in caring for a patient whose prior wishes regarding life-sustaining treatment are unclear or unknown. Is it possible for the physician to follow state law favoring the preservation of life and still maintain the physician's traditional duties to the patient of non-maleficence, beneficence, and autonomy?

What would you do?

History of the Case: Cruzan v. Director, Missouri Department of Health, 110 SCt 2841 (1990)

On January 11, 1983, at age 25, Nancy Cruzan lost control of her car in Jasper County Missouri. She was found in a ditch "without detectable respiratory or cardiac function." She was successfully resuscitated at the site and transported to the hospital unconscious. She was diagnosed by a neurosurgeon as having "probable cerebral contusions" and anoxic brain injury [1].

Ms. Cruzan remained in a coma for 3 weeks and then progressed to a persistent vegetative state (PVS). A clinical study of PVS from 1985, around the time of Ms. Cruzan's treatment for the condition, defined diagnostic criteria for PVS as "(1) wakefulness with periods of normal-appearing sleep; (2) no signs of awareness of self or environment or evidence of interpersonal response; (3) no comprehensible utterance or signal; (4) only reflex or purposeless motor response to stimuli; and (5) normal pulse, blood pressure, and respiration" [2]. As a result of her PVS, Ms. Cruzan was unable to utilize oral nutrition to meet her metabolic needs. In order to ease feeding and recovery, surgeons implanted a gastrostomy tube and hydration tube with the consent of Ms. Cruzan's then husband. However, her condition did not improve.

At the time of the Supreme Court decision, Cruzan v Missouri Department of Health [1], Ms. Cruzan lay in a persistent vegetative state at a Missouri State

Hospital. At this time, the State of Missouri absorbed the cost of her care. When it became clear she had virtually no chance of recovery, Ms. Cruzan's parents requested that hospital employees terminate artificial nutrition and hydration (ANH). All of Ms. Cruzan's providers agreed that this action would cause death and refused to honor this request without court approval.

Ms. Cruzan's parents then sought and received authorization from the state trial court for termination of ANH. The trial court found that a person in Ms. Cruzan's condition had a fundamental right under the Missouri and Federal Constitutions to refuse or direct the withdrawal of "death prolonging procedures." The trial court found that Ms. Cruzan's conversations with her roommates at age 25, in which she expressed that she would not want to continue her life if she were ill or injured unless she could "live at least halfway normally," were sufficient evidence that Ms. Cruzan would not want to continue ANH and thus continue her life in its current state [1].

Both the State of Missouri and Ms. Cruzan's guardian ad litem (a person appointed by the court to protect Ms. Cruzan's interests) appealed the trial court's decision to allow termination of ANH. In 1988, the Supreme Court of Missouri reversed the trial court's decision [3], citing Missouri's policy prioritizing preservation of life. Further, the court stated that medical treatment could not be withdrawn for an incompetent person without the formalities outlined in the living will statute or unless "clear and convincing, inherently reliable" evidence was present. The court found that neither of these were present in Ms. Cruzan's case.

The case was appealed to the US Supreme Court, who agreed to hear the case "to consider the question of whether Cruzan has a right under the U.S. Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances [1]." The US Supreme Court affirmed the decision of the Missouri Supreme Court on the grounds that the Constitution "did not forbid a state (such as Missouri) from requiring clear and convincing evidence of an incompetent individual's wishes regarding the withdrawal of life-sustaining treatment [1]".

Justice Rehnquist described, in *Cruzan*, precedent dating back to the nineteenth century that supported the right to bodily integrity and right to refuse medical treatment. He noted that until the 1976 Quinlan case [4], there were relatively few right to refuse cases, many of which focused on medical treatment forbidden by religious belief. Judge Rehnquist further noted in his decision, "On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and *competent* persons generally are permitted to refuse medical treatment, even at risk of death [1]."

In *Cruzan*, the Supreme Court held that (1) the US Constitution allows Missouri to require that evidence of an incompetent person's wishes regarding life-sustaining treatment be proved by the standard of "clear and convincing evidence" (a level of evidence greater than a "preponderance of the evidence" (approximately a 51% chance), but less than the "beyond a reasonable doubt" standard required in criminal cases). (2) A competent person would have a constitutionally protected right to refuse life-saving hydration and nutrition—and that an incompetent person is not able to make an informed choice and does not possess the same right. (3) The state

is not required to accept substituted judgment from family members "in the absence of substantial proof that their views reflect the patient's."

After the 1990 Supreme Court ruling, Ms. Cruzan's family petitioned the Missouri trial court to rehear their request to withdraw ANH. The Cruzan family brought additional witnesses who had prior discussions with Ms. Cruzan about her wishes regarding life-sustaining treatments. Cruzan's treating physician also testified that he was in favor of discontinuation of tube feedings. The state of Missouri withdrew its opposition to withdrawal of ANH. In December of 1990, Judge Teel ruled by "clear and convincing evidence" that Nancy Cruzan's desire, if she were competent, "would be to terminate her nutrition and hydration." Artificial nutrition and hydration were withdrawn and Nancy Cruzan died 12 days later [5].

Basics of Informed Consent

Informed consent refers to the active collaborative process in which the physician and patient discuss potential risks and benefits of an intervention or treatment. Informed consent refers to this process in both medical care and also research contexts. Informed consent is a fairly recent and evolving concept and has evolved since the 1914 case, Schloendorff v. Society of New York Hospital, established the basic right to consent to medical care [20].

Central to the concept of informed consent is the idea that an individual requires adequate information in order to meaningfully participate in making decisions about their own health care and participation in research. In other words, patients require information about likely risks and outcomes in order to make decisions that express their preferences and values [6].

The American Psychiatric Association (APA) delineates the psychiatrist's duty in assuring meaningful informed consent and identifies core components of informed consent. The APA Commentary on Ethics in Practice states: "Psychiatrists should recognize the importance of informed consent for assessment or treatment as an essential means to recognition of and respect for the patient's autonomy and personhood. Informed consent is an ongoing process that involves disclosing information important to the patient and/or decision-maker, ensuring the patient/decision-maker has the capacity to make treatment decisions, and avoiding coercive influences." [7]. The basic elements of disclosure include "an accurate description of the diagnosis and the proposed treatment, its potential risks and benefits, any relevant alternatives, including no treatment at all, and the relative risks and benefits of each option."

In anticipation of being unable to participate meaningfully in the informed consent process, an individual may complete an advance directive. Advance directive is a broad term that refers to a written statement of a person's wishes regarding medical treatment should that person later lack capacity to make decisions. An individual may also designate others to make decisions for them. These are called substitute decision-makers. A power of attorney (POA) is a written document that appoints a person or organization to manage an individual's affairs if he or she becomes unable

to do so. A POA may be narrow or quite broad. An example of a POA is a healthcare proxy or healthcare power of attorney. This is a legal document that allows an individual to designate someone they know to make medical decisions for them should they become unable to make or communicate decisions.

Core Principles of Cruzan

Cruzan Affirmed Competent Decision-Making

Cruzan affirmed the right of competent persons to refuse medical treatment. While this was not the central focus of the Cruzan family's initial petition, it was an important component of the Supreme Court's written decision [8]. *Cruzan* emphasized patient autonomy and self-determination and the right of competent persons to make informed treatment decisions. *Cruzan* highlights the need for physicians to respect the treatment preferences and desires of competent persons regarding end-of-life and life-sustaining treatments [8, 9].

Treatment Decisions of Incompetent Patients Should Be Based on Previously Expressed Preferences

Cruzan and the literature on the decision emphasize that physicians should have discussions with their patients about their desires regarding life-sustaining treatments while they are legally competent and have the capacity to fully understand the complexities of such decisions. Physicians should systematically initiate conversations about the patient's desires regarding life-sustaining treatments. The importance of having patients complete advance directives has been emphasized broadly in the literature commenting on the clinical implications of the *Cruzan* decision [8–10].

Most elderly persons and people with chronic illnesses have given thought to their preferences regarding life-sustaining treatments and want to discuss this with a physician [10]. A recent study of approximately 8000 community-dwelling US adults found that about a quarter had an advance directive in place [11]. Of those without advance directives, the most frequent reasons noted they had not completed one were "I don't know what advance directives are" and "My family knows my wishes." While age was associated with completion of an advance directive, 32% of respondents 55 years of age or older did not have one in place. Having an advance directive was more frequent among women, whites, married persons, persons with a chronic disease, those who reported having a regular source of medical care, and those with greater formal educational attainment [11].

Literature on end-of-life decision-making after *Cruzan* highlights the importance of initiating substantive discussions with patients about advance directives. Physicians can have an instrumental role in helping patients to understand potential decisions at end-of-life and to make informed choices when they possess the

capacity to do so. Advance directives make it more likely that people's choices regarding life-sustaining treatment will be recognized later, when they may lack the capacity to discuss options or provide informed consent. A physician can engage a patient in conversations about debilitated states and the complex implications of different life-sustaining treatments. These conversations should be initiated and documented before injury and disability.

Decisional capacity exists on a continuum, from fully able to assimilate and manipulate new information and engage in complex decision-making all the way to a comatose state. Sharing decision-making models between clinicians and patients, as opposed to a paternalistic model where clinicians make decisions on behalf of patients, are gaining increasing prominence in healthcare policy and clinical practice [12]. *Cruzan* dictates a definitive departure from paternalistic decision-making to a patient directed one, by affirming a competent person's right to make medical decisions, including the refusal of care.

When considering the clinical implications of *Cruzan*, shared decision-making (SDM) can provide a model for clinicians to use in having complicated conversations with patients. SDM is a model "where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences [12]." The earliest mention of SDM was in 1982, but the idea draws on the principles of patient-centered care that predate this. A body of research has shown that shared decision-making can improve the participation of patients, including mental health patients, and the quality of decisions in terms of knowledge and values [13].

In the medical and legal literature reacting to *Cruzan*, the paradigm of substituted judgment or recreating the incompetent patient's choice through proxies and written documents has been "proposed as the main method to address this problem of diminished capacity in dying patients [14]." The purpose of such documents and substitute decision-makers is to convey patient choice in end-of-life situations, when the patient cannot cogently express a choice. In the *Cruzan* decision, Ms. Cruzan's parents could discontinue her care only if Ms. Cruzan had previously expressed such a choice. The *Cruzan* decision allowed Missouri to require that a higher evidentiary standard be applied to choices regarding the withdrawal of life-sustaining treatment.

But how does this actually work in clinical situations? A 2002 analysis critiqued the application of advance directives. The author suggested that quality-of-life assessment and quality-of-care policies "offer a better way to improve human dying than bolstering individual patient choice [14]." The author emphasized the potential for choice and preference to change with circumstances. He described the case of a woman with significant dementia who enthusiastically enjoys activities and interactions and whose "bliss seems to grow as her personhood fades." He then asks us to imagine that she had developed a treatable pneumonia and she had executed a formal document outlining that she did not wish to have life-sustaining treatment should she develop Alzheimer's disease. Should the patient's advance directive be honored and should she be allowed to die? The author details that the patient experiences many joys in her life, despite her profound dementia. One cannot, of course, predict the circumstance of one's death: this presents a clear limitation to the utility of advance

directives. This analysis argues for the development of a consensus on what constitutes a good death—that this idea is not wholly idiosyncratic and that each individual need not entirely reinvent what a good death is for himself or herself.

There are many potential difficulties in substitute decision-making. Patients may change their minds, as has been described above. Spouses or other surrogate decision-makers may not know the patient's preferences. Those involved with the patient may also have competing interests or may not act in the patient's best interest. There may also be external pressures that either explicitly or implicitly influence decision-making, for example, financial pressures (from insurance companies, taxpayers, families, or the patient's own concerns about money).

Be Familiar with Relevant Statutes

It is important for physicians to know their state statutes and case law relevant to the care of patients who lack capacity to make decisions and do not have advance directives in place. Physicians and other healthcare providers should be aware of the limits on healthcare provider regarding decision-making in the state in which they practice.

A 2011 commentary on medical ethics and end-of-life decision-making noted that all 50 states and the District of Columbia had statutes that address advanced directives with a focus either on "patient designations of surrogate decision-makers or patient wishes regarding end-of-life care, if not both [15]." Many states also listed in their statutes, by category, "persons to whom physicians can turn for medical decision making if an incapacitated patient has not previously designated a decision maker." Additionally, Physician Orders for Life-Sustaining Treatment present a standardized approach and documentation that aids physician/patient end-of-life decision-making are increasingly recognized by the states [15]. These tools denote a person's treatment preferences. The author noted that health and welfare are under state rather than federal control, and because of this, and the controversial nature of institution and withdrawal of artificial nutrition and hydration, it was unlikely there would be an "overarching federal advance directive statute [15]." The authors gave the example that Connecticut's statutes do not explicitly limit a surrogate or proxy decision-maker's ability to authorize withholding or withdrawal of artificial nutrition and hydration, while Oklahoma and Arizona strictly limit such decisions. It is also useful to be aware that the language used to describe substitute decision-making and decision-makers can vary from state to state. Most states use the term "proxy" to describe a designated substitute decision-maker, while other states use the term "surrogate" [15].

Cruzan Defined Artificial Nutrition and Hydration as Medical Treatment

The *Cruzan* decision legally defined ANH as medical treatment. In Justice O'Connor's concurring opinion in *Cruzan* she wrote, "…Artificial feeding

cannot readily be distinguished from other forms of medical treatment… Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." By defining ANH as medical treatment, the *Cruzan* decision supported a position long held by American physicians and courts [9].

The American Medical Association (AMA) Code of Medical Ethics addresses withholding and withdrawal of life-sustaining treatment [16]. Consistent with *Cruzan*, the code dictates that a patient with decisional capacity has the right to decline or request cessation of any medical intervention even when it is expected that this will lead to death. A surrogate decision-maker may also decline or ask for a medical intervention to be stopped "in keeping with ethics guidance for surrogate decision making." The Code goes on to describe that while there "may be an emotional difference between not initiating an intervention at all and discontinuing it later in the course of care, there is no ethical difference between withholding and withdrawing treatment. When an intervention no longer helps to achieve the patient's goals for care or desired quality of life, it is ethically appropriate for physicians to withdraw it."

The AMA's Code of Medical Ethics gives practical guidelines to aid in accurate and respectful substitute decision-making regarding life-sustaining treatments. The Code emphasizes inclusion of the patient's surrogate decision-maker early in the course of care, even when the patient retains decisional capacity. It outlines a number of safeguards and protections for the patient when withholding or withdrawing life-sustaining treatment including making a plan to assess if the medical intervention has achieved its goals and if it should be withdrawn and circumstances that should elicit consultation with an ethics committee or equivalent body.

Cruzan and the Potential for Defensive Medicine

Cruzan raises the issue of whether life-sustaining treatment must be given to terminally ill, incompetent patients. There has been concern after *Cruzan* that the ruling would engender uncertainty and promote defensive medicine [10]. The concern has been that hospitals and healthcare providers, when faced with legal uncertainty about initiation or withdrawal of life-sustaining treatment, would routinely administer treatment to terminally ill patients or would frequently seek prior judicial approval of decisions. The authors note that in such circumstances, "routine involvement of the courts would be time-consuming, intrusive, and inappropriate [10]."

A 1991 commentary following the *Cruzan* decision highlights the potential for misinterpretations of law dealing with life-sustaining treatments and their termination. The authors describe scenarios leading to inappropriate care and

even horrific and tragic outcomes. One such example is the 1989 *Linares* case in Chicago, where physicians mistakenly believed that the state law prohibited them from discontinuing mechanical ventilation of 15-month-old Samuel Linares. The child had lain comatose for more than 6 months without hope of recovery. The parents were frustrated that the hospital would not remove life support. Ultimately, the situation ended dramatically when the child's father disconnected the child's mechanical ventilation and held him until he died, while holding hospital staff away at gunpoint [17]. According to a *New York Times* article on the incident, Mr. Linares told the police, "I did it because I love my son [19]." Other significant examples where treatment was recommended by hospital counsel include a dying woman in Massachusetts was resuscitated 70 times in 24 h; placement of a pacemaker was planned in a brain-dead patient; and family members had to bar the door of a patient's room to prevent unwanted resuscitation [10].

Conclusion

While much of the *Cruzan* decision is consistent with established standards of medical practice, *Cruzan* brings up ethical dilemmas that healthcare providers may face when they find their professional ethical obligations are in conflict with legal directives. The hypothetical clinical scenario outlined in this chapter posed the question of whether withdrawal of ANH (which would in effect end the patient's life) when the patient does not have a written directive and is unable to give meaningful informed consent be considered harm? Going one step further, a response to the *Cruzan* decision raises the following question: "Beyond doing no harm, physicians are bound to provide care that is beneficial to the patient. This would seem to argue against offering interventions that provide no net benefit even if they do no direct harm. The provision of artificial hydration and nutrition, or other interventions, simply keep the patient in a state that is not desired by the individual and do not appear to create a net benefit. Can the physician follow the ruling of the state and over-ride her traditional duties to the patient of non-maleficence, beneficence and autonomy [8]?" Other commentaries on Cruzan note the cost of care implied by Ms. Cruzan's indefinite and intensive treatment and invoked the moral requirement of justice in distribution of healthcare resources given "the context of scarce and relatively fixed health-care resources [18]."

Several practical points can be taken from the *Cruzan* decision. Physicians should respect the treatment decisions of competent adults including the decision to refuse life-sustaining treatment. Physicians need to *proactively* discuss patient's wishes regarding life-sustaining treatment preferences should they no longer have the capacity to make these decisions while still capable of making such decisions. *Cruzan* emphasizes a move away from paternalistic decision-making and affirms the right of competent persons to make decisions

for themselves about life-sustaining treatments. In light of *Cruzan*, treatment preferences expressed by an individual when competent are valued over family or caretaker preferences and quality-of-life concerns.

Shared decision-making models can be an important tool to help people make informed treatment decisions. Given that decisional capacity lies on a continuum, shared decision-making is preferable to substitute decision-making when some decisional capacity is preserved. Shared decision-making models respect autonomy for those requiring decisional support, rather than reflexively reverting to substitute decision-making.

Physicians should record patients' wishes in a legally acceptable instrument, concerning their preferences regarding treatment decisions and also the use of a surrogate or proxy decision-maker. While advance directives are imperfect, they are currently the best tool available to allow competent patients to convey their treatment preferences for a time in the future when they may lack competence. Healthcare providers should be familiar with relevant state statutes regarding medical decision-making and life-sustaining treatment.

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Confidentiality and Privilege

3

Amanda Yuan Sun and Tobias Wasser

Clinical Vignette

You are a psychiatrist working in an outpatient clinic. One day, you are sitting in your office when the secretary calls and informs you that you have a new patient, Mrs. James, ready for you in the waiting room. You go out to greet the patient and she informs you that she would prefer to be referred to as Officer James, since she is a police officer in the local police department.

You ask Mrs. James what brings her to the clinic and she indicates that she is there to comply with the police department's request that she engage in psychiatric treatment following a recent traumatic event she experienced while on the job. She explains that a few weeks prior, she was the first officer to respond to a "fight in progress" call at an apartment complex. As she arrived at the scene, two young women ran toward her squad car, waving their arms and shouting that there had been a stabbing in one of the apartments. Officer James relayed this information to her dispatcher and requested an ambulance. She then exited her car and walked toward the apartment building. Before Officer James reached the building, several men ran out, one waving a pipe. She ordered the men to get down on the ground, but they ignored her. Fearing for her life, she drew her firearm.

Suddenly, two other men burst out of the apartment building. One of the men, Mr. Todd Aiken, was chasing the other while brandishing a butcher knife. Officer James repeatedly directed Mr. Aiken to drop the knife, but he disregarded her commands. Fearing that Mr. Aiken was about to fatally wound the other man, Officer James fired her gun and shot Mr. Aiken. Mr. Aiken died at the scene. After the shooting, Officer James missed several days of work. When she returned, she was noted by her

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employer to appear distant and distracted, and her work performance declined. As a result, the department recommended she engage in psychiatric treatment.

You then perform a psychiatric evaluation and diagnose Officer James with post-traumatic stress disorder (PTSD). You recommend medication and that Officer James begins a course of cognitive processing therapy for her PTSD. Officer James begins attending treatment regularly and after several months completes a course of the recommended therapy.

After Officer James had completed her course of treatment with you, Mr. Aiken's family filed a lawsuit in federal court against Officer James alleging that Officer James had used excessive force during the encounter at the apartment complex resulting in Mr. Aiken's death. A hearing commences, and during the course of the hearing, Mr. Aiken's family learned that Officer James had participated in psychotherapy with you immediately following the shooting. The family seeks access to your medical records regarding Officer James' psychotherapy sessions so they can use it during the trial. Officer James' attorney vigorously resists this request, but the judge ultimately sides with Mr. Aiken's family.

Several months after you have completed your course of treatment with Officer James, you are sitting in your office at the end of the day finishing up your work. Suddenly one of the clinic's front office staff comes bounding into your office and informs you that a court officer has come to issue you a subpoena ordering that you come to Officer James' hearing tomorrow. The subpoena further stipulates that you should bring copies of all of the medical records and psychotherapy notes pertaining to your treatment of Officer James.

What do you do?

History of the Real Case and Its Significance: What Really Happened

Jaffee v. Redmond, US Supreme Court, 1996 [1, 2]

Mary Lu Redmond, a police officer, shot and killed Mr. Ricky Allen while Officer Redmond was out on patrol. Officer Redmond said that Mr. Allen was chasing another man while brandishing a butcher knife and that Mr. Allan disregarded Officer Redmond's repeated commands to drop the weapon. Ms. Carrie Jaffee, the executor of Mr. Allen's estate, filed a lawsuit in Federal District Court alleging that Officer Redmond had violated Mr. Allan's constitutional rights by using excessive force against him.

After the shooting, Officer Redmond participated in approximately 50 counseling sessions with Ms. Karen Beyer, a licensed clinical social worker. During the lawsuit, Officer Redmond and Ms. Beyer refused to provide the court access to treatment notes concerning their sessions together. They asserted that the conversations were protected against involuntary disclosure by a psychotherapist-patient privilege. The trial judge rejected this argument.

The judge then issued instructions to the jury that Officer Redmond's refusal to turn over Ms. Beyer's treatment notes had no "legal justification" and that the jury

could therefore presume that the contents of the notes would have been unfavorable to Officer Redmond. The jury awarded $545,000 in damages to Mr. Allen's estate.

Officer Redmond appealed the decision to the Seventh Circuit Court of Appeals (a federal appeals court). The appeals court reversed the trial court decision, concluding that "reason and experience" compelled the recognition of a psychotherapist-patient privilege in federal courts. Ms. Jaffee then appealed the decision to the US Supreme Court.

The US Supreme Court affirmed the decision of the appeals court and ruled that the conversations between Officer Redmond and Ms. Beyer were protected from compelled disclosure. The Court recognized the existence of a federal psychotherapist-patient privilege which applied to confidential communications made to psychiatrists, psychologists, and licensed social workers during the course of psychotherapy. As supporting evidence, the Court noted that all 50 states and the District of Columbia had enacted some form of privilege for psychotherapists and that such a privilege served the public interest since the mental health of citizens is "a public good of transcendent importance."

Core Principles in Understanding Confidentiality

Confidentiality is a core principle critical to the practice of medicine and psychiatry. According to the American Psychological Association, healthcare providers have "a primary obligation and (must) take reasonable precautions to protect confidential information through or stored in any medium" [3]. The American Psychiatric Association and American Academy of Psychiatry and the Law have similarly stressed the importance of confidentiality in patient care [4, 5]. Furthermore, confidentiality can significantly affect patients' willingness to seek care and disclose health information [6–8]. Due to its complexity, variability in local statutes and institutional policy, and broad scope, however, it can be daunting to approach patient care with the task of both respecting patient privacy and advocating for efficient and safe provision of care. Therefore, this chapter aims to provide clarity on how to approach confidentiality through discussion of important core concepts in patient confidentiality, as well as exceptions to confidentiality including mandatory reporting duties, and common questions regarding the Health Insurance Portability and Accountability Act (HIPAA).

Distinguishing Confidentiality Vs. Privilege

Confidentiality is defined as the *physician's obligation* to safeguard the patient's personal and health information and not divulge that information gathered in confidence without the patient's informed consent [9–11]. It is a broad concept describing physicians' ethical obligation distinct from their legal duty to protect patients' private information arising from HIPAA and state laws. Another related concept, *privacy*, addresses the question of who has access to personal information and under what conditions. In health information privacy, privacy refers to the patient's sense of freedom to share personal information with a practitioner knowing that this sensitive information will be safeguarded.

The importance of confidentiality is based on both its utilitarianism as well as the patient's right to privacy. The concept of utilitarianism represents the recognition of

value in promoting the integrity of the therapeutic relationship and patient trust in the physician, which enhances patients' willingness to be honest about their medical problems [12]. Many ethicists also argue that privacy of personal health information has value in and of itself by advancing patient autonomy and individuality and conveying respect for the patient as a human being with dignity [11].

In comparison, **privilege** is the *legal protection* of communications which have previously taken place between two people from being disclosed in open court (e.g., spousal, attorney-client, clergy, and—importantly for medical providers—physician-patient and therapist-patient) [13]. This is a departure from what typically happens in a court of law, where the pursuit of truth and justice generally compels anyone testifying to disclose everything they witnessed or experienced. This legal concept of privilege stems from the recognition that society places a high value on preserving the sanctity of certain special relationships. In regards to the doctor-patient relationship, for example, if a patient fears that a doctor will be compelled to disclose the patient's illegal behavior to the legal system, the patient may be less likely to seek care or when receiving care may be more likely to withhold important information, thereby potentially impeding the physician's ability to provide accurate diagnosis and treatment.

Common Exceptions to Confidentiality

Given the heterogeneity in state statutes and institutional policies, it is important to investigate specific exceptions to confidentiality in your jurisdiction or workplace. However, here are some common exceptions to confidentiality to consider, summarized in Table 3.1 [3, 14–16]:

- The patient, guardian, or surrogate decision-maker provides written consent to limited disclosure of confidential information.
- The patient poses a danger to self (e.g., suicidal) or others (e.g., assaultive, homicidal).
- To comply with mandatory reporting duties (see section on "Mandatory Reporting Duties" below).

Table 3.1 Exceptions to confidentiality [3, 17]

"Motto": exceptions to the duty of confidentiality	
Mandatory reporting duties	The provider may reveal confidential information to comply with mandatory reporting duties
Obtain consent	The provider may disclose confidential information if the patient, conservator, guardian, or other surrogate decision-maker provides consent
Threat to self or others	If a patient is deemed an imminent danger to himself/herself or others, the clinician has a responsibility to protect those individuals
Treatment coordination/ continuation	A provider may disclose confidential information if necessary for continued treatment of the patient, for example, to obtain necessary consultations, coordinate treatment with other specialties and clinics, care coordination, facilitate payment
Order from a court	If a provider receives a court order by a court of competent jurisdiction, he/she may release confidential information

- Other exceptions under legal basis:
  - The physician receives a judge-issued court order. (*Of note, a subpoena is *not* equivalent to a court order in many jurisdictions, and the clinician should consult a legal representative upon receiving a subpoena. Generally, under a subpoena, the patient may waive or invoke privilege, following which a trial judge would then determine if the treater must comply with the subpoena by issuing a court order.)
  - The patient is a litigant in a court case and needs records to establish emotional or mental damages as part of the lawsuit.
  - As part of an evaluation by a court-appointed psychologist or psychiatrist to determine mental competence or sanity in a criminal proceeding (of note, in many states, any disclosures made during the interview would not be confidential, but the patient must sign a release of information for the clinician to access the patient's medical records).
- To continue provision of healthcare:
  - To provide and coordinate needed professional services (e.g., electronic medical record systems, care coordinators, integration of medical care with other specialties and clinics)
  - To obtain appropriate professional consultations
  - To obtain payment for services, in which insurance companies, management companies, pharmacy benefit managers, utilization reviewers, quality improvement consultants, and others may receive patient health information without requiring their consent or knowledge

Importantly, exceptions generally *do not* include [3, 14, 18]:

1. Using confidential information for didactics (e.g., writings, lectures) unless one (1) takes reasonable steps to protect the individual's identity, (2) has obtained written consent, or (3) obtained legal authorization to use this information.
2. Reporting to law enforcement a patient's criminal activity unless it is ongoing and poses a threat to the life or safety of others, or for the purposes of "identifying or locating a suspect, fugitive, material witness or missing person."
3. The patient's death: the duty is then transferred to an executor, administrator, or other person with authority under state or other law to act on the deceased individual's behalf.

The topic of confidentiality is particularly challenging in children and adolescents considering the physician's dual responsibility to keep parents informed of information relevant to their child's care and to respect the child's right to privacy, which becomes especially important as they develop greater independence during adolescence. The law dictates that parents or guardians must consent to treatment on a minor's behalf, with the following exceptions [14, 19–22]:

- The minor meets the state's legal conditions for emancipation (e.g., married, military service, or otherwise obtained court permission) or has reached the age of majority (18 in most states).
- The law deems an unemancipated minor to be mature under the mature minor doctrine, a legal concept that determines whether a minor may be considered

"mature" and thus affords them the ability to consent to medical care after considering the age, situation, and intelligence of the minor.
- The patient is requesting confidentiality regarding conditions that receive statutory confidentiality protection, which may include sexually transmitted illnesses, substance abuse, contraception, and reproductive healthcare services.
- Someone other than the biological parent has been granted legal authorization to provide consent on the minor's behalf.
- The parent agreed to a confidential relationship between the provider and minor.

Some believe that parents hold the right to their children's information. However, others believe there is intrinsic value in advocating for adolescents' right to confidentiality since they are more likely to seek care when confidentiality is ensured [23]. Regardless of where one stands, it is important to discuss confidentiality with adolescents during their first visit and offer conditional confidentiality with explicit discussion of the circumstances under which confidentiality would be broken [24].

In scenarios requiring release of confidential information, one must employ the *minimum necessary standard* in which the provider makes the minimal disclosure necessary to achieve the disclosure's intended purpose [25]. Additionally, it is important to discuss the limits of confidentiality, including risks of electronic communication, at the outset of the professional relationship, and as needed thereafter.

Mandatory Reporting Duties

An important exception to confidentiality are situations in which a mental health provider is legally required to become a "mandated reporter" of certain concerning events or conditions. For example, one significant category of mandatory reporting duties relates to the protection of vulnerable persons from harm.

Child Abuse and Neglect Most states require physicians and other mandatory reporters to break confidentiality to disclose child maltreatment [26, 27]. In deciding whether or not to report a suspected case, mandatory reporters should know that the law requires only suspicion or reason to believe that neglect or abuse has occurred, and the burden of proof does not lie with the reporter [27]. If reported in good faith, reporters have immunity from civil and criminal liability. The process involves submitting both an oral report by phone and written notification to the relevant public office, such as Child Protective Services [15, 27, 28]. Generally, states find it helpful to know a reporter's identity, and in some states, mandatory reporters must provide their name and contact information, thus reporting anonymously may not be possible. However, in the majority of states, reporters may submit anonymously, and their information is protected from disclosure to alleged perpetrators [27]. Institutions frequently have their own internal policies and procedures for handling reports of child abuse and neglect, and most states have mandatory procedures which must be followed. Therefore, it is important to investigate and understand the state laws and institutional policies in the area where you practice (see www.childwelfare.gov for mandatory reporting laws by state).

Elder Abuse and Neglect Abuse or neglect of the elderly is also required to be reported in most states when occurring in the home and in all states when it occurs in an institution [29]. The reporting agency in greater than three quarters of US states is the State Social Service Department (Adult Protective Services) and in the remainder of states is the state unit on aging [29]. If one suspects abuse or neglect in an institution, contact the local long-term care ombudsman office. The telephone numbers for these agencies may be found through the Eldercare Locator (800-677-1116 or www.eldercare.gov) or the National Center on Elder abuse (855-500-3537 or www.ncea.acl.gov).

Abuse of Disabled Persons Like reporting for the elderly, the designated reporting agency in these situations is generally the state social service department [30]. There is also often the option of calling a state-designated hotline [31].

Other vulnerable persons falling under mandatory reporting may include victims of human trafficking (sex and/or labor trafficking), intimate partner violence (IPV), and identifiable third parties deemed at risk for violence (see Chap. 4 for further details) [32, 33]. With reporting of IPV, some states require reporting weapon-related injuries; some require reporting injuries resultant of violations of criminal laws, violence, or non-accidental means; and others mandate disclosure for any form of IPV itself [34].

Lastly, other medical conditions that must be reported to state agencies include certain infectious diseases (e.g., HIV, gonorrhea, chlamydia, syphilis, hepatitis, Lyme disease, Zika virus) and noninfectious conditions (e.g., certain types of cancer, elevated lead levels, and carbon monoxide poisoning) [35].

HIPAA: Frequently Asked Questions

Question: What is HIPAA and what does it do?

Answer: HIPAA stands for the Health Insurance Portability and Accountability Act, a law implemented in 1996 that addresses how to manage protected health information (PHI), defined as identifying information related to [36]:

- The individual's past, present, or future mental or physical condition
- The provision of healthcare services or treatment
- The individual's past, present, or future payment for said services or treatment

PHI includes common identifiers such as name, address, birth date, and Social Security number. HIPAA also dictates the patient's right to (1) obtain copies of their own records, (2) request modification of incorrect or incomplete information, and (3) receive information on outside entities to whom their records were disclosed, unless the information requested takes the form of psychotherapy notes or the release of this information would threaten the life or safety of the patient or others [37].

Contrary to common belief that HIPAA was an effort to increase restrictions on medical staff when releasing patient health information, one of the intended

Table 3.2 Health Insurance Portability and Accountability Act (HIPAA)-related legislation after 1996 [36]

Regulation/legislation	Description
HIPAA Privacy Rule	Established national standards for the use and disclosure of protected health information (PHI)
HIPAA Security Rule	Established the safeguards and security measures to protect the confidentiality, integrity, and availability of electronic PHI that covered entities and their business associates must implement
HIPAA Breach Notification Rule	Required notification of affected individuals, the US Department of Health and Human Services (HHS) and in some cases the media, of any breach of PHI (generally no later than 60 days after discovering a breach)

HIPAA Health Insurance Portability and Accountability Act, *PHI* protected health information

purposes was to expand circumstances in which PHI may be released, expand medical record accessibility, and "improve portability and continuity of health insurance coverage" [38]. With the growth of third-party payers in the mid-1900s and development of managed care systems in the 1980s and 1990s, the expansion of the number of people with access to patient medical records revealed flaws in the existing framework of consent [13, 39]. In response, HIPAA was an effort to establish national privacy standards of individually identifiable health information that would help build a new health information infrastructure and balance protecting patient medical privacy and allowing uses and disclosures for treatment and payment [20]. Table 3.2 outlines subsequent legislation enacted after 1996 to enforce the principles and goals that HIPAA delineated.

Question: Does HIPAA provide special protections for mental health information?

Answer: The HIPAA Privacy Rule does not differentiate between psychiatrists' documentation of PHI and that of other medical specialties, with the notable exception of psychotherapy notes [20]. The Privacy Rule defines psychotherapy notes as "notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record" and do not include information about [40]:

- Medication prescription or monitoring
- Modalities and frequencies of treatment
- Therapy session start and stop times
- Symptoms
- Test results
- Summaries of diagnosis
- Prognosis

Psychotherapy notes are managed differently due to the particularly sensitive nature of their contents and because they are the therapist's personal notes, not to be used for treatment or payment purposes. Thus, a covered entity must, with few

exceptions, obtain the patient's authorization for all disclosures of psychotherapy notes [41]. The Privacy Rule also does not provide patients the right to access their own psychotherapy notes, a significant exception to the Privacy Rule's provision of individuals' right to access their health information [14].

Question: What does HIPAA say about communication with friends, family, or others regarding an adult patient's care?

Answer: The Privacy Rule allows communication between providers and third parties when the patient has capacity to make healthcare decisions and does not object [20, 42]. This may include explicitly requesting the patient's permission and providing the patient the opportunity to agree or disagree. It also applies in circumstances implying the patient does not object (e.g., the patient has invited the individual to participate in a clinical encounter). If an adult patient with capacity refuses to consent to communications with outside parties, the Privacy Rule permits disclosure *only* if the patient is deemed a serious and imminent threat to the safety of self or others. However, HIPAA does allow providers to listen to third parties who wish to express concern about the patient's safety and well-being as long as the provider does not themselves disclose any private information. If the patient later requests access to their medical record, the provider may withhold information relating to a disclosure given by a third party under the promise of confidentiality if this information would likely reveal to the patient the source of the information [43]. This allows third parties to openly share relevant safety information without fear of damaging their relationship with the patient.

To safeguard the protection of patient confidentiality, it is important to adhere to the following recommended practices [3, 44]:

1. Make sure doors and partitions are closed when discussing confidential information, particularly in locations like the emergency department where privacy is difficult to ensure.
2. Avoid discussing patient information within earshot of unauthorized persons.
3. Limit health information conveyed and number of colleagues, consultants, or other staff receiving the patient's information to what is necessary for the identification, evaluation, and treatment of patients.
4. Maintain privacy of paper and electronic medical records and electronic communication, such as by locking computers when stepping away and only using encrypted email to discuss patients.
5. Do not share passwords that may lead to the compromise of and unauthorized access to computerized patient information.
6. Correctly dispose of patient information when no longer needed by shredding and placing in a designated locked receptacle for proper disposal.
7. Obtain informed consent before disclosing information to third parties (family, friends, law enforcement officers, observers such as students) or allowing them to visit.
8. Obtain written informed consent before recording or filming the patient and before disseminating, publishing, or broadcasting patient images or information.

Question: What happens when state law and HIPAA differ?

Answer: This is an important question as there are already extensive state regulations on confidentiality in place. Generally, HIPAA creates a "uniform floor of protection throughout the country" that supersedes state law only when HIPAA is more protective of patients' privacy than the existent state law [13, 14]. However, states retain the authority to require a more stringent level of protection in their locale. See the Health Privacy Project (www.healthprivacy.org) to learn more about each state's privacy laws [45].

Conclusion

The legal implications of HIPAA laws and possible breaches of confidentiality can be both fear-inducing and confusing. Physicians and other mental health providers must face the challenge of effectively balancing the obligation to safeguard their patients' personal health information and the task of using protected health information to efficiently deliver treatment and payment. To do so, it is important to keep the following principles in mind:

- Confidentiality is the *physician's obligation* to safeguard the patient's personal and health information, whereas privilege is the *legal protection* of communications between two people from disclosure in court (e.g., physician-patient and therapist-patient privilege).
- Common exceptions to confidentiality can be summarized by the acronym "MOTTO": to comply with *m*andatory reporting duties, to *o*btain consent, in circumstances where the patient is a *t*hreat to self or others, for purposes of *t*reatment coordination or continuation, and to comply with a court *o*rder.
- An important mandatory reporting responsibility is to report cases involving the abuse or neglect of vulnerable populations such as children, the elderly, and disabled persons. One should become familiar with the mandatory reporting guidelines in the state where one practices.
- It is vital to understand both the general principles and exceptions governing confidentiality and the legal obligations dictated by HIPAA. Further, one should become familiar with the local state law and facility/organizational policy where one practices. When in doubt, seek consultation from a colleague, risk manager, or attorney.

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Duties to Third Parties

4

Katherine Michaelsen

Clinical Vignette

You have just started your third year of psychiatry residency and have been assigned to complete your outpatient training requirements in the mental health clinic of the University Health Center affiliated with your program. At the clinic you typically treat undergraduate and graduate students enrolled at the university with therapy and medication management. In addition to your regular caseload, each week you spend one half day working in the intake clinic, where you evaluate patients who are new to treatment at the clinic.

During your first half day in the intake clinic, a young man named Paul comes to the clinic seeking "emotional counseling" at the urging of his roommate. Paul presents to the evaluation as a young, thin male dressed in stained clothing and smelling of beer. He exhibits slowed speech and movements. You do not observe any evidence that he is responding to internal stimuli. During the evaluation Paul informs you that he just finished his junior year of college at the University, where he is studying biology. Last fall he met a young woman, Tina, in a yoga class at the dormitory where he was living. The two became good friends, and, a few months later, on New Year's Eve, they kissed. After this kiss, Paul realized how much he loved Tina and believed that she felt the same about him. He planned to tell her his feelings and expected that the two would enter into a romantic relationship. However, when he approached Tina and expressed his feelings to her, Tina told him she had been drinking too much that night and that she didn't like him "like that." Over the ensuing weeks, he made repeated efforts to show her how much he cared for her but without a change in her response. Paul says that when he finally realized Tina would not return his romantic feelings, it "broke [his] heart."

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Paul reported that over the final month of the semester, he stopped attending classes and his GPA plummeted. He spent hours in his room contemplating what he had done wrong and why Tina would not love him back. He became more and more depressed and started neglecting his hygiene and appearance. He says that he now spends most of his time alone in his room drinking beer and playing video games or watching movies. Encouraged by his friends, he decided to seek counseling, prompting his visit to the clinic today.

You recommend that Paul engage in ongoing treatment at the clinic. He indicates that he is not interested in taking medications, but agrees to begin meeting with you for psychotherapy. You begin meeting with him, and he spends the majority of each session talking about Tina. Initially these discussions focus on how depressed he is that she does not return his love. Over time, he focuses more on his anger toward her and his developing belief that Tina is involved in an intricate plot with the university administrators to cause him to fail out of school. After several sessions, Paul tells you, "I'll make her pay." You inquire further, and he discloses to you that he intends to buy a gun and kill Tina once she returns to school after summer vacation.

What do you do?

What Really Happened

Tarasoff v. The Regents of the University of California, Supreme Court of California 1974

Prosenjit Poddar was a graduate student at the University of California, Berkeley, who met Tatiana Tarasoff, a college freshman, at a school dance. They went on a couple of dates and kissed a couple of times. Mr. Poddar had never had a romantic relationship before and was not familiar with American traditions. He felt he had a special relationship with Ms. Tarasoff and felt betrayed when she engaged with other men and did not reciprocate his further advances. Over the summer, Ms. Tarasoff was abroad for a few months. At the urging of a friend, Mr. Poddar went to see a psychologist at the University Mental Health Service, Dr. Moore. During the course of their therapy, he shared his intention to obtain a gun and shoot Ms. Tarasoff. When asked further about his plan, Mr. Poddar terminated therapy. Dr. Moore sent a letter to the campus police requesting that they detain Mr. Poddar and take him to a psychiatric hospital. Campus police detained and interviewed Mr. Poddar and concluded that he was not dangerous. He promised to stay away from Ms. Tarasoff, and the police released him. When the psychiatrist in charge of the Mental Health Service learned of Dr. Moore's actions, he instructed Dr. Moore not to take any further actions and to destroy the letter that was sent to the police.

When Ms. Tarasoff returned from vacation, Mr. Poddar stalked her and stabbed her to death. Ms. Tarasoff's parents sued the campus police, the Mental Health Service employees, and the Regents of the University of California for failing to warn them of their daughter's danger. The trial court dismissed the case. Before Tarasoff, outpatient physicians had a duty to their patients, but not to third parties. The Appeals Court supported the dismissal.

In 1974, the California Supreme Court disagreed with the trial and appellate court decisions. It held that a therapist has a duty to use "reasonable care" to give a threatened victim the *warning* needed to avert a foreseeable danger arising from a patient's condition (Tarasoff I decision), creating a "duty to warn" [1].

However, psychiatrists and police protested the decision due to concerns about psychiatrists' inability to accurately predict violence and the chilling effect the decision might have on patients' willingness to seek care. The California Supreme Court reheard the case in 1976 (this became known as the Tarasoff II decision).

Tarasoff v. The Regents of the University of California, Supreme Court of California 1976 ("Tarasoff II")

This time the court held that when a therapist determines or *should have determined* that a patient presents a serious danger of violence to another, she has an obligation to use reasonable care to *protect* the intended victim against this danger [2]. Fulfilling this duty may require a therapist to take one or more steps, including notifying the intended victim, notifying law enforcement, and/or hospitalizing the patient. Thus, the court replaced the "duty to warn" with a "duty to protect." As supporting evidence, the court noted that doctors have the responsibility to warn others of certain contagious diseases and concluded that the "protective privilege ends where the public peril begins" [2].

Duties to Third Parties: Introduction

The Tarasoff decisions addressed clinicians' duty to "third parties"—that is, their legally defined duty to consider the welfare of someone beyond their direct patient. As the *Tarasoff II* decision alludes to, there is some precedent for this in other situations, for example, the diagnosis of certain contagious diseases requires a physician to break confidentiality with his or her patient and inform the health department, which may in turn warn the patient's recent contacts of their exposure. In mental health care, prior to the Tarasoff decisions, some duty to protect or warn potential victims was recognized in cases involving violence by patients found to be negligently released from a hospital [3]. The Tarasoff cases formally extended this responsibility to the outpatient setting as well. As a result, the duty to protect or warn third parties of a patient's potential violence became commonly referred to as a "Tarasoff duty."

The *Tarasoff* decisions created a new responsibility or "duty" for clinicians in California—once a patient makes a threat—to the patient's intended victims. In other words, the court found that Mr. Poddar's threat to kill Ms. Tarasoff should have triggered Dr. Moore's duty to protect Ms. Tarasoff. Which situations may trigger this duty and which actions may be required to "discharge" the duty have varied over time and place. For example, the *Tarasoff I* court defined discharging the duty as *warning* a potential victim of the threat. This would have required

informing Ms. Tarasoff of the threat so that she could then take steps to protect herself. However, the *Tarasoff* II court redefined discharging the duty as *protecting* a potential victim from the threat. This, among other things, may have required hospitalizing Mr. Poddar, warning Ms. Tarasoff, and/or informing the police.

Although Tarasoff was a California State Supreme Court decision and applied only in California, the ruling had national repercussions. Courts and legislatures have addressed duties to third parties in other states, though the duty varies significantly between states.

There are two main ways a state can create a Tarasoff duty: through the courts and through legislative action. Many courts have heard cases with similar characteristics and turned to Tarasoff for guidance, creating precedents in their jurisdictions (also known as "common law" or "case law"). Many state legislatures have also passed statutes which explicitly outline a provider's duty to warn or protect third parties in that state. Various states define the duty to third parties differently and some states don't recognize any duty. The interstate variability, difficult-to-interpret case law, and ongoing changes to Tarasoff regulations create a number of challenges for practicing clinicians. Many professionals have heard of Tarasoff and its implications, but statutes or case law in a clinician's state may differ significantly from the original Tarasoff decisions.

Tarasoff regulations can cause anxiety about liability, but in certain situations, Tarasoff duties can play a legally protective role for the clinician. For example, Tarasoff laws may create liability if a clinician fails to act (when they should have) and a patient commits a violent act; however, they may also provide legal protection if a clinician appropriately acts and a patient later sues for breach of confidentiality [4].

Trends in Duties Toward Third Parties

After the original Tarasoff decisions, courts in other jurisdictions began to expand clinicians' Tarasoff duties. Courts held clinicians accountable for patient violence toward unidentified victims in the general public [5], patient violence toward property [6], and even violence toward victims who were already aware of the risk posed by the patient [7]. Some courts also expanded the definition of clinician responsibility to include an extended period after termination of treatment. For example, a court found that even when violence occurred five and a half months after hospital discharge, clinicians could still be found negligent for failing to foresee a patient's potential to act violently [8]. Courts further expanded clinician duties with a series of so-called driving cases, where providers were held liable for unintentional violence committed by their patients in the form of traffic accidents [9–11]. The driving cases in particular caused concern about the expanding scope of dangerous activity for which clinicians may held liable, regardless of negligence in care [10, 11]. Pettis and Gutheil suggested that Tarasoff-like reasoning applied to driving injury seems inappropriate because the injury is not clearly an extension of the mental-illness-derived intentional violence that justifies a Tarasoff duty [11]. Rather, the injury is more likely related to negligent driving, and they contend that clinicians don't have the ability to predict patients' future negligence.

As a result of clinicians' and professional organizations' arguments that court rulings created unreasonable expectations, many state legislatures have passed "Tarasoff-limiting statutes": statutes that try to clearly define and limit the circumstances that trigger a duty to potential victims and how clinicians can discharge the duty. Details of statutes vary greatly, but they typically require that the threat be explicit and credible, that the patient has the ability to carry it out, and that it is directed at an identifiable victim(s) [12–14]. Similarly, courts, both on their own and in response to statutes, have moved to reject or limit Tarasoff's application to clinicians' duties.

Soulier et al. undertook a review of more recent appellate cases (1985–2006) and identified 70 Tarasoff-related cases, only six of which were decided in favor of plaintiffs (typically individuals or families of individuals injured or killed by a patient, with a clinician as the typical defendant) [13]. They found that courts were making decisions in favor of the defendant clinician even with scenarios similar to the cases that were decided for the plaintiff in the early days after Tarasoff. The authors attributed this trend to legislation limiting the scope of Tarasoff duties, an increase in judicial sympathy toward clinicians evaluating threats, and an ill-defined "social climate change" [13]. Soulier et al. divided states based upon whether laws mandated, permitted (allow but do not mandate), or do not allow warnings or protection. They found that in contrast to earlier cases, defendant clinicians were exonerated when a patient did not communicate a threat directed at an identifiable victim, when victims were aware of their danger, or when violence occurred long after termination of treatment.

Based on their review, Soulier et al. concluded that states that mandate warnings or protection in Tarasoff situations were the most protective of clinicians, whereas as permissive states may expose clinicians to more legal liability [13]. The protections of Tarasoff-limiting laws did not extend to negligent care and poor clinical judgment—that is, when a clinician's care failed to meet the standards that could be reasonably expected for clinicians in a similar position—such as failing to assess a patient's violence risk when there are clearly reasons for concern (e.g., agitation with a history violence). The authors give the *Bragg v. Valdez* case as an example, where an individual who had been involuntarily hospitalized was discharged due to lack of insurance (rather than clinical readiness) and went on to assault his mother [15]. Although reassuring, Soulier et al.'s findings are somewhat limited by the authors' difficulty capturing cases settled out of court or decided in local courts.

More recent cases have raised concerns about the pendulum swinging back toward expansion of Tarasoff duties. Notably, the Washington State Supreme Court decision in *Volk v. DeMeerleer* expanded mental health professionals' duty to protect "foreseeable victims" of their patients, rather than identified victims [16]. Further, even in states with Tarasoff-limiting statutes, courts have not been consistent in their interpretation of the statutes and have sometimes even disregarded or discounted them. Kachigian and Felthous reviewed cases involving a possible Tarasoff duty that courts decided after passage of Tarasoff statutes in those states [17]. They found that many court decisions did not reference or did not use the state's Tarasoff statute in the analysis for the court's conclusions. Other courts considered the Tarasoff statutes but

found that a clinician's common law duty to potential victims (established by the courts) still applied, regardless of any limits set by the state statutes. The authors concluded that courts were not reasonable or consistent in their interpretations of Tarasoff-type statutes and contended that statutes have not provided the hoped-for clarity for the duty to protect [17]. This sentiment is echoed by Herbert and Young, who added that the variety of possible interpretations by courts limit the utility of Tarasoff statutes [18]. Weinstock and colleagues, while advocating for states to implement statutes so as to provide guidance to clinicians and courts, also expressed concerns about their unintended consequences, including the "criminalization of Tarasoff," a practice where prosecutors use Tarasoff statutes to force therapists to testify as prosecution witnesses against their patients [19].

The California experience is illustrative of the struggles around regulating and interpreting duties to third parties. After the original Tarasoff court decisions, the legislature passed a statute codifying and limiting the duty. However, subsequent court cases expanded the duty to include threats communicated by other parties (e.g., family members of the patient), rather than limiting the duty to threats communicated directly by the patient, and held that a warning was necessary to discharge a Tarasoff duty (rather than one of several options for discharging the duty) [19]. Subsequent efforts to limit the types of threat that trigger a Tarasoff duty and to codify a duty to "protect"—with issuing a warning as just one of many options available to the clinician—led to further revisions of the statute [19, 20]. Even with these changes, expanded duties, including a duty to protect the general public (rather than an identified victim) and a duty triggered without an explicit threat, continue to be litigated in the California courts [21]. Further, despite efforts to revise California's statute away from a duty to "warn," recent gun legislation requires a clinician to issue a report to the police when patients trigger a Tarasoff duty, creating a de facto warning requirement, regardless of any flexibility written into the Tarasoff statute itself [22].

Concerns Raised by Tarasoff

Since the original Tarasoff cases, professionals have debated the best ways to conceptualize, regulate, and discharge a duty to third parties. This section will review some of these areas of concern.

Though legal liability is frequently the focus of the literature and of clinician anxiety, many experts give moral and clinical concerns precedence in their consideration of the Tarasoff duty [12, 14, 23, 24]. When considering the ethical basis for a duty, some focus on the moral claims of the potential victim [4], while others prioritize the claims of the patient in treatment—including confidentiality, agency, and avoiding the consequences of having harmed another person [23, 25, 14]. Clinicians must grapple with the difficulty of predicting future violence and then using relatively uncertain predictions to develop management plans that balance patient and public concerns. Professionals also disagree on the best method for discharging a duty to third parties, with some focusing on treatment and others on issuing warnings.

Assessing Threats

How do we best understand the Tarasoff duty? When considering management of Tarasoff situations, clinicians must weigh the risks to the patient (involuntary detention, loss of privacy, embarrassment) with those to the potential victim [23, 14]. Mossman notes that Tarasoff and similar decisions and statutes assume that clinician judgments can take a binary form of "yes-or-no" assessments about whether a patient presents a serious danger of violence [14]. In reality, therapists' judgments place individuals into categories of risk for violence, which do not translate well into a "yes-or-no" answer. Further, there is no guidance about the threshold of risk that should trigger a Tarasoff duty, because society cannot agree upon which level of risk is serious enough to prompt a Tarasoff-type response at the expense of a patient's freedom [14].

While structured risk assessments—ranging from lists of pre-identified variables associated with higher risk of violence to actuarial instruments (use statistical methods of estimating the risk of a particular event)—may improve overall violence prediction, there are limits to their use in clinical practice [26]. In particular, violence prediction techniques may not be accurate enough in outpatient clinical settings to sufficiently distinguish high- from low-risk patients [14, 27]. Further, base rates of violence are so low that they are unlikely to be useful when considering violence risk in a specific patient and victim [14, 27, 28].

Responding to Threats

Due to difficulties noted above and the clinician's duty to the patient, Mossman advocates regarding the patient as an end unto himself or herself (i.e., intrinsically valuable and important) rather than as a source of statistical risk. He proposes an approach (and statutes that support this approach) where duty is triggered when a patient utters a credible threat that the patient can feasibly carry out, thereby avoiding the need for prediction and letting a patient's actions be the trigger for a protective duty and guide an appropriate response [14]. Gutheil contends that the clinician has a duty to put the patient's interest first, in particular the interests of the healthy side of the patient (the side that presumably does not wish to harm another person) [23]. In Tarasoff situations, both Gutheil and Mossman advocate focusing on the best interest of the patient—which is likely to include helping the patient avoid engaging in violent acts and their resultant consequences [23, 14].

Considered at a population level, unusual events, like violence after a threat, are inherently difficult to detect and prevent, and many people would need to be confined in order to prevent even a few acts of violence [24, 27]. For example, Buchanan estimated that given a population with a baseline rate to assault with a weapon or cause serious injury of 3.6% (a rate derived from the Clinical Antipsychotic Trials of Intervention Effectiveness study), the number of patients that would need to be detained and hospitalized in order to prevent one injury is 15 (based on the accuracy of current risk assessment tests) [27]. Given this and the

lack of clear risk threshold to trigger a Tarasoff duty, Mossman argues that violence prediction alone may be a futile approach to decreasing violence and that, instead, treatment is the most effective response [24]. Clinical interventions, which are simultaneously beneficial to the patient, may also decrease the patient's risk of violence, including treating substance abuse and improving treatment adherence through community monitoring [24].

When analyzing the original Tarasoff case through this lens, Gutheil argues that keeping Mr. Poddar in treatment and working to decrease his shame, rage, and dangerousness would have been a better response to his threats—for both Mr. Poddar and Ms. Tarasoff—than warning Ms. Tarasoff or hospitalizing Mr. Poddar. At the time of the threats, Ms. Tarasoff was not in imminent danger (she was out of the country), it is unlikely that commitment would be justified (given the lack of imminent danger) or extended long enough to protect Ms. Tarasoff, and warnings would have been impractical and of questionable efficacy [23].

Warnings

There is also some disagreement about the importance of the distinction between the duty to "warn" and to "protect." Although some initially interpreted "protect" as giving clinicians additional responsibilities to control their patients, Weinstock and colleagues argue that a duty to "protect" allows the clinician more legally (and clinically) acceptable options when managing Tarasoff situations, with a warning serving as only one of several options [20]. Felthous and Kachigian contend that a duty to "protect" creates a duty both to warn and control and thus, though it may increase clinical flexibility, allows more room for courts to find clinicians responsible for bad outcomes [29]. Herbert and Young argue that regardless of statutory language, court interpretations suggest there exists only a duty to warn [18].

Warning is a complex issue [30], as is what might trigger a warning [4, 23, 30]. As the discussion above indicates, some authors prefer patient- and treatment-focused interventions. Despite concerns that warnings might have a chilling effect on therapy, an early study found that warnings incorporated into treatment seldom had a negative impact on the therapeutic relationship and only warnings not discussed with the patient or given without good reason were harmful to the relationship [31]. The study's author surmised that discussed warnings might strengthen the therapeutic alliance because they demonstrate an ability to retain therapeutic concern even in the face of imminent danger. However, despite an apparent lack of therapeutic harm and potentially serving as the clinician's most legally protective recourse, warning alone is rarely clinically appropriate and may not protect the potential victim [23]. There is often little that the victim can do after receiving a warning [23], and warnings may exacerbate the danger by further upsetting the patient [20]. In addition, warnings may not be feasible or warranted at the time of an evaluation (e.g., for an admitting physician in the emergency department with no control over discharge) and do not address the underlying causes of the threat [20].

State-by-State Variation

The lack of regulatory consistency across jurisdictions—when a Tarasoff duty applies and what it requires—complicates clinical practice. The variation in court responses to Tarasoff, even in states with statutes, adds to the confusion. As above, the trend has been toward more reasonable limits on the duty to third parties, but the duty still creates significant anxiety among clinicians. Current variations in regulations between states include the types of legal guidance (mandatory vs. permissive), the types of health professionals included, the types of threats included, whether the victim must be identifiable, and whether a specific intervention is mandated (see Table 4.1).

There are three general types of legal guidance [4]. In mandatory jurisdictions, the provider is *required* by law (statute or case law) to break confidentiality and act on threats by doing something to warn or protect the potential victim, and the provider is protected from liability when so doing. Statutes often contain language distilled down to these main criteria: an explicit, credible threat that the patient intends and is able to carry out and against an identifiable or reasonably identifiable person or group of people [4, 12, 32, 33]. In permissive jurisdictions, providers *may* breach confidentiality if their patients make serious threats and will be legally protected if they do, but providers are not obligated to protect or warn a potential victim [4]. However, there is no legal protection if the provider chooses *not to act* and the patient later harms a third party. In the third type of jurisdiction, providers have neither a legally established duty to warn or protect potential victims nor a justification to breach confidentiality to make a warning [4]. Providers in these states are potentially open to legal risk no matter how they proceed. If they breach confidentiality, the patient can sue. If they fail to breach confidentiality and a patient harms an individual, then the victim can sue. As of 2014, 23 states had a duty mandated by statute, and 11 states had a duty mandated by case law [4]. Ten states plus the District of Columbia had permissive regulations. Six states remained without any legal guidance (see Fig. 4.1).

Some states specify the types of professionals who have a duty to third parties [4]. For example, seven state regulations specifically include psychiatrists, psychologists, clinical social workers, and sometimes even associates of those professions, and 19 states include the above plus physicians who are not necessarily accredited in psychiatry. Six states do not specifically include psychiatrists. States also differ in which types of threats trigger a Tarasoff duty [4]. Some states limit the duty to an "imminent" threat but vary in the definition of imminent—ranging from days to months—and often differ from the definition of imminent used for civil commitment. A few states limit the duty to a "serious" threat, which may be defined related to the nature of the

Table 4.1 State variations in legal regulation of Tarasoff duties [4, 31, 34]

Examples of Tarasoff duty variables				
Legal regulation	Health professionals	Threats	Victims	Intervention
• Mandatory • Permissive • No Guidance	• "Mental health provider" (Definition varies) • Physicians only • Not specified	• Imminent • Serious	• Identifiable • Reasonably foreseeable • Property	• Many options • Warning required (Target of the warning varies)

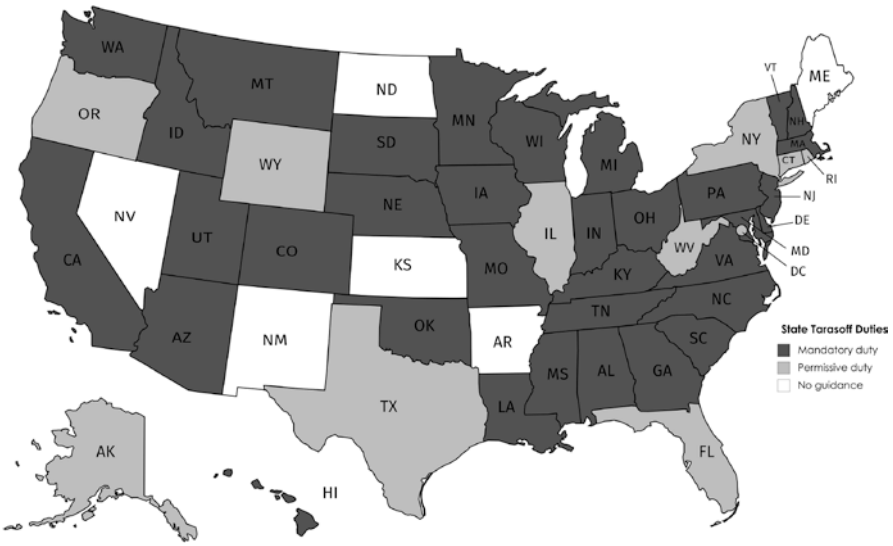

Fig. 4.1 Regulation of Tarasoff duties by state, as of 2014 [4]

threat or the likelihood it will be acted on, without a particular time frame [4]. Some states also recognize threats communicated by third parties (such as family members) or threats that can be inferred by a patient's actions or circumstances (e.g., a patient's escalating agitation that has in the past been associated with violent outbursts), rather than limiting the duty to threats directly and explicitly stated by a patient [18]. Most states require that the victim be identifiable [4, 32], though some require only that the victim be "foreseeable" [16]. Only New Hampshire also requires such a duty if there is a threat to damage property [33]. Some states also specify a course of action the clinician must follow—usually whether a warning is required and who must be warned, including identified victims, law enforcement, or both [4].

Discharging a Tarasoff Duty

Given all this confusion, what do you actually do to fulfill your professional duty?

In general, a Tarasoff situation raises two questions:

- Does the client pose a serious risk of violence to another person? If so, what steps might reasonably be taken to protect the victim [28]?
- How can we balance the risk to a potential victim while considering the patient's care and—to the extent possible—maintaining confidentiality?

For an overview of the steps involved in assessing and managing risk in these situations, please see Table 4.2.

Table 4.2 Discharging a Tarasoff duty: summary

When a patient makes/presents a threat	
Before	• Understand local Tarasoff regulations
Assess risk	• Thorough clinical assessment • Individualized assessment of factors that may contribute to violence • Treat threat as a therapeutic issue for assessment (and management) purposes • Obtain collateral (records, contacts) • Consider - General risk factors associated with increased risk of violence - Risk factors associated with increased risk after a threat - Where is patient on path toward violent action? ACTION questions
Manage risk	• Consider competing interests: autonomy, confidentiality, others' safety, etc. • Address risk factors that are amenable to intervention • Increase treatment (consider hospitalization) • Increase monitoring • Warnings, if appropriate - Consider involving the patient - Protect patient's confidentiality as much as possible • Consult colleagues or legal counsel if uncertain
Clearly document	• Risk assessment • Management plan • Rationale behind choices

Assessment

A basic approach to violence risk assessment in clinical settings begins with familiarity with the Tarasoff duty in the state where a professional is practicing. A clinician must conduct a thorough assessment of the patient—including a thorough history and evaluation of current mental state—seek appropriate collateral, strive for objectivity, show respect for all parties involved, and demonstrate understanding of the limits of accuracy that can be expected from psychiatric violence risk assessments [26].

Not everyone who makes a threat poses a threat, and not everyone who poses a threat actually makes a threat [28]. It is important to take an individualized approach to assessment and intervention based on the facts at hand [23]. As part of a clinical assessment, clinicians should address the threat toward third persons as a therapeutic issue with the patient [31]. This may provide additional risk assessment information, minimize harm to the therapeutic relationship, and provide ongoing opportunity for risk containment. Clinicians may want to explore the meaning of the threats and discuss their concerns with patients.

Clinicians should consider additional sources of information that will help them better assess a patient's risk of dangerousness, including past medical records, and collateral sources such as partners, friends, and relatives. If circumstances permit, a clinician should consider discussing the decision to breach confidentiality with a patient in advance—both for collecting collateral and issuing warnings—to try to preserve the relationship with the patient [12]. However, in a psychiatric emergency

(including risk of violence), the need to preserve life supersedes the need to obtain consent from the patient, though it is helpful to document this decision [12].

There is only a weak statistical association between a patient making a threat and his or her later risk of engaging in violence, but there is an association [34]. A patient's risk can be conceptualized as a pathway from idea to action [28]. As part of a clinical risk assessment, clinicians must determine whether a patient is progressing on the pathway toward a violent act. Clinicians may consider characteristics associated with a greater risk of violence in general psychiatric settings, including factors related to past history [26]:

- Prior violence
- Prior arrest
- Young age at time of first arrest
- Drug and/or alcohol abuse
- Cruelty to animals and people
- Fire setting
- Risk taking
- Behavior suggesting loss of control or impulsivity

And factors related to current context and clinical picture [26]:

- Male under 40 years
- Noncompliance with treatment
- Access to weapons
- Role of significant other and/or caretaker (either provocative or not protective)
- Sees self as victim
- Lack of compassion/empathy
- Intention to harm
- Lack of concern over consequences of violent acts

Depending on setting, clinicians may want to take into account other risk factors. For example, in the emergency room and inpatient unit [26]:

- Aggressive attributional style: hostile, suspicious, or believing others intend to harm
- Command auditory hallucinations to harm others
- Poor therapeutic alliance

An assessment should include special consideration of factors that are associated with a greater risk of violence after a threat (albeit not always violence directed at the original target) [34]:

- Substance abuse
- Not receiving mental health care
- Limited education
- Prior history of violence

Clinicians should integrate their understanding of a patient's risk factors, personality, symptoms, and environment with potential causes of violence in an individual case [26]. For example, in the case of Mr. Poddar, though he had delusions about and violent ideation toward Ms. Tarasoff, there was no indication he presented a risk to anyone else or that he presented a risk to her while she was out of the country. As part of their integrated assessment, clinicians should consider ACTION questions to evaluate where an individual patient is on the pathway toward violent action [28]:

- **A**ttitudes that support or facilitate violence (Belief that use of violence is justified under the circumstances? Belief that violence will accomplish the goal?)
- **C**apacity or means to carry out the violence
- **T**hresholds crossed (Behaviors to further a plan? Especially consider acts that require rule and law breaking.)
- **I**ntent (Distinguish between fantasies/ideas and intent/commitment to action)
- **O**thers' reactions and responses (What responses did/does the patient receive/anticipate? Do collateral sources believe the patient is serious?)
- **N**oncompliance with risk reduction interventions

Risk Management

Assessing violence risk is not the same as managing risk. The basic principle behind risk management includes identifying risk factors that are amenable to treatment interventions (dynamic risk factors), such as active substance use and lack of mental health treatment, and targeting treatment interventions to these factors. Clinicians must evaluate and attempt to balance competing interests, including the patient's right to autonomy and confidentiality and other individuals' right to safety. As noted above, it is difficult to determine what risk threshold should trigger a duty to warn/protect, so some advocate focusing on treatment as having the greatest likelihood of benefiting the patient, while also potentially protecting the victim [23, 14]. However, it is still important to be aware of state requirements affecting this threshold, including whether a victim must be identifiable and whether a threat must be imminent or serious.

Once clinicians determine that there is a risk, there is an array of treatment options, depending on the specifics of the situation and on state regulations [12]:

- Hospitalization
- More frequent therapy sessions
- Starting or increasing medication
- Other forms of closer monitoring
- Warnings to victim and/or police

Hospitalization may have the following advantages over warnings: keeps parties safe during crisis, minimizes the scope of the breach of confidentiality, allows more time for assessment, and allows for intensive treatment that may provide an effective means of reducing a patient's risk.

If clinicians are unsure about how to manage a particular case, they should seek appropriate supervision or consultation. Clinicians may seek clinical consultation (i.e., from an attending or colleague) or legal consultation from the facility's legal counsel. This can also be helpful in malpractice cases as it is more difficult to prove that a "reasonably prudent practitioner" would not have made the same decision, when two psychiatrists arrived at the same conclusion [12].

Warnings

If, based upon the characteristics of the situation and local regulations, a clinician decides to make a warning, it is important to discuss this with the patient, if possible [31]. If appropriate, clinicians may consider working with the patient and having the patient give the warning in session [23]. This allows the patient to maintain control of the disclosure, the victim is put on notice, and no professional rules are violated. In addition, a warning handled in this manner may decrease the danger by facilitating communication between the parties. Importantly, warnings may provide little protection to the victim or the patient [23]. Warnings alone are usually appropriate only in emergency situations (e.g., if the patient leaves a clinician's office after making a threat before the clinician has a chance to obtain additional information or to hospitalize the patient).

Warnings should be made as discretely as possible to protect the patient's confidentiality (i.e., give only the minimum necessary information to law enforcement/potential victim) [12]. Zonana suggests that if a warning may have legal consequences (e.g., a threat against the president), clinicians may suggest that the patient consult with an attorney regarding how to handle the consequences and how to protect the patient's rights [25]. He also cautions against assuming a role as agents of the police or assisting with extracting confessions. This is especially important in situations where there may be legal ramifications for a threat, such as threats against a president.

Documentation

Good clinical documentation is critical. It provides the patient's future clinicians with important information for further assessment and treatment and may also be protective in case of a lawsuit. Notes should demonstrate that the clinician performed a careful risk assessment and provided a rationale for implementing a reasonable risk management plan based on the assessment [12]. Including the rationale for management choices demonstrates that the clinician was using reasonable professional judgment when choosing certain actions and not others [12].

Clinicians should document their assessment of the specific threat made by the patient, the identity of the potential victim, the patient's ability to carry out the stated threat, consultations, collateral information (and attempts to communicate with collateral sources), treatment choices, and other risk management strategies—including

any attempts made to contact the potential victim or law enforcement [12, 32]. Notes should also include information on noncompliance with treatment recommendations and, when possible, include direct quotes from the patient [12].

Liability

The "standard of care" does not require that psychiatrists predict violence or prevent all tragic outcomes [12]. The legal expectation is that a clinician will follow the standard of care for the state [12], though some argue that there are no clear professional standards in Tarasoff situations [28]. Professionals are most likely to be assessed based on whether they considered information that most similarly trained professionals would (or should) consider and, in light of that information, whether the conclusion they reached was one that a reasonable professional would have made [28]. Psychiatric malpractice cases involving harm to third parties often depend on foreseeability [12]. A clinician is more likely to be found liable if she made a judgment based on mistaken beliefs as a result of not having obtained sufficient data (e.g., due to failure to review medical records), than if she made an informed clinical decision in good faith that turned out to have been a mistake.

In states without a duty to warn, legally there is no protection for breaching confidentiality, but there may be a clinical and moral duty to act to ensure the safety of your patient and potential victims. When in doubt, consult with colleagues or legal counsel in your state.

Conclusion

The Tarasoff cases have had a significant impact on state regulations and clinical practice. However, duty to third parties remains one of the more complicated and confusing areas of practice regulation. The difficulty inherent in violence prediction and management has led some to advocate for a focus on the information at hand (rather than probabilities) and on treatment as directed by this information. Although legal concerns receive a lot of attention, clinical and moral considerations may transcend these:

- Regulation of Tarasoff duty is complicated: know local state regulations.
- Complete thorough assessments of patients, including collateral—from the medical record and from individuals close the patient.
- Develop thoughtful plans for treating patients and managing any identified risks. When possible, treat a threat as a therapeutic issue and focus on treatment.
- Consider consultation (clinical and/or legal).
- Thoroughly document evaluations, plans, and rationale.

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Voluntary and Involuntary Hospitalization

5

Stephanie Yarnell and Reena Kapoor

Clinical Vignette

While you are working in the emergency department, police officers bring in a young man for evaluation. The officers report that he was found wandering along the highway, where they witnessed a near miss when a car almost hit him. The police decided to bring him to the hospital for "his own safety."

On exam, the young man is malodorous. His clothing is covered in dirt. The remainder of his hygiene is also poor and he appears unkempt. You also note significant bruising on his legs and a minor, superficial wound on his left forearm. You clean and dress the wound. While doing so, you begin to interview him, asking why he was on the road this evening. His eyes dart back and forth around the room, and in a soft, barely audible voice, he tells you he was abducted by aliens who "deposited" him on the road. He again looks around the room suspiciously, saying, "They are still watching me." He cannot recall the exact details of how he got from the road to the emergency department, but he thinks a "chariot" was involved. He becomes markedly distraught and begins crying, asking you to protect him from any further abduction. Suddenly, he becomes fixated on the ceiling light over his head. He states that he "knows you are [his] guardian angel" and will protect him. He begins to talk about God and angels, and he abruptly ends the interview.

You quickly review his medical record. He carries a diagnosis of schizophrenia and has a history of stopping treatment. Based on his current presentation, you determine that he is decompensating again and needs to be admitted for further observation and treatment. You return to his room and try to explain this to him. However, he

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continues to ramble about God, angels, and aliens. It is a busy night in the emergency department, and you are getting behind on seeing patients. You start to feel pressured by the nursing staff to finish up your evaluation so that you can move onto the next patient, so you hurriedly explain the advantages of signing into the hospital voluntarily over an involuntary admission. The patient eventually agrees to sign the voluntary admission form, remarking that "heaven is safe from the aliens."

How do you proceed? Should you allow the patient to sign himself in?

What are the criteria for competency to sign oneself into a psychiatric hospital?

History of the Real Case (Zinermon v. Burch, 494 US 113 (1990))

Background/Facts

On December 7, 1981, Darrel Burch was found wandering on a Florida highway. His face and chest were bruised and bleeding, so police officers took him to Apalachee Community Mental Hospital for evaluation. Upon arrival, he was "hallucinating, confused, and psychotic" and believed he was in heaven. The staff decided he required hospitalization and allowed him to sign voluntary admission forms. While in the hospital, Mr. Burch was diagnosed with paranoid schizophrenia and prescribed psychotropic medications. On December 10, the staff decided he needed longer-term stabilization and referred him to Florida State Hospital (FSH). Again, Mr. Burch was allowed to sign in voluntarily to FSH despite his ongoing psychotic symptoms, including the belief that he was in heaven. During the hospitalization, Mr. Burch was treated by Dr. Zinermon, who noted on multiple occasions that Mr. Burch was "disoriented, semi-mute, confused, and bizarre in appearance and thought" but remained compliant with medications and care. On December 23, Mr. Burch signed a form stating that he consented to all treatment modalities necessary except ECT, which was witnessed by Dr. Zinermon. Mr. Burch subsequently received treatment and remained hospitalized until May 7, 1982, (152 days) without any formal legal hearing.

After release, Mr. Burch contacted the Florida Human Rights Advocacy Committee. He sued Apalachee Community Mental Hospital, Florida State Hospital, and several FSH employees, alleging that he was incompetent to sign voluntary admission forms and that the hospitalization had deprived him of his liberty without adequate due process. He based his suit on the 14th Amendment of the US Constitution, which states that "[no state shall] deprive any person of life, liberty, or property, without due process of law."

Process and Outcome

The hospitals argued to dismiss the case on the grounds that Dr. Zinermon's actions were unauthorized and unpredictable, and the state had no way of knowing that he would accept Mr. Burch's signature on the voluntary admission forms without

assessing Mr. Burch's competence. The hospitals argued that they have only limited liability for the unauthorized actions of an employee, and they could not prevent the conduct that led to Mr. Burch's deprivation of liberty. The District Court agreed, and the case was dismissed. Mr. Burch appealed this decision to the Court of Appeals for the Eleventh Circuit, which reversed the lower court's decision and found in his favor. The hospitals then appealed the case to the US Supreme Court. In a five-to-four decision, the Court ruled in favor of Mr. Burch, finding that the state of Florida and the hospitals were obligated to create a procedure for voluntary psychiatric admission that adequately safeguards patients' Constitutional rights.

The main legal principle established in *Zinermon v. Burch* is that patients must give informed consent to voluntary psychiatric hospitalization. When Dr. Zinermon failed to assess Mr. Burch's competence at the time of his admission to the hospital, Mr. Burch's Constitutional rights were violated. The courts suggested that, to avoid such violations in the future, physicians should utilize established procedures for involuntary hospitalization for "all patients who cannot be admitted voluntarily, both those who are unwilling and those who are unable to give consent."

Final
Even if a person is agreeable to psychiatric hospitalization, he or she must demonstrate the capacity to provide informed consent before signing voluntary admission forms.

Core Principles

Background

Treatment of acute psychiatric illness frequently requires hospitalization. In some instances, patients recognize the need for hospitalization and agree to be admitted for their own safety. Other times, patients refuse or are unable to understand the need for hospital admission. In these situations, psychiatrists must pursue an emergency involuntary admission (henceforth referred to as involuntary admission). Involuntary admission is the process by which a person can be admitted to a psychiatric hospital or psychiatric unit within a general hospital against his or her will [1]. In the United States, criteria for involuntary psychiatric hospitalization vary from state to state but customarily require a diagnosis of mental illness and either a risk of harm to self or others or evidence of deterioration in the person's mental condition to the extent that the person cannot care for himself or herself [1–4]. Less common criteria used by states include refusal of voluntary admission, lack of capacity to consent to psychiatric treatment, the need for treatment available in a hospital, and future danger to property [4]. Generally, any involuntary observation or treatment should be in the patient's best interest and be the least restrictive alternative available [5]. Because the legal criteria for involuntary admission vary significantly between states, clinicians must be sure to educate themselves regarding the specific criteria in their own state.

Legal Theory and History

The clinical decision to involuntarily admit a person to a psychiatric hospital is guided by legal criteria. Laws regulating involuntary admission are often written using phrases such as "serious mental disorder," "best interest," "risk of harm," and "need of treatment and care." These terms are subjective, leaving room for clinical discretion [5] and considerable latitude for mental health professionals to act in the health interests of patients [5]. However, although state laws still generally defer to the judgment of mental health professionals, clinicians' power has actually been significantly limited in the past century.

In colonial times, individuals with mental illness were typically kept in jails and poorhouses, and communities (i.e., families, doctors, and local officials) were given broad discretion to confine individuals as they saw fit. The facilities were often unsanitary, treatment was nonexistent, and no laws limited the duration of confinement. In the mid-1800s, Dorothea Dix began a campaign for more humane treatment of persons with mental illness. Dozens of large asylums were built around the country, offering a tranquil environment in which patients could convalesce. However, over time, concerns arose about patient abuse and a lack of meaningful treatment in these institutions.

Beginning in the 1960s, the field of mental health law underwent a fundamental shift toward emphasizing patients' civil rights [6]. These changes arose largely out of concerns about "warehousing" individuals with mental illness, poor conditions in state hospitals, skepticism of psychoactive drugs, and the lack of legal avenues to challenge involuntary commitment [6]. Many patients' rights advocates were concerned about the seemingly unquestioned ability of mental health professionals to commit a patient to a mental health facility [7], arguing that too much trust had been placed in professional opinions. The advocates sought to define procedures and criteria for involuntary admission more narrowly. As a result of these efforts, limits were placed on the amount of time an individual could be held involuntarily, and criteria for involuntary admission were carefully defined [7]. The result was a significant reduction in the number of involuntary admissions, which has persisted over subsequent decades. Today, most states apply narrow criteria for involuntary admission, though they still make allowances for its short-term use in emergency situations, usually just a few days [8].

The legal authority granted to a physician to involuntary hospitalize a patient arises from two legal principles: *parens patriae* and the police power of the state. *Parens patriae* is Latin for "parent of the country." This principle entrusts a sovereign power (e.g., the state) with the authority to protect citizens who, for reasons of mental or physical disability or because they are minors, cannot adequately protect or care for themselves. Under this principle, the state is permitted to intervene on behalf of individuals who are deemed unable to make rational decisions for themselves, including those with mental illness who are "gravely disabled" or dangerous to themselves. Whereas *parens patriae* provides for the protection of the individual, police power provides for the protection of society from an individual [4]. The legal theory of police power allows the state to act in order to protect the welfare of its

citizens. Individuals who may be detained under the principle of police power include persons engaged in crimes, persons with highly contagious diseases, and persons with mental illness who pose a danger to others [4].

Ethics

Mental health providers face complex ethical considerations when deciding whether to hospitalize a patient involuntarily [9]. Clinicians must balance two competing ethical principles: beneficence (providing care in the best interest of the patient) and autonomy (respecting the patient's desire and ability to make decisions for himself) [9, 10]. Because of the potential infringement upon individuals' freedom and decision-making powers, the practice of involuntary hospitalization is controversial [9]. Indeed, modern psychiatry has even been described as "uncomfortably wedged between the territories of law and medicine, between coercion and care" [11].

In order to help resolve the ethical dilemma between beneficence and autonomy, clinicians must carefully assess patients' decision-making capacity [12]. If mental illness impairs a patient's ability to make informed and rational choices about treatment, then it may be ethically permissible for the clinician to hospitalize the patient against his will. In fact, many patients lack insight into their illness and need for treatment [13–15], and some scholars have argued that severe mental illness robs inflicted persons of their innate ability to make voluntary decisions [16]. Patients with schizophrenia or other psychotic disorders—the most common diagnoses in involuntarily hospitalized populations—may have delusions or hallucinations that influence their decisions about treatment [10, 16]. Similarly, patients with severe depression may be hopeless and lack motivation to engage in potentially life-saving treatment. Even intoxication or substance dependence may detrimentally affect an individual's ability to make free choices [10]. In each of these cases, clinicians must carefully assess the degree to which mental illness impairs the patient's ability to make rational, informed decisions about psychiatric treatment.

It is important to note that, in most states, incapacity or incompetence by itself is not sufficient to warrant involuntary hospitalization [17, 18, 10]. The clinician (and, if necessary, the courts) must determine that the individual cannot be treated in a less restrictive environment than the hospital [5]. Generally, this "least restrictive alternative" [5] standard requires a determination that the individual would be dangerous to himself or others if not confined in the hospital. If an individual can be placed, for example, in an unlocked residential setting or an outpatient program, then hospitalization may not be warranted [10].

The determination of dangerousness comes with its own ethical complications. Clinicians must sometimes balance the obligation to keep patients' information confidential with the ethical and legal duty to protect third parties from harm at the patients' hands. Violence risk assessment is explored more fully in Chaps. 4 (Duties to Third Parties) and 12 (Violence Risk Assessment), but it warrants a concise discussion here because decisions about dangerousness are closely tied to decisions

about involuntary hospitalization. Psychiatrists are commonly asked to assess a patient's risk of dangerousness. Based on this assessment, the mental health provider chooses whether or not to pursue involuntary hospitalization. This is an inherently difficult decision, and evidence-based risk assessment instruments may be too detailed or cumbersome to apply in an acute clinical setting such as the emergency room. Therefore, psychiatrists are sometimes left wondering whether their clinical assessment alone can justify—both ethically and legally—a patient's involuntary hospitalization. Additionally, psychiatrists may be concerned about the larger societal consequences of working within a legal framework that ties mental illness with dangerousness [5]. Some may see an adverse effect on public opinion of psychiatric illness or treatment, leading to greater stigma and the increased perception that individuals with mental illness are violent and dangerous.

Outcomes

Most involuntarily detained persons ultimately come to view their hospitalization as warranted [19, 20]. In fact, a significant number of patients who were initially admitted to the hospital involuntarily transition to a voluntary status during the course of their treatment. These patients have a higher likelihood of following up with post-discharge planning than those who remain involuntary throughout the admission [21, 22]. Of course, some patients never believe that their detainment was warranted. A considerable number of patients, even after discharge, do not see the justification for their involuntary treatment, and many report negative outcomes as a result [19, 20, 23]. These individuals believe that involuntary hospitalization violated their rights and was not helpful [23].

When patients actively deny their illness and fight against hospitalization, their treatment is generally less successful. For example, patients who no longer meet the criteria for involuntary admission (i.e., are no longer dangerous or gravely disabled) but who remain psychotic often must be released from the hospital before adequate resolution of their symptoms can be achieved. Such an abbreviated hospitalization may not allow for psychiatric stabilization or necessary adjustments to medications. Studies have found that involuntary patients have the shortest lengths of stay in the hospital and are discharged on the least number of medications [21], indicating that, in some cases, their treatment was only partially completed. Studies have also found that insight into illness and positive attitudes toward treatment improve long-term treatment outcomes in individuals with severe mental illness [24]. Involuntary hospitalization risks worsening these individuals' attitudes toward their treatment, potentially leading to higher rates of noncompliance with treatment, treatment discontinuation, and subsequent involuntary admissions [25]. Indeed, individuals previously hospitalized involuntarily have a higher rate of subsequent involuntary readmissions than those who were voluntarily admitted [26–29]. Conversely, patients who convert to voluntary status during the course of their admission are more likely to be discharged from the hospital when their symptoms have sufficiently resolved, which increases the chance for successful community reintegration [21].

In general, psychiatrists approve of the current system of involuntary hospitalization. National surveys have found that psychiatrists express strong support for admission criteria based on danger to self, danger to others, and grave disability [30, 31]. However, some have argued that psychiatrist's determination of voluntariness can, at times, be influenced by external factors. For example, the deliberateness or purposefulness of intent (i.e., how serious is the person about their threat), authenticity and sincerity of the patient, coherence with the patient's prior life, and agreement with psychiatrist have all been shown to influence a psychiatrist's decision regarding capacity and ability to sign one's self into the hospital [32]. Similarly, studies have found that mental health professionals' use of coercive measures, including involuntary hospitalization, is influenced by factors other than pure clinical judgment. Such factors include the hospital's financial situation, local treatment cultures, staff attitudes, sociodemographic characteristics of the patient, and patient characteristics, such as housing stability, degree of family involvement, and disability status [21, 22, 33–41]. Thus, while psychiatrists generally support the current criteria utilized for determining involuntary hospitalization, care should be taken to ensure that decisions about such involuntary admissions are made in a fair and equitable manner.

Conclusion

This chapter began by reviewing a scenario commonly encountered in emergency rooms across the United States: what to do when a patient agrees to voluntary psychiatric admission but lacks the capacity to make this decision. The landmark US Supreme Court case *Zinermon v. Burch* addressed this question directly. Mr. Burch was allowed to admit himself to the hospital voluntarily, even though the mental health staff knew that he believed he was signing into "heaven." After admission, Mr. Burch was allowed to sign multiple subsequent legal documents consenting to treatment, despite clear documentation that he was psychotic, confused, and disoriented. He was treated successfully and discharged from the hospital. However, Mr. Burch later sued the hospital and treatment staff for violating his 14th Amendment rights, claiming he had been deprived of liberty without adequate due process. The US Supreme Court agreed with Mr. Burch, finding that his Constitutional rights were violated because he was detained in the hospital based on voluntary admission paperwork that he was incompetent to sign.

In retrospect, the principles articulated in *Zinermon* seem obvious; patients must give informed consent for voluntary hospitalization. However, the case must be viewed in light of the complicated history of psychiatric hospitalization in the United States, which turned sharply toward protecting patients' civil rights in the latter half of the twentieth century. In response to serious concerns about mental institutions of the mid-1900s, an overhaul of laws regarding psychiatric hospitalization began in the 1960s. The result is our current complex framework of legal (e.g., *parens patriae*, police powers) and ethical (e.g., beneficence) justifications for involuntary hospitalization, which must be balanced against patients' rights to make their own medical decisions and remain free from confinement. While most doctors support the current legal and clinical

criteria for commitment, some patients and patient advocacy groups do not. In cases where patients actively resist hospitalization, outcomes are generally poor, and the risk of long-term treatment complications is increased. Psychiatrists should work collaboratively with patients in planning for hospitalization, carefully assessing whether the patient can give informed consent for admission. When in doubt, psychiatrists should proceed with caution, using involuntary hospitalization protocols to ensure that the patient's due process rights are adequately protected.

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Civil Commitment and Involuntary Outpatient Commitment

6

Marina Nakic

Clinical Vignette

You are working as a psychiatrist in a psychiatric emergency room when the nurse informs you that there is a new patient waiting to be seen. The patient is a 22-year-old man who was brought in by his parents. According to parents, the patient, who has just started his first year college in a different state, suddenly returned home last week and announced that he planned to drop out of school. Over the past week, the parents have noted that his behavior has become increasingly bizarre—he has not bathed in over a week, spends most of his time in his bedroom, and appears preoccupied with paranoid concerns that the government is spying on him through his TV and cell phone. He is so worried about these governmental intrusions that he has taken multiple steps to protect himself, including destroying his cell phone and taping shut the windows in his bedroom. After his parents expressed concern and insisted on bringing him to the hospital, the patient became worried that his parents were part of the government's conspiracy and attempted to flee the home. On his way out, the patient pushed his father, causing his father to fall to the ground and sustain a wrist fracture. The patient ultimately agreed to accompany his parents to the hospital so his father could have his wrist evaluated, and once in the emergency room, he agreed to come speak to a psychiatrist.

When you meet with the patient, he states there is nothing wrong, and he doesn't understand why his parents are so concerned about him. He admits the history provided above by his parents, but does not appreciate anything concerning about his

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behavior. He states that he has no intention of hurting himself or others, that he has no history of self-harm or violence, and that the injury sustained by his father today was an accident. He refuses to be voluntarily hospitalized or accept a referral for outpatient treatment and states that he wishes to return home with his parents.

What do you do?

Does the patient need to be hospitalized or not? If so, how can you accomplish this over his objection and what legal justification do you have for making this decision?

History of the Real Legal Case

In the case of Addington v. Texas [1], Mr. Addington, who was diagnosed with schizophrenia and had a history of assaults, property damage, and threatening injury to his family and others, was committed to various Texas state mental hospitals on seven occasions between 1969 and 1975. In 1975, Mr. Addington's mother filed a petition for his indefinite commitment.

Following formal evaluation by experts, Mr. Addington was assessed as probably dangerous and committed. The trial court judge submitted the case to the jury, asking if Mr. Addington was mentally ill and if he required hospitalization in a mental hospital for his own safety and the protection of others. The jury was instructed to base their decision on "clear, unequivocal, and convincing evidence" [1]. The jury found that Mr. Addington was mentally ill and that he required hospitalization for his own welfare and the welfare of others, after which he was indefinitely committed to the state hospital.

Mr. Addington appealed this decision. In his appeal, Mr. Addington conceded that he suffered from a mental illness. However, he held that there was no substantial basis for concluding that he was probably dangerous to himself or others.

Mr. Addington argued that any standard of proof for commitment less than that of beyond reasonable doubt violated his procedural due process rights. The Texas Court of Appeals agreed with Mr. Addington and reversed the trial court judgment. However, the case was then appealed to the Texas Supreme Court, who reversed the Court of Civil Appeals' decision. The Texas Supreme Court questioned the ability of the state to prove beyond a reasonable doubt (the highest possible legal standard used in criminal court cases) any person's future dangerousness. The court also distinguished a civil commitment from a criminal conviction, noting that under Texas law the committed patient has many more rights than someone convicted of a crime, including the right to treatment, the right to periodic review of his condition, and the right to immediate release when no longer deemed to be a danger to himself or others. Thus, the court declined to adopt the criminal law standard of beyond a reasonable doubt and instead indicated that the state needs to prove the presence of an individual's mental illness and dangerousness by the lesser standard of "clear and convincing evidence" as a requirement to meet criteria for civil commitment.

Involuntary Psychiatric Commitment

Although the vast majority of individuals with mental illness are able to manage their disorders on an outpatient basis, few would question that individuals who are suicidally depressed, manically reckless, overwhelmed with persecutory delusions and auditory commands to hurt others, or failing to thrive due to a cognitive impairment are in need of a higher level of psychiatric care. Unfortunately, severe mental illness may impair a person's perception of reality and compromise insight and judgment, making refusal of care common in psychiatry. In order to ensure safety and administer necessary treatment, psychiatrists must resort to involuntary or civil commitment, a legal process through which an individual with symptoms of severe mental illness is court-ordered into psychiatric treatment.

Involuntary commitment decisions present a unique challenge for psychiatrists [2, 3]. Psychiatric interventions are guided by four ethical principles of medical practice; non-maleficence, autonomy, beneficence, and justice. Physicians are expected to refrain from causing harm (non-maleficence) and obliged to provide treatments that are in the best interest of their patients (beneficence). The principle of autonomy recognizes the right of an individual to self-determination and requires that a physician respects the authority of a patient to make their own medical decisions, even when these decisions appear to be unwise. Justice dictates that medical benefits should be dispensed fairly. Intuitively, these principles seem to be of clear value and application. However, challenges arise when principles of autonomy and beneficence are in conflict, such as when considering involuntary commitment [4–6].

Clinical decisions related to depriving patients of their civil liberties carry tremendous responsibility, and thus psychiatrists rely on state law and hospital regulations to guide their decision-making process. Contemporary involuntary commitment statutes are the product of over two centuries of work to effect a balance between individual liberty rights and concerns for patients' best interests.

Brief History of Civil Commitment Laws in the United States

Traditionally, the state's power to involuntarily commit individuals is derived from two basic legal doctrines: parens patriae and police power. Parens patriae translates from Latin as "parent of the nation" and originally referred to the sovereign's duty to care for the members of the society who were unable to care for themselves. In modern times, the term refers to a doctrine that grants the government the power to care for and protect persons who are legally declared unable to act on their own behalf. The doctrine of police power refers to the government's obligation to preserve societal order and protect the public from harm. Both powers are limited by the provisions of the US Constitution that protects specific civil rights of individuals, such as the right to privacy; the right to protection from the interference of the government in private matters, including medical decisions; the right to freedom of thought and expression; and the right to freedom from bodily restraints and confinement [4].

The mentally ill in early American communities were cared for by their family members, confined in county jails, or detained in shelters for the poor [3, 7]. The first organized societal effort to care for the mentally ill began in 1752, when Quakers opened Pennsylvania Hospital in Philadelphia. In the nineteenth century, social reformers such as Dorothea Dix fought for more humane alternative to jails and poorhouses. In response to their efforts, the first generation of American mental asylums was created, and the states began to assume increasing responsibility for the care of indigent mentally ill. Although the establishment of early asylums was motivated by humanitarian impulses, patients in such institutions suffered from stigmatization, clinicians' limited understanding of neuropsychiatric disorders, and lack of effective treatments [7, 8].

Admissions of mentally ill individuals to such facilities were often initiated at the request of family members who were willing to cover the cost of care or overseers of the poor representing indigent persons. The sole requirement for admission was that the individual be in need of treatment. Involuntary admission was a common practice, since mental illness was thought to compromise mental faculties to such an extent that patients would not be capable of requesting care on their own behalf [3]. In the absence of effective treatments, interventions consisted primarily of restraints, sedation with medications such as bromides and chloral hydrate, or exposure to various experimental treatments such as purging, bloodletting, cold or hot water immersions, and prayer [3, 7]. Chronically symptomatic patients were subjected to trepanations (having holes drilled into the skull) or being placed in "tranquilizing" or "gyrating" chairs. Although admissions to asylums were quick and easy, exiting was not, and many patients remained confined with virtually no rights for an indefinite period of time. As such, early asylums primarily served to sequester mentally ill individuals and the disabled from the rest of society [7].

With time, asylums became notorious for their poor living conditions, lack of hygiene, overcrowding, and widespread abuse. In the mid-nineteenth century, a few cases challenged the exiting norms.

In 1845, Josiah Oakes was committed for 4 years at McLean Asylum in Massachusetts following the petition of his children because soon after his wife's death he became engaged to a much younger woman and dissipated his estate. Mr. Oakes challenged his confinement, and the court responded by acknowledging that the US Constitution did not permit the detention of persons against their will without procedural and legal safeguards. This decision represented the first specification of criteria to be used in determining the appropriateness of involuntary hospitalization [9]. In 1860, Elizabeth Packard challenged her confinement for 3 years to the Illinois State Hospital following the petition of her husband after she expressed disagreements with his religious beliefs. At that time, Illinois statute allowed for the commitment of wives by their husbands without wives' consent or any formal hearing. Following Ms. Packard's release from the hospital, her lobbying efforts on behalf of disempowered women contributed to changing the commitment laws in four states [10]. Oakes and Packard cases were instrumental in initiating a societal discussion regarding the need to develop substantive criteria and procedural safeguards for involuntary commitment standards and resulted in significant legal

reform by the end of the nineteenth century that established safeguards against unjust commitments.

In the first half of the twentieth century, liberal commitment statutes based on parens patriae doctrine again predominated, requiring only the presence of mental illness and the need for treatment. Statutes often equated involuntary hospitalization with global incompetency, and civil commitment could result in the violation of basic human rights, such as barring individuals from enacting their right to register to vote [11, 12].

In the 1950s, the nationwide inpatient census peaked at around half a million, with many mentally ill individuals remaining hospitalized for decades with little or no hope of relieving their symptoms, let alone discharge from the hospital or resuming a meaningful life outside of an institution. At that time a confluence of several cultural and political factors altered the practice of psychiatry and affected civil commitment laws in the United States [11, 13]. In 1946, in response to increasing number of mental health problems in Second World War veterans, President Truman signed the National Mental Health Act, calling for the establishment of the National Institute of Mental Health to advance treatment and understanding of psychiatric disorders. The discovery of the mood-stabilizing effect of lithium carbonate in 1948, and antipsychotic effect of chlorpromazine in 1955, dramatically advanced psychiatric treatment. In the 1960s, the civil rights movement exposed the abysmal conditions in state asylums. Together with criticism from within the psychiatric profession and increase in governmental funding for community support, these events shifted paternalistic commitment criteria to criteria based in dangerousness [2, 11] and initiated the process of replacing long confinements in psychiatric hospitals with community mental health services. In 1964, Washington, DC, instituted a standard for civil commitment that established that a person must be determined to have a mental illness before being involuntarily hospitalized. In addition, the person had to pose an imminent threat of self-harm or harming others or be assessed as no longer capable of providing for the necessities for basic survival. One by one, other states followed suit in implementing similar statutes until the prevailing standard for civil commitment in the United States required the presence of dangerousness or grave disability as a result of mental disease. In 1966, the US Court of Appeals for the Second Circuit ruled that civilly committed patient may not be held in a hospital if a less restrictive alternative for treatment delivery is available. Similar reasoning was subsequently adopted by many jurisdictions [2, 11].

The most radical change in jurisdictional law to protect individual autonomy came from a case in the Wisconsin Federal District Court in 1971. In the case, Alberta Lessard challenged mental health professionals' assessment that she should be permanently committed to a state psychiatric hospital as a result of her schizophrenia. She filed a class action lawsuit on behalf of all involuntarily committed adults in Wisconsin arguing that Wisconsin's involuntary commitment statute violated her due process rights. The court ruled in her favor, reasoning that because civil commitment represented a significant deprivation of liberty, the state was required to prove mental illness and dangerousness beyond a reasonable doubt and to ensure that a less restrictive treatment setting was unavailable [2, 13, 14].

Although the US Supreme Court later lowered the evidentiary standard in such cases (from beyond a reasonable doubt to clear and convincing evidence), the Lessard decision established several rights due to the individual. These included the right to a jury trial, the right to an attorney, the right to exclude hearsay evidence, and the right to have it proven that the individual is both mentally ill and dangerous.

In 1975, the US Supreme Court heard the case of Kenneth Donaldson, who was committed to a Florida State Hospital on his father's petition. After about 15 years of treatment with "milieu therapy," no significant psychotherapy or pharmacotherapy and having his repeated requests for discharge denied, Mr. Donaldson sued the hospital contending that his constitutional right to liberty had been violated without providing adequate treatment. The court found Mr. Donaldson's commitment unconstitutional holding that "A State cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by themselves or with the help of willing and responsible family members or friends" [11, 15].

Decisions in these historic legal cases reverberate in contemporary commitment statutes.

Contemporary Civil Commitment Laws

Presently, evaluations to assess whether or not to involuntarily commit patients to inpatient psychiatric treatment are usually performed in emergency settings, where patients are brought by ambulance, police, family, friends, or coworkers. Common presentations which prompt such evaluations include acute mental status changes, expressions of suicidal or homicidal ideation, or after engaging in self-injurious or violent behavior. Additionally, a patient may be referred by their outpatient clinician when assessed to be at risk for self-harm, harming others, or grave disability.

Types of Involuntary Commitment

If after a thorough evaluation and review of collateral information the patient is assessed to be in need of acute psychiatric hospitalization, the patient can be offered a voluntary admission. However, if the patient refuses or is deemed to not have the capacity to make such a decision, two mechanisms for involuntarily hospitalizing the patient are generally available to the psychiatrist—emergency commitment and civil commitment.

Relying on emergency commitment laws, psychiatrists may initiate an *emergency commitment* for which court involvement is often not initially required for a brief period of time, ranging from 3 days to 2 weeks. Most states require that a physician or psychologist sign the commitment certificate, but some states require more than one professional to sign, and some allow state agencies, such as the police or the courts, to initiate commitment when no mental health professional is available. The purpose of an emergency commitment is ensuring a patient's safety during a time of crisis and implementation of necessary treatment to improve their mental health.

In most states procedural safeguards are implemented to protect the rights of the patient against unjust confinement. For example, many states allow the patient to challenge their emergency confinement in probate court (in some states referred to as a "probable cause hearing") in order to review the necessity of the emergency hospitalization. At the hearing, the decision-maker, usually a probate court judge, is charged with determining whether probable cause existed to believe that the patient met emergency commitment standards at the time the initial psychiatric evaluation was completed. At the conclusion of the hearing, the judge decides to either release the patient or commit them to the hospital for the remaining duration of the emergency certificate [16–18].

A 2016 review of emergency commitment laws by Hedman et al. found that even though every state in the United States and the District of Columbia has emergency commitment laws, state's laws vary regarding the duration allowed for emergency holds, who can initiate an emergency hold, the extent of judicial oversight, and the rights of patients during the hold. The core criterion justifying an involuntary hold is mental illness that results in danger to self or others, but many states have added further specifications. Only 22 states require some form of judicial review of the emergency commitment process, and only 9 require a judge to certify the commitment before a person is hospitalized. Astonishingly, five states do not guarantee assessment by a qualified mental health professional during the emergency hold [19].

Civil commitment is a more complex process than emergency commitment and involves filing of a petition for civil commitment with the court of proper jurisdiction. This process is typically utilized in two types of situations. First, if a patient committed on an emergency basis is determined to still require hospitalization beyond the duration of the emergency commitment certificate, civil commitment procedures may be invoked prior to the expiration of the emergency commitment. Second, when a patient who was initially hospitalized voluntarily requests discharge and the clinical team does not assess that discharge would be safe at that time, the team may petition the court for civil commitment in an attempt to continue the patient's treatment on an involuntary basis [16].

In some states, when an inpatient has been adequately stabilized but has a history of treatment noncompliance and frequent hospitalizations, an evaluation for outpatient civil commitment may be initiated prior to discharge [3, 16].

Involuntary Outpatient Commitment

Following hospitalization, some psychiatric patients discontinue or have no access to treatment, and their condition may rapidly decompensate. Especially concerning is a subpopulation of severely ill patients who, without treatment, may become violent and dangerous. To address concerns related to frequent rehospitalizations, risk of dangerousness in the community, and increased access to needed care, many states have developed involuntary outpatient commitment or assisted outpatient treatment programs. Such programs offer intensive outpatient services, including medication management and a variety of psychosocial services, and are

usually coordinated by a case manager. States which have laws authorizing involuntary outpatient commitment attempt to provide due process protections equivalent to those afforded patients subject to involuntary hospitalization. Although treatment plans may include adherence to psychotropic medications (when indicated), involuntary medication administration on an outpatient basis is subject to the state's same review processes as when patients are hospitalized. As of 2015, 45 states and the District of Columbia have commitment statutes permitting involuntary outpatient commitment. However, several ethical concerns have been raised about the excessive use of involuntary outpatient commitment when there is insufficient evidence of the patient's risk of dangerousness, its disproportionate use for patients of ethnic minorities, and the inability of states to implement the treatment programs mandated by these laws due to inadequate state resources [20–25].

Legal and Statutory Requirements for Commitment Laws

Civil commitment deprives individuals of their freedom and other liberty interests, and as such, several procedural and substantive safeguards have been established by federal and state statutes to ensure that such measures are only enacted when an individual's life is in peril. Procedural and substantive safeguards are delineated in the Fifth and Fourteenth Amendments to the US Constitution in the *due process clauses*, and this right is owed to all persons living in the United States. Due process guarantees fair treatment throughout the judicial process and protects the individual from governmental abuse of power [3]. There are two basic types of due process—procedural due process and substantive due process. Procedural due process ensures a course of formal proceedings (such as legal proceedings) carried out regularly and in accordance with established rules and principles. Substantive due process is a judicial requirement that enacted laws may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of an individual [26].

Procedural due process in civil commitment refers to procedural limitations placed on the manner in which civil commitment standards must be administered. Procedures include examination of the patient by one or more psychiatrists or other qualified individuals designated by the court, requirement that adequate notice of the civil commitment proceedings be given to the patient, court appointment of a legal representative to the patient, and an opportunity to participate in an adversarial hearing at which cross-examination of witnesses may occur as well as examination of evidence. The hearing may take place, depending on the state, in a district, superior, family or probate court, or at the hospital. The majority of civil commitment cases are heard by judges, and the decision whether or not to commit the individual is based on written reports and oral testimonies. A small number of states guarantee the patient the right to have a jury render a decision on the question of commitment, but the vast majority of cases are heard solely by judges. In some states, the duration of the commitment is explicitly limited, and recommitment after that specified

period requires additional hearings, while other states do not specify the duration. In most states a periodic review of the patient's status is statutorily required to determine if the criteria for involuntary commitment continue to be met or if the patient should be discharged.

Substantive due process is a constitutionally protected principle which allows courts to protect certain fundamental rights from governmental interference, even where procedural protections are present. As the term applies to civil commitment, substantive due process requires the establishment of a set of legal standards for imposing civil commitment on a patient. Although jurisdictions vary regarding the details of their statutory provisions, the essential requirements of civil commitment laws are that the decision-maker establishes the presence of a mental illness, that there is clear and convincing evidence that the patient presents a substantial risk of harm to themselves or others due to their mental illness, and that no less restrictive alternative treatment setting is appropriate or available [1, 3, 11].

In American legal system, there are three levels of certainty, or standards, necessary to establish proof in criminal or civil proceedings: The standards serve to allocate the risk of error between the parties and to indicate the relative importance attached to the ultimate decision.

The lowest standard of proof is called "preponderance of the evidence." This standard is met if the proposition is assessed by the fact finder to be more likely true than not. The involved parties share the risk of error in roughly equal fashion under such a standard. This is the standard of proof used in most civil cases and when trying to prove an insanity defense.

At the other end of the spectrum is the highest standard of proof known as "beyond a reasonable doubt." This standard is used in criminal cases where erroneous decisions may have severe consequences for the accused, such as long-term loss of liberty or even life. In such cases, the risk is imposed almost entirely on the state by forcing them to prove the accused's guilt "beyond a reasonable doubt."

The third and intermediate standard, known as clear and convincing evidence, is used in civil commitment proceedings and requires that the trier of fact must be firmly convinced that the evidence presented is substantially more likely to be true than not. This standard was established in the landmark US Supreme Court case Addington v. Texas [1]. The court in Addington balanced individual interests in preserving liberty against the societal interest in committing dangerous mentally ill individuals. The court reasoned that because the possible injury to the individual from an erroneous decision is significantly greater than any possible harm to the state, the state has to justify confinement by a standard higher than the lowest standard of preponderance of the evidence. The court also distinguished civil commitment proceedings as being different from criminal proceedings (which require the beyond a reasonable doubt standard), emphasizing that civil commitment is not a punishment. Rather, mentally ill individuals are entitled to treatment, to periodic

and recurrent review of their mental condition, and to release when they are no longer dangerous to themselves or others [1, 4].

Statutes often define a "person with psychiatric disabilities" as anyone who has a mental or emotional condition that substantially and adversely affects his or her ability to function and who requires care and treatment. The term "dangerous to himself or others" conveys that there is a substantial risk that the individual will inflict physical harm to themselves or others. The term "gravely disabled" refers to a person who, due to mental or emotional impairment, is in danger of serious harm because he or she has failed or is unable to provide for his or her own basic needs such as food, clothing, shelter, or safety.

Involuntary Commitment of Minors

The US Supreme Court established commitment procedures for involuntary commitment of minors in the legal case In re Gault in 1967 [27]. The case involved a 14-year-old boy who had been found guilty of making obscene phone calls to his neighbor and was subsequently committed to a state industrial school until his adulthood. The court ruled that minors accused of crimes must be afforded many of the same due process rights as adults, such as the right to timely notification of the charges, the right to confront witnesses, the right against self-incrimination, and the right to counsel.

In Parham v JR (1979), the US Supreme Court established a constitutional minimum for involuntary commitment of minors, holding that there was no requirement for an adversarial hearing. Rather, a "neutral fact finder" (e.g., a doctor not involved in the patient's care) would review and oversee cases, placing a greater emphasis on medical rather than judicial decision-making [28].

Conclusion

In psychiatry, as in all of medicine, there are situations in which clinicians and patients do not agree on the need for hospitalization. In these situations, the risk to the patient and others of foregoing hospitalization must be carefully balanced against the patient's civil rights and liberty interests. To address these concerns, certain standards have been developed to help balance these competing interests. These standards differ across states and clinical situation, including emergency commitment, civil commitment, and involuntary outpatient commitment. It is important for mental health practitioners to become familiar with local state law to ensure they are balancing these competing interests and their professional responsibilities in conformity with the standard of care in their geographical area.

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Involuntary Medication

7

Kyle C. Walker

Clinical Vignette

You are a psychiatrist working for the state Department of Correction, specifically in a facility intended for the housing and care of convicted offenders with major mental illness. Your role is clinical, providing diagnosis and treatment for these inmate patients, primarily through psychotropics including antipsychotic medications.

One such patient comes to your attention, a middle-aged man by the name of Mr. Harris. He was convicted 5 years ago of a violent robbery and has been incarcerated since. Mr. Harris is known to have a history of bipolar disorder, which has negatively impacted his ability to function within the state penal system. He is often nonadherent to medication and during acute mood episodes becomes uncooperative or even violent; twice before, these episodes have led to transfers from general population to your special treatment center where he has voluntarily accepted medication, improved, and returned to his prior facility to continue his sentence. When he does take medications, his behavior is clearly safer for himself, for other inmates and security staff, and for the general operation of the facility as a whole. However, he has recently begun to refuse them yet again and been transferred to your unit for evaluation and treatment.

Upon his arrival you meet Mr. Harris and diagnose him with a manic episode with psychotic features based on his pressured speech, distractibility, psychomotor agitation, irritable mood, and grandiose and persecutory delusions. He denies suicidal or homicidal ideation and has not actively attempted to harm himself or anyone else during this current episode, though he has not been able to function safely on his prior housing unit due to the level of disruption he has created. You

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recommend treatment with mood stabilizing and antipsychotic medication; however, Mr. Harris insists that he does not have an illness and is unwilling to take anything voluntarily.

The facility superintendent informs you that the inmate will not be able to return to his prior penal setting in his current mental state and asks you to begin treatment over the patient's objection in order to speed along his re-stabilization. The superintendent points you toward an internal Department of Correction policy allowing for such involuntary treatment after the review and approval by an administrative panel composed of institutional staff. The superintendent informs you that he is planning to assemble such a panel so as to pursue such involuntary treatment for Mr. Harris.

How do you proceed?

Historical Case: Washington v. Harper, US Supreme Court, 1990

Walter Harper was convicted of robbery in the state of Washington in 1976 and sentenced to prison. He was incarcerated at the Washington State Penitentiary from 1976 to 1980, spending most of his time there in the prison's mental health unit voluntarily receiving antipsychotic medication. Upon his parole in 1980, he was civilly committed to a state psychiatric hospital, but this status was revoked in 1981 after he assaulted two nurses there. He was sent immediately to the Special Offender Center (SOC), an institute developed within the state Department of Corrections (DOC) for convicted felons with major mental illness. He was diagnosed by that facility's psychiatrist with manic-depressive illness and voluntarily accepted medications initially; however, after a year of such treatment, he refused to continue them and his condition deteriorated.

The institution attempted to treat him over his objection based on an SOC policy which was developed in light of prior US Supreme Court rulings. This policy provided for involuntary treatment of incarcerated felons under particular circumstances, including four components intended to protect the inmates' due process rights:

1. The inmate must be found by a psychiatrist to have mental illness and be gravely disabled or present a likelihood of serious harm to himself or others.
2. The inmate is entitled to a hearing before a special committee composed of a psychiatrist, psychologist, and the Center's Associate Superintendent, none of whom may be directly involved in the inmate's treatment. The majority of the committee must agree with both the initial psychiatrist's diagnosis of mental illness and assessment of disability and/or risk of harm (1) in order to proceed with involuntary treatment.
3. The inmate has several procedural rights leading up to the hearing, including at least 24-h notice of the Center's intent, notice of the preliminary diagnosis, a right to present evidence in his support, the right to cross-examine witnesses, and the right to assistance from a lay (non-attorney) adviser. In the case of an adverse decision, the inmate may appeal to the superintendent.

4. Involuntary treatment can only continue with periodic review by the DOC, first after 1 week by the administrative committee and then every 14 days by the DOC Medical Director.

In this context, in 1982, the committee found that Mr. Harper did meet the above requirements and proceeded with involuntary medication. In 1985 he filed suit in state court alleging infringement by the state on his due process, equal protection, and free speech rights. The Washington Supreme Court found that the SOC policy was *in*sufficient for protecting inmates' rights and that involuntary medication could only be administered after a full judicial hearing in court. This decision was appealed to the US Supreme Court, who reversed the decision, determining first that a state may treat a prison inmate with mental illness against his will if that inmate poses a threat to himself or others and the treatment is medically appropriate and second that the SOC policy fulfilled these requirements even without a full judicial review.

Core Considerations

The controversy around involuntary medication, also known as treatment over objection, stems from a basic conflict between two medicolegal concepts: on the one hand, that a competent adult has the right to refuse unwanted intrusions on his physical space including injections or other forced medications and, on the other hand, that many major mental illnesses simultaneously require psychotropic treatment and also severely impair insight such that a patient cannot appreciate this need.

History of Involuntary Medication Treatment and Landmark Cases

In the United States prior to the 1970s, the concept of a hospitalized patient's right to refuse medication had not been independently delineated but was rather generally tied into the concept of hospital commitment itself. In other words, because patients were hospitalized (whether voluntarily or involuntarily) for the purposes of treatment, it was implied that they would receive the indicated medical interventions whether they desired them or not. While a voluntarily hospitalized patient was de facto able to refuse a recommended treatment by leaving, once a patient was committed involuntarily to a facility, then it was presumed that they had lost capacity to make their own decisions and those of the treating psychiatrists were imposed instead [1].

The late 1960s saw the beginning of a state-by-state trend of drawing back what was seen as the coercive power of psychiatric commitment and moving toward criteria which focused on dangerousness rather than need for treatment. Since that time, on the heels of an active nationwide campaign seeking greater protection of civil liberties for psychiatric patients, courts in various jurisdictions reinterpreted the psychiatric inpatient's right with respect to treatment decisions. *Rennie v. Klein*

[2] and *Rogers v. Commissioner of Mental Health* [3] were two of the first cases in the United States to determine that a patient was not automatically incompetent to make his or her own treatment decisions once committed, but rather required a separate court hearing regarding decision-making competency, with full procedural protections, in order to authorize treatment over objection.

The US Supreme Court has at times seen things differently. The case of *Youngberg v. Romeo* [4] featured a man with profound intellectual disability (rather than mental illness) who had been committed to an institution and was suing the state for relief from heavy use of physical restraints and frequent injuries. In that opinion, in line with other decisions of that time, the Court wrote, "The mere fact that Romeo has been committed under proper procedures does not deprive him of all substantive liberty interests." They go on to say though that "decisions made by the appropriate professional are entitled to a presumption of correctness" and "courts must show deference to the judgment exercised by a qualified professional." This opinion is often interpreted as giving greater latitude to physician decision-making. However, it is difficult to apply to the problem of involuntary medication treatment in psychiatric hospitals, as both the population (intellectual disability versus mental illness) and interventions (medication versus physical restraint) are different. In *Washington v. Harper* [5], referenced in the vignette above, the Court determined that a correctional institution was required to meet certain due process obligations prior to involuntarily medicating a mentally ill inmate, though again contrary to the two lower court cases *Rennie* and *Rogers* accepted that an administrative panel process (rather than full judicial hearing) granted sufficient protection.

More recent is the Supreme Court's *Sell v. United States* [6] decision regarding involuntary medication of a mentally ill defendant facing charges in federal court. The defendant Charles Sell had been found incompetent to stand trial (a legal term referring to a defendant's inability to understand the criminal charges or to assist his or her defense attorney) due to a severe delusional psychiatric illness and committed to a hospital for evaluation and treatment. The hospital attempted, after an internal administrative panel, to involuntarily medicate him both for the purposes of reducing his dangerousness and in order to restore his competency to stand trial. In its opinion the Court determined that involuntary medication was indeed permissible in order to restore the competency of a defendant but only once the government had proved certain elements [7]:

1. That important government interests are at stake—namely, bringing a serious crime to trial
2. That the medication is both substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel
3. That any alternative, less-intrusive treatments are unlikely to achieve the same results
4. That the proposed medications are medically appropriate—that is, in the patient's best medical interest

Notably the nationwide judicial precedents set by the Supreme Court with regard to medication all involve individuals being managed in the criminal justice system, either as defendants or convicted inmates. There are no decisions on that level regarding the right to refuse treatment of purely civilly committed patients; rather we have varying decisions from state supreme courts and federal district courts or circuit courts of appeals.

One line of judicial thinking that has developed over time in some courts has resulted in the differentiation of antipsychotic medications from all other psychiatric medication treatments. The antipsychotics have been often seen as "higher stakes" with greater risk of severe side effects and even a risk that they will suppress other "normal" behaviors or personality features—a fear more easily understood when considering the high dosing strategies that were adopted in the early days of antipsychotics. Because of these concerns, they are in some jurisdictions classified more closely to invasive treatments like psychosurgery and ECT rather than other psychotropics and have been required to undergo a heightened level of judicial review as a result [1].

Conceptualizing Approaches to Involuntary Treatment

The court decisions referenced above, along with a host of other local court precedents, state laws, and departmental policies, have led to a state-by-state patchwork of mechanisms for attempting to treat psychiatric inpatients over their objections. These approaches can be broadly categorized into those driven by treatment needs versus those driven primarily by considerations of a patient's legal rights.

Emergency Versus Non-emergency Medication

As a general rule, legislatures and courts have given much broader latitude to physicians acting in the course of a medical/psychiatric emergency to override patient objections, as compared to non-emergency situations. In psychiatry, the application of highly restrictive interventions such as seclusion, physical restraint, and injected antipsychotics or other sedatives can take place in most medical settings in the event of a true emergency without judicial review, as that would obviously be too time consuming to be an effective requirement in such acute situations.

The main hitch in these scenarios is parsing how an "emergency" is defined. There will often be language either in state law or court case opinions describing what constitutes an emergency for the purposes of involuntary treatment, perhaps describing factors like imminence of danger or risk of death or serious injury to the patient or others. Massachusetts law, for instance, states: "Restraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide" [8]. When determining how to approach the decision of whether to treat involuntarily, it is important to know whether you are operating under the rubric of an emergency or non-emergency situation according to local law.

If the psychiatric problem in front of you is not determined to be an emergency, the requirements for how to proceed often become much more complex. Below are some conceptual models for addressing these scenarios that different jurisdictions or institutions may utilize based on the local history of lawmaking and/or court opinion.

Treatment-Driven Models

Some approaches to involuntarily medicating patients hearken back to the older philosophies—that because patients are hospitalized essentially for the purposes of treatment of their psychiatric illness, and medical treatment is often the only thing that will ever get them out of there again, then the specific medical treatment recommended by their psychiatrist is what they should receive. The process of this can be as simple as it sounds: a patient is committed, the psychiatrist recommends an appropriate medication for their condition, the patient accepts or refuses, and then the patient receives it regardless (orally or injected, whichever is required). Some jurisdictions in which neither legislatures nor courts have forced a higher standard of review could still use this process [9]. They may apply variations in which an independent reviewer such as an institution's medical director or administrative panel considers the appropriateness of the medication in the case of patient refusal. However, under these models, concerns arise regarding the patient's lack of due process rights to certain processes such as a formal hearing, legal counsel, appeals, etc. (akin to those outlined in *Washington v. Harper*). Rather, the primary concern in such a model is that whatever treatment is selected is medically appropriate for the patient's condition, with little emphasis placed on the patient's civil liberty rights.

These models can be favored by many clinicians, who desire to treat the patient quickly and effectively and chafe at burdensome legalistic processes. Similarly, hospital administrators can appreciate the rapid, streamlined approach which reduces clinician distraction with nonreimbursable paperwork and court activities and may reduce patients' duration of hospitalization by way of more aggressive application of psychotropics. On the other hand, these methods are generally disfavored by disability and patients' rights advocates, who foresee the trampling of the civil liberties of a vulnerable population due to the combination of therapeutic zeal and insufficient procedural oversight [9].

Rights-Driven Models

As advocates of patient rights have pushed for increasing recognition over the past several decades, many states have moved toward a process which is designed to preserve patients' legal rights. Concerns at hand are the protection of both common law and constitutional rights, such as freedom from unwanted physical intrusion, and due process rights. These come together in the concept of competency and are frequently expressed in other medical disciplines in the examination of informed consent and decision-making capacity [10]. Because a competent and fully informed adult is free to accept or reject any treatment recommendation even to their own detriment, any patient's preference to refuse a recommended medication can only be overridden if they are found to be incompetent to make such a decision.

The question then becomes how to determine a patient's competency in this regard and what sort of decision-making process (including what sort of decision-maker) is fair to all parties.

A model could potentially address these concerns without too drastic a change from the "old-fashioned" treatment-oriented reviews described previously. In the case of a nonconsenting patient, an independent review panel could be gathered as described above; however, instead of simply reviewing the recommended treatment for medical appropriateness, they would also consider the patient's competency to make medical decisions. Upon determining both that the medication was appropriate for the condition and that the patient did lack competence, the treatment could then proceed involuntarily. A version of this is available in Connecticut as one of two options for seeking involuntary treatment of psychiatric inpatients [11]. This incremental change in the process can be disheartening to the aforementioned rights advocates, who assert that competency decisions are legal, not clinical, determinations and should be made by a judge or magistrate. They might further be concerned about the objectivity of even a non-treating, independent panel composed of clinical staff, who might be biased toward agreeing with their colleagues in overriding the patient's preferences.

A more stringent model would involve the use of a judge, generally in either civil or probate court, any time a psychiatrist wanted to treat a patient over their objections. This decision-maker would be both better trained in the facets of determining competency such as medical decision-making and less likely to be seduced by medical collegiality. Requiring the involvement of a judge would also increase the transparency of the inpatient psychiatric world to external oversight and ideally prevent a return of the heavy-handedness in treatment that was seen in early days after the antipsychotic revolution. This judicial review could come either at the same time as the commitment process as many states do or shortly afterward once the patient was better known and had not agreed to a voluntary treatment regimen.

There is also a difference of opinion among even the states that use a full judicial process as to how the judge should proceed with an incompetent patient. Some impose the "best interest" standard, requiring that the decision-maker impose any medical treatment which would be in the patient's best interests as the judge sees them. Others find that this standard is vague and paternalistic, preferring the "substituted judgment" standard. In this case the judge would attempt to determine what the patient's preference with regard to accepting and selecting medications *would* be, if they did have the capacity to make that decision [1]. This standard is fraught with its own challenges: in the absence of a clear stated preference prior to the onset of major mental illness (a conversation that few are able to have, particularly considering the young age of onset of many of these illnesses), the fact finder may have to rely on sparse or piecemeal observations about the patient's family dynamics, cultural practices, religious preferences, or other circumstantial concerns. Adding difficulties even further, many patients in this cohort with illnesses such as schizophrenia may lack insight to such a degree, even outside of the major episodes requiring hospitalization, that they have not been fully competent with regard to the elements of informed consent in many years. Court officials attempting to satisfy a substituted judgment standard in these cases face quite a challenge indeed.

Competence vs. Dangerousness

In yet another variation, in some states, the decision to medicate a non-consenting patient may turn on the patient's dangerousness to others as an alternative consideration to their medical decision-making capacity. This is similar to the determination that must be made in most jurisdictions for the initial involuntary commitment decision itself, which generally requires a finding of dangerousness to self or others (or in some cases "grave disability" or similar). For example, the state of Connecticut allows for this approach: if either a nonjudicial administrative panel in the institution, or probate court judge, finds that the patient *does* have capacity to provide informed consent but still refuses medication treatment and does have an illness which places the patient or others in "direct threat of harm" and which can only be treated with those medications, then they may authorize that the patient receive those medications involuntarily [11].

Consequences for Inappropriately Administered Treatment

In light of such complicated and variable requirements for legally overriding a patient's refusals, a psychiatrist may be tempted to "damn the torpedoes" and proceed with medication unabated. The fallout from such a decision can be significant.

Professional Ethics Complaints

The easiest route for patients to make their concerns known to higher authorities is by way of filing ethics complaints with the agencies or societies tasked with monitoring these professionals. For psychiatrists this could be something like their state licensing board or the American Psychiatric Association district branch ethics committees. Outcomes could include professional censure, license probation or suspension, or in more severe cases complete loss of license to practice (and therefore livelihood).

Criminal Charges

The crime of battery is usually defined as unwanted physical touch or application of force to another person's body. The related crime of assault means inducing in another person the apprehension that they will be so handled. Inserting pills or needles into a person who does not want them, without the proper lawful oversight, could be categorized in this way. Despite this possibility, the courts have not often pursued criminal charges against doctors who improperly conduct treatments, more frequently preferring civil routes of correction.

Malpractice

A patient targeted by inappropriate involuntary treatment could consider filing a suit for malpractice, a special form of negligence (described in greater detail in the related chapter in this text). The usual parameters of a successful malpractice lawsuit require that a practitioner deviated from the standard of care, resulting directly

in damages to the patient to whom that practitioner had a duty of care. As the professional standards regarding informed consent and involuntary treatment fall in line with legal requirements, a psychiatrist who fails to follow them becomes increasingly vulnerable to such a claim.

Civil Rights Violations

A US federal law from the post-Civil War Reconstruction era provides a mechanism for citizens to sue for monetary damages anyone who, under color of state law or ordinance, violates their constitutional rights or privileges [12]. This is another way for patients to enter the court system when they believe their management in a facility is oppressive or inappropriate. The cases of *Rennie*, *Rogers*, and *Washington* described previously all began with such a federal court complaint. Malpractice insurance is unlikely to cover the financial damages that would result from a successful suit under this law [1].

Summary

Prior to the 1970s, state and local governments offered little oversight of inpatient psychiatric prescribing practices, generally assuming that once a patient was committed then they should also receive the recommended treatment by their treating psychiatrist regardless of the patient's preference. Since that time a variety of court decisions and legislative statutes have led, in general, to far greater rights for patients who wish to refuse psychiatric treatment, including medication. Legal approaches to overriding this refusal vary across state and federal jurisdictions and even between criminal and civil settings within the same geographic area.

- Prescribing clinicians should be aware of the legal limitations to involuntary treatment in their area of practice and times when these limitations may not apply (e.g., during life-threatening emergencies).
- Clinicians should understand the appropriate legal mechanisms to enact in their jurisdiction when a patient refuses a recommended course of treatment which is deemed necessary for the health and safety of the patient and/or others.
- Failure to understand and practice within these restrictions could lead to serious consequences for a psychiatrist, including monetary damages, loss of licensure, or even criminal liability.

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Civil Competence

8

Maya Prabhu

Clinical Vignette: Part One

You are a PGY1 resident rotating on an internal medicine rotation at a small community hospital. Because it is a small hospital, when you take call for the medical service, you also cover admissions for the obstetrical service. One night while you are on call, a married female patient presents in labor, soon to deliver her first child. You conduct a standard history and physical examination of her including a psychiatric screening. The patient is cooperative with the examination and both excited and scared about the upcoming delivery but responds easily to your reassurances. You don't identify any significant medical or psychiatric concerns. During the course of your admission evaluation, your patient tells you that she is a Jehovah's Witness and that she does not wish any blood or blood products to be given to her regardless of the circumstances. This is your first time working with a patient who is a Jehovah's Witness and you are unsure what to do. You ask your senior resident, who directs you to the hospital form for Jehovah's Witness patients. The form is a release of liability which relieves the hospital and employees for legal responsibility for any adverse effects which might result from her refusal to use blood or blood products. The patient and her husband sign the release. You review the case with the attending physician and move on to your next patient.

Later that evening, the patient gives birth to a healthy baby, but starts to hemorrhage secondary to retained placenta. Your attending physician recommends a dilation and curettage (D&C) to stop the bleeding. The patient agrees to undergo the procedure, but once again reminds the team she doesn't want any blood transfusions. Prior to the D&C, the patient signs a second release requesting no blood products and relieving the hospital from liability. Your patient undergoes the D&C,

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but continues to bleed and subsequently requires transfer to the intensive care unit because she needs to be placed on a respirator. Several alternatives to a blood transfusion are tried to treat the patient's condition, but she continues to deteriorate. All involved in her care agree that nothing short of a blood transfusion will save this patient's life.

The clinical team is divided about how to proceed with the patient's care. Some of your colleagues express strong feelings that the patient's refusal to accept blood products when her own life is at stake is an indication of irrational thinking and that her wishes should be overruled by the team in favor of giving her a transfusion. Even though the patient seemed to speak for herself in a clear and organized manner, your colleagues express concern that she may have felt pressured by her husband to refuse the blood products. They argue that the hospital and the medical team have an obligation to provide the best possible care for the patient and that failing to take to do so constitutes medical negligence. One team member argues that the hospital has a duty to act in the best long-term interest of the patient's newborn child, who is also the hospital's patient, and thus has a duty to transfuse to save the mother's life. You are confused—initially you didn't see any reason not to follow the patient's request, but now you are less certain.

Your attending physician speaks with the hospital attorney. After this discussion, the hospital attorney files a request with the court asking for permission to transfuse the patient. You are informed that a judge from the court will come to the hospital to conduct an emergency bedside hearing. Your attending physician instructs you to review the medical record as you will be asked to describe your interactions with the patient and what she discussed with you. As you quickly review the chart, you wonder what kinds of questions you will be asked.

Questions to Consider Based on Part One

What aspects of your history and physical are relevant to the question the court is deciding?

What are the interests at stake for the patient, for you as a member of the clinical team, and for the hospital?

Looking back, what additional discussions might you have had with the patient prior to the delivery that would help inform your current decision about whether to provide a transfusion?

Clinical Vignette: Part Two

The judge arrives and appoints the patient's husband as her substitute decision-maker as the patient is now unconscious and unable to communicate her wishes. Her husband testifies that because of his wife's beliefs as a Jehovah's Witness, she would continue to refuse transfusions, if she were able to communicate her wishes herself, notwithstanding the danger to her life. Your attending physician testifies that within a "reasonable degree of medical certainty," the patient will die without blood transfusions and that all nonblood options have been exhausted. You provide

testimony about the patient's expressed wishes to you and her medical and mental state at the time she discussed her wishes. After hearing all of the testimony, the judge grants permission to the hospital to administer blood transfusions against the patient's (and her husband's) wishes. Your patient recovers and is later discharged home from the hospital with her baby. You are happy that your patient survived, but you continue to wonder whether the court came to the right decision.

History of the Real Life Legal Case

This vignette was based on the legal case *Stamford Hospital* vs. *Nelly E. Vega*, 674 A. 2d 821 (Conn., 1996) [1] which was argued before the Supreme Court of Connecticut in October 1995 and decided in 1996. Mrs. Vega had presented to Stamford Hospital in order to deliver her first child. On the night of her admission, Mrs. Vega, a Jehovah's Witness, signed a hospital form which indicated that no blood or its derivatives be administered to her during her hospitalization; the form explicitly relieved the hospital and its personnel of liability for any adverse effects that might result from her refusal to permit the use of blood in her treatment. Mrs. Vega's husband also signed the release. Mrs. Vega was able to deliver the baby successfully, but then began to bleed due to retained placenta. The patient agreed to the obstetrician's request for a D&C in order to stop the bleeding. Before the procedure, she signed a second waiver requesting that she be given no transfusions and releasing the hospital from liability.

Despite undergoing the procedure, Mrs. Vega continued to hemorrhage. All available treatments (other than blood transfusions) were attempted, but were unsuccessful. Her condition continued to deteriorate until she eventually required a respirator and transfer to the ICU. Throughout this period, Mrs. Vega and her husband were insistent that it was against their religious beliefs to allow a transfusion, even though they were aware she could die without one. Eventually, Stamford Hospital, on behalf of the physicians caring for Mrs. Vega, sought a court order to transfuse Mrs. Vega. The judge came to the hospital in the middle of the night, and a hearing was held at the patient's bedside even though Mrs. Vega's attorney had not yet arrived by the start of the hearing. Her husband, Mr. Vega, was formally appointed by the court as Mrs. Vega's substitute decision-maker. The court ultimately ruled that Mrs. Vega should be given the transfusion; she subsequently recovered.

Mrs. Vega and her family appealed the decision in the case. What is unusual about this case from a procedural perspective is that although the immediate question of whether or not to provide her a blood transfusion was "moot," (i.e., no longer immediately pressing since the issue had been resolved), the Supreme Court of Connecticut agreed to hear the case on appeal. Recognizing that similar cases were likely to arise in the future, the court agreed to provide future "guidance," at the request of the patient, her family, the Watchtower Bible Society of New York (the parent organization of the Jehovah's Witness faith), and the hospital. The question the court addressed is whether the hospital was right to administer a transfusion

against the patient's wishes to prolong her life; it also considered whether the hospital was correct in seeking to protect her child's "long-term interest" in being raised by her biological mother.

The Supreme Court of Connecticut ruled in favor of the patient's right to medical self-determination, in this case, the refusal of a relatively safe and effective intervention which would avoid death. The court reasoned that the "right to refuse medical treatment" is "deeply rooted" in the US's tradition of "self-determination" and in the common law. It cited a 1891 precedent from the US Supreme Court stating, "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his or her own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law." The court stated that the hospital did not have the right to "substitute its judgment for that of the patient" under the presumption that it better represents societal interests, the State, or the profession of medicine. It did recognize the right of a healthcare facility "as a practical matter" to seek guidance before going ahead, or holding back, in such life-and-death situations [1]. On the subject of liability, the court concluded that Mrs. Vega's decision as a "competent" "fully informed" adult "immunized" the hospital from adverse consequences since she "knew the possible price of her refusal." The ruling is also significant for its enumeration of important societal interests, including the hospital's interest in preserving life and protecting the integrity of the medical profession. Nonetheless, the court found that these interests were "not sufficient to take priority over (a person's) common law right to bodily integrity, even when the assertion of that right threatens her own life" [1].

Clinical Discussion

Before proceeding, it is important to distinguish between the terms "civil competency" vs. "civil capacity" as they are sometimes used interchangeably. "Civil competence" is in fact a legal term of art not a medical one which "refers to the degree of mental soundness necessary to make decisions about a specific issue" [2]. By contrast, capacity is "an individual's ability to make an informed decision" [2]. In other words, a determination about competency reflects the outcome of a legal process, whereas an opinion about capacity reflects the assessment of an evaluating physician. Capacity determinations are intended to be narrow and related to the patient's ability to make a decision about a specific clinical issue. However, given the similarities between these concepts, it is not uncommon for consulting psychiatrists to be asked to determine if a patient is "competent." In such cases, the psychiatrist should clarify that the request is for a capacity assessment regarding the patient's ability to make a specific medical decision and clarify the specific concern which has prompted the consult.

For the remainder of the chapter, the term "capacity" will be used as it refers to the clinical considerations and steps taken by the psychiatrist.

The case of *Stamford Hospital* vs. *Vega* raises three significant issues for physicians:

(a) Medical Capacity: The presumption that patients have the right to choose or refuse treatment for themselves, including the right to refuse lifesaving treatment so long as they have decision-making capacity
(b) Substitute Decision-Making: How to proceed if there are concerns about a patient's decision-making capacity, in other words, when to turn to a proxy decision-maker
(c) Jehovah's Witnesses: Special considerations in the treatment of Jehovah's Witness patients

Medical Capacity

The notion of capacity encompasses two related but distinct concepts: informed consent and decision-making capacity.

The concept of "informed consent" is now a fundamental principle of ethical medical care. Informed consent requires that patients be apprised of the nature of their illness, potential treatment options, risks and benefits associated with those options, potential for complications, and all alternatives, including the option of no treatment at all. Encompassed in the notion of informed consent is that physicians must provide the relevant material information to allow patients to make their own decisions, free of coercion. It is also based on the principle that "respect for persons" encompasses persons' right to decide what happens (and does not happen) to their bodies. This idea was signaled in the Stamford case when the court noted that respect for decision-making must be granted even in the "most serious" "matters of life and death" [1].

Also implicit in the idea of informed consent is the assumption that a patient has the *ability* to understand and use the information provided to make a decision that reflects their own wishes and values. Patients are presumed to have this ability unless proven otherwise. Even when patients carry the diagnosis of a serious mental illness, the mere fact of such a diagnosis does not mean patients have lost decision-making capacity unless their illness has caused them to be so impaired that they cannot make an informed choice regarding their care (e.g., if they are acutely manic or psychotic). Once an acute psychiatric or medical decompensation has resolved, capacity may be restored.

Although psychiatrists are often called upon to assist in more complicated capacity evaluations, capacity determinations ought to be able to be made by any clinician familiar with a patient's case. In fact, some writers have posited that in capacity evaluations, "treating physicians may in fact have the advantage of greater familiarity with the patient and with available treatment options. Psychiatric consultation may be helpful in particularly complex cases or when mental illness is present [3]."

Concerns about a patient's decision-making capacity tend to be prompted when patients disagree with a medical recommendation. However, even when there is "no reason to anticipate need for a formal court proceeding, a clinician is expected to consider a patient's decisional capacity" [4]. Although the *Stamford* case represents a scenario where the capacity of the patient did not appear to be in question, there is evidence that physicians frequently underestimate decisional *incapacity* among their patients [5].

At the crux of a capacity assessment is a thorough clinical interview to determine if there is any medical, psychiatric, or neurological condition impacting cognition. Very often in clinical practice, screening tools for cognition such as the Mini-Mental Status Exam (MMSE) or the Montreal Cognitive Assessment (MoCA) are used to aid in the assessment of decisional capacity. However, readers are cautioned that while impaired cognition is correlated with impaired capacity, the two are not synonymous [4]. In addition, there are several tools which have been developed to aid in the assessment of clinical capacity. These include the Aid to Capacity Evaluation (ACE), the Hopkins Competency Assessment Test (HCAT), the Understanding Treatment Disclosure (UTD) test, and the MacArthur Competence Assessment Tools for Treatment [6]. Some of these instruments use standardized vignettes, and others use semi-structured interview questions. The use of these is limited in clinical practice for a variety of reasons, including lack of availability for clinician use, lack of large-scale validity studies, and lack of consistency across instruments in what is being measured [7].

The schema for assessing decision-making capacity first outlined by Appelbaum and Grisso in a 1988 classic article [8] is still very helpful at the bedside (also see [3]).

(a) The ability to communicate a choice
(b) The ability to understand the relevant information
(c) The ability to appreciate a situation and its consequences
(d) The ability to reason rationally

One mnemonic developed by Chow et al. for determining medical decision-making capacity which some readers might find helpful is "CURVES," which stands for [9]:

C—choose and communicate
U—understand
R—reason
V—value
E—emergency
S—surrogate

Physicians should also remember that they are permitted to educate their patients to help them attain capacity either by engaging them in multiple discussions about

the decision or by involving the patient's natural support system (e.g., family members or clergy). Mechanical impediments to capacity may exist but can also be overcome, whether they be hearing aids or glasses.

When to Proceed with a Proxy or Substitute Decision-Maker

A healthcare proxy or representative is someone who has been designated in writing to make decisions about treatment in the event that the patient is unable to communicate their wishes. The healthcare representative is supposed to make decisions on the patient's behalf *based on what the patient's wishes might have been*, not the beliefs of the representative or what physicians might think is in the patient's best interests. There are some treatments, for example, ECT, for which even a proxy cannot give consent but instead requires special hearings before a judge. Very often in the process of identifying a healthcare proxy, a patient may have also created an "advanced directive" or "living will" which may provide additional guidance as to the patient's wishes.

Ideally, the designation of a healthcare proxy has been documented in writing, and a copy of the legal paperwork is in the chart throughout a hospital admission. However, in some circumstances, medical decisions are made at the bedside hastily in the context of an emergent situation. When there have been no prior arrangements made, patients who are unable to make their own decisions should be asked *whom* they would like to make decisions on their behalf. The choice of a surrogate decision-maker is increasingly thought to require a less rigorous standard of capacity [5]; a social worker or chaplain (depending on hospital protocol) may be able to complete the proxy paperwork with the patient immediately.

Often times medical teams will turn to the most readily available family member to help make decisions for the patient. However, it is strongly recommended that providers review hospital policy regarding the hierarchical order in which family members should be considered for this role. The family members most often considered are spouse, parent, adult children, and siblings, though the preferential order will vary by state.

In some cases, a conservator or guardian may have already been appointed by a probate court because the patient has previously been found to be unable to make decisions about his or her medical treatment. Probate courts are distinct from criminal courts, which handle potential violations of criminal law, and civil courts, which handle noncriminal disputes. Rather, probate courts are specialized forums which hear matters related to the personal and financial rights of adults who may be unable to care for themselves.Conservators and guardians can be considered "permanent" decision-makers for patients who have been found to be unlikely to regain decision-making capacity (e.g., a patient with dementia). Ideally, if a conservator has already been appointed, the clinical team has already been made aware of this and is in communication with the conservator regarding treatment decisions. Probate proceedings, terms and procedures differ from state to state.

Considerations with Regard to Jehovah's Witness Patients

Jehovah's Witnesses (JW) is a Christian organization which was founded in the 1870s in Pennsylvania [10]. While there is variability about what individual patients may consider acceptable, many JW members do not accept transfusions of whole blood or any blood component [11].

Since the *Stamford* case was decided in 1996, blood and surgical technology have advanced such that multiple substitutions for blood products have emerged which may allow for many alternate avenues before transfusions need to be considered. Indeed, best transfusion practice is trending toward limiting blood products for all patients, not just those with religious objections, except in the most high-risk situations [12].

However, life-threatening hemorrhage is not an unforeseeable situation in obstetrical patients. Belaouchi et al. strongly recommend that obstetric patients who reject blood transfusion be evaluated as early as possible "in order to select a specific blood management protocol should it be needed, taking into consideration that not all JW refuse all blood products and that each case is different." Topics for discussion would include which transfusion alternatives the patient would accept, who her surrogate decision-maker will be, should she be unable to communicate her wishes, what information can be discussed with family members, and which decisions should be kept private from family [13]. Careful planning would include having the patient sign consent documents in advance and making sure that copies of advance directives are in the chart. Advance directives may take the form of a "blood refusal" card.

Since *Stamford*, the law is more settled, as is medical practice, with regard to the accommodations that must be made to recognize and respect the wishes of a JW patient. In the past physicians have attempted to force patients and children to accept transfusions when deemed medically necessary through the use of court orders [14]. However, this is hardly considered the standard of care in current practice. What is paramount in such situations, however, is to engage all patients in anticipatory decision-making, discussions about available treatment options, and the designation of substitute decision-makers. Making use of an interdisciplinary team in such situations, including consultation with psychiatry, ethics, and anesthesiology, may also mitigate anxiety on the part of both patients and clinical teams. Although much attention is given to cross-cultural differences when they refer to differences in the patient's ethnic background, equal respect for a patient's religious beliefs is also essential.

Conclusions

- Always inquire and document whether a patient has a conservator, healthcare representative, or advanced directive.
- In reviewing complex or high-risk decisions with patients, be sure to review and document discussions about illness, options for treatment (including no treatment), patient's opinions, consistency of opinion, and significant potential adverse consequences of all treatment options (including no further treatment).

- When there is concern about a mental illness or complex family/team/patient dynamics, consider a psychiatry or ethics consult.
- Capacity assessment is part of the necessary skill set for all physicians, in particular psychiatrists, so readers should become familiar with a range of capacity assessment aids (including the Grisso and Appelbaum framework described above).
- It is important to investigate hospital protocol when working with a JW patient, including any requirements for special documentation, and be sure to note any existing advance directives in the medical chart.

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Ethics

9

Karsten M. Heil and Charles C. Dike

Clinical Vignette

You are a committee member on your state's medical board. You are asked to review a case of possible unprofessional behavior by a physician who is licensed to practice in your state and decide what sanctions, if any, this physician should incur.

Dr. James, the physician in question, has been practicing medicine for 10 years. A few months ago, the medical licensing board in your state received a complaint by the author of a scholarly article published decades ago. The author is alleging that Dr. James plagiarized one of his articles and claims that this is not the only instance of plagiarism by Dr. James. The board has decided to investigate the claim.

You review extensive evidence which clearly shows that Dr. James plagiarized several scholarly articles when he was a medical student. He took scholarly articles previously published by other researchers, changed data in the articles, and then republished them under his own name in other journals. He did this several times over the span of several years while in medical school, but never repeated this behavior after graduation. A review of his recent clinical work does not reveal any substandard clinical care. In fact, many patients sent in letters to the medical board advocating on Dr. James' behalf stating that he is an excellent doctor and they are very happy with his care.

In considering this situation, would you vote in favor of Dr. James being sanctioned by the medical board? If so, how severe should the sanctions be and what specific sanction(s) would you impose?

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What Really Happened?

In the 1989 case *Alsabti vs. Board*, the Supreme Judicial Court of Massachusetts (the highest court in the Commonwealth of Massachusetts) decided [1] on a very similar issue: Dr. Alsabti graduated from medical school in 1980 and completed his internship at a hospital in Massachusetts. He had not practiced medicine in Massachusetts since completing his internship, but had been practicing medicine in Pennsylvania. Before graduating from medical school in 1979, four scholarly articles in which he was lead or coauthor were published in medical journals. These articles were almost identical to previously published work by other scholars. The differences in the data and wording between the original articles and Dr. Alsabti's articles were minor and considered immaterial by the Massachusetts Board of Registration in Medicine (*the Board*) that was investigating the case. Three of the four articles had been previously published by other authors in different medical journals than the journals Dr. Alsabti published his articles in. The fourth article he published had been filed as part of another researcher's grant application. Dr. Alsabti did not cite the original authors in his manuscripts and could not explain to the *Board* the substantial similarities between his articles and the previously published work. All four of the articles in question were submitted in 1978. Dr. Alsabti argued that he was not enrolled in medical school at that time (it is unclear why he was not enrolled 2 years before graduation), nor was he yet a physician. He also stated that he had not counted the published articles toward any requirements to obtain his medical degree and, therefore, should not be sanctioned by a medical licensing authority. *The Board* received letters from over 20 of Dr. Alsabti's patients describing him in uniformly positive terms. Board members did not challenge his clinical care or professional conduct during his time as a practicing physician.

The Board nonetheless decided to revoke Dr. Alsabti's state medical license after concluding that he lacked the "good moral character" that Massachusetts law required for practitioners of medicine. Board members argued that his misconduct formed a pattern and was not isolated and that he had likely gained a dishonest advantage in employment following medical school due to his misconduct. Further, the Board argued that he had harmed the public by damaging the integrity of the pool of common scientific knowledge by making it appear as though there were more evidence to support the original work he plagiarized than was merited based on the available empirical work of others.

Dr. Alsabti appealed the revocation of his license to the Supreme Judicial Court of Massachusetts, which affirmed *the Board's* decision. The court found the Board's arguments to be sound and, citing prior legal precedents, elaborated on the importance of physicians' integrity [2] and good moral character [3] for the promotion of public health, welfare, and safety. They wrote: "The board was clearly justified in assessing as serious Alsabti's disregard at that time for basic fairness to competitors and for the possible consequences to patients who might be exposed to medical treatment by physicians relying on experiments Alsabti purported to have done but never did." [1]

Testimonials from Dr. Alsabti's patients' were not taken into consideration by *the Board*, and the Massachusetts Supreme Judicial Court held that *the Board* was not required to do so.

Lessons from the Case: Ethics, Morality, Law, and the Medical Profession

One of the major reasons for investing the government with the power to decide who can and cannot practice as a physician is the protection of patients from incompetent providers who might harm their patients. Dr. Alsabti's medical skills were not questioned in this case however. Instead, his unethical behavior itself, which was also illegal in Massachusetts, was deemed to be damaging to the public's health, welfare, and safety. The damage was viewed as so severe that the loss of his medical license—the ultimate power a state licensing board has—was deemed appropriate.

There is copious debate in philosophy about the delineation of ethics and morality. One useful way to think about the difference is to think of morality as the personal understanding of right and wrong, and of ethics as a more systematized way of thinking about how our understanding of right and wrong should guide individual and group behavior [4]. The relationship between law and ethics is complex. While there is great overlap, they are not interchangeable—what is ethical may be illegal and vice versa. For example, civil protests by a psychiatrist may be illegal if there is a law banning protests, but it may not be unethical, especially if the protests are in support of patients. On the other hand, as a psychiatrist engaging in a sexual relationship with a patient's consenting adult relative would not be illegal, but it would be considered unethical. In Dr. Alsabti's case, his behavior was both unethical and illegal.

As demonstrated by *Alsabti vs. Board* above, unethical behavior by physicians can have severe professional consequences. In the USA, each state has jurisdiction over the licensure of medical professionals practicing in its territory. It is therefore important to keep in mind that while many of the laws and rules governing licensure are very similar between states, they are not the same. Alsabti's plagiarism contravened the "good moral character" that Massachusetts law requires physicians to possess in order to gain or maintain their state medical license. Courts interpreting legal standards such as "good moral character" can rely on their own understanding of such terms but can also look at what they perceive the ethical standards of the group in question (here physicians) to entail. Nongovernmental entities such as specialty boards, e.g., the American Board of Psychiatry and Neurology (ABPN), also require high standards of ethical behavior from everyone seeking or holding a certification and have procedures to sanction unethical behavior up to the revocation of board certification [5]. Likewise, professional bodies, such as the American Medical Association (AMA), American Psychiatric Association (APA), and American Academy of Psychiatry and the Law (AAPL), publish and regularly update codes of ethics that are held as binding for physicians [6], psychiatrists [7], and forensic psychiatrists [8], respectively.

These associations have very little formal power to sanction offending members other than revoking their membership, which, unlike state medical licenses or board certifications, is generally not required for clinical practice. Indirectly however, being sanctioned by a professional organization could have significant consequences for practice and could embolden a complainant to seek redress through litigation in civil court. Additionally, physicians who practice in subspecialty areas cannot afford to ignore their ethical guidelines even if they do not belong to the subspecialty organization. For example, in one such case in 1996, the Supreme Judicial Court of Massachusetts held that the ethical guidelines of AAPL applied to a psychiatrist specializing in adult and child and adolescent psychiatry who was practicing in a forensic role, even though the psychiatrist was not board certified in forensic psychiatry and not a member of AAPL [9].

In this chapter, we will highlight ethical guidelines relevant to the practice of psychiatry in general, as well as introduce those specific to forensic psychiatry. We will discuss some of the key ethical issues addressed by the AMA, APA, and AAPL ethical codes.

Principles of Medical Ethics As Applicable to Psychiatry

The ethics of medical practice date back to the classical Hippocratic Oath (said to have originated in the late fifth century BC) that, to this day, guides the ethical practice of physicians in one form or another. The bond between the physician and patient is highlighted by quotes from the text such as: "I will keep them (the sick) from harm and injustice," and "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves" [10].

The Oath further defines this relationship as including a commitment to: beneficence (doing the best physicians can for the patient's benefit), non-maleficence (keeping the patient from harm), and justice (protecting the patient's legal and civil rights). It also states that these commitments should not be influenced by the patients' socioeconomic status, race, ethnicity, or gender ("be they free or slaves"). Hence, the Hippocratic Oath established the primacy of the patient's benefit in all physician–patient interactions.

Since the formation of the American Medical Association in 1847, American physicians have been guided by a Code of Medical Ethics to which physicians commit themselves as members of the medical profession [6]. The code, comprised of the principles of medical ethics, and the opinions of the AMA's Council of Ethical and Judicial Affairs (CEJA), is updated regularly to address the changing nature of medicine and was last updated in June 2016.

The AMA's principles of medical ethics [6] begin by reminding physicians of the ethical "responsibility to patients first and foremost, as well as to society, to other health professionals, and to self." These principles "are not laws, but standards of conduct that define the essentials of honorable behavior for the physician." They are

the foundation of the ethical guidelines for all specialty medical organizations. The principles state that a physician shall:

1. Provide competent and compassionate care, and respect human dignity and rights.
2. Uphold the standards of professionalism, be honest, and report physicians who are incompetent or deficient in character.
3. Respect the law but also seek to change laws that are contrary to the best interests of patients.
4. Safeguard patients' privacy within the constraints of the law.
5. Continue to further their knowledge and remain committed to medical education.
6. Be free to choose whom to treat and in which setting they want to practice, except in emergencies.
7. Participate in activities that improve the community and public health.
8. Regard responsibility for the patient as paramount.
9. Support access to medical care for all people [6].

These principles of medical ethics can be summarized as reflecting the following four ideals—justice (fairness), beneficence (benefitting the patient), non-maleficence (do no harm), and autonomy (respect for persons). The AMA ethical rules are far reaching and their application in individual cases can be quite complicated. They would be difficult to interpret for and apply to the practice of psychiatry without further elaboration. As a result, the APA developed annotations to the principles of medical ethics that are applicable to psychiatry [7]. For ease of discussion, we have grouped psychiatrists' ethical guidelines into three areas: (1) the physician–patient relationship, (2) psychiatrists' relationships with other providers and third parties, and (3) other ethical duties of psychiatrists.

The Physician–Patient Relationship

The physician–patient relationship is the cornerstone of psychiatric practice. As noted in the APA Commentary on Ethics in Practice (Topic 3.1.1), "Patients often lack medical expertise and sometimes struggle with symptoms that adversely affect their autonomous decision-making; the psychiatrist is responsible for rendering medical care in the patients' best interest while respecting the patient's goals and autonomy." The relationship is a "collaborative endeavor between two autonomous individuals… every effort should be made to have the relationship begin by mutual consent" [11].

Important elements of this relationship include:

- All treatment should be voluntary and provided only after the informed consent of the patient has been secured, except in emergencies or when a patient lacks the

capacity to give informed consent to treatment. Even when such exceptions apply, it is unethical to certify the necessity of involuntary treatment or detention without a personal examination of the person in question.

- The care provided to patients should be competent. This means psychiatrists should not provide services for which they are not qualified. If necessary, the psychiatrist should consult with, or refer the patient to, a more qualified colleague.
- Treatment should be based on the best available evidence and science. When established treatments have failed, psychiatrists may offer nonestablished or novel interventions. Risks and benefits of treatment, risks and benefits of alternatives to such treatments, as well as risks and benefits of no treatment must be discussed with the patient to empower the patient to be able to provide informed consent. Offering treatments that lie outside of the scientific consensus, such as unapproved chemical compounds, is problematic except within the context of a clinical study.
- Because of the highly personal and intensely emotional nature of the physician–patient relationship in psychiatry, proper boundaries should be maintained at all times. Engaging in any form of sexual intimacy with one's patient or former patient is unethical (and in some States illegal). This ethical injunction extends to a patient's close relatives and friends.
- Address boundary and privacy issues when using the internet or other electronic communication technologies. Psychiatrists should inform patients of the appropriate use of these technologies. Their use in emergency situations, if applicable, should be discussed and documented. Psychiatrists should be alert to the risk of HIPAA (The Health Insurance Portability and Accountability Act of 1996) violations when using technology to transmit patients' personal information. Likewise, the dangers of boundary violations are high when patients' access a psychiatrist's personal information through shared websites such as Facebook, or other means of communication. Due to rapidly advancing and changing technologies, the ethics in this area are likely to evolve. Psychiatrists should remain vigilant when using new media and technology and consult APA ethical guidelines as necessary.
- It is ethical to charge for missed appointments or appointments not canceled within a stipulated period in advance as long as that policy was communicated to the patient beforehand.
- It is paramount that patients' privacy be protected. Further, any clinical information used in teaching or scholarly writing must be disguised to effectively conceal patients' identities. However, in certain clinical situations, breaking confidentiality is not only permissible but required. For example, when a patient's behavior presents a high risk of danger to the patient or other persons, breaking confidentiality is permissible to avert danger.
- It is ethical to refuse psychiatric treatment of persons who are not suffering from a mental illness amenable to treatment.
- If a patient's care is transferred to another provider, the psychiatrist should cooperate with the patient's request to share information with and release files to the new provider [7, 11].

Important ethical issues that frequently come up during clinical training include: maintaining boundaries, when to break confidentiality, and how to handle situations where involuntary treatment or detention may be warranted.

Maintaining clear boundaries with your patients is meant to protect both you and the patient from harm and increase chances of treatment success. Empathic and compassionate care should not be confused with becoming emotionally involved with a patient. An emotionally involved psychiatrist could refrain from asking a patient uncomfortable questions or providing vital but distressing information to the patient for fear of hurting the patient's feelings, situations that could be harmful to the patient in the long run. On the other hand, the quality of care provided by psychiatrists is positively influenced by empathy, compassion, and the establishment of clear boundaries between the psychiatrist and the patient. Where these boundaries lie in individual cases is often nuanced and may be influenced by culture and personal style. There are some hard lines, however. For example, sex with a current or former patient is unethical in all circumstances. According to the APA, sex with a former patient is always unethical regardless of how much time has elapsed since treatment was discontinued. Although some scholars disagree with this stance [12], there is currently no wiggle room for psychiatrists practicing in the USA.

Another important issue of great concern involves accepting large financial gifts from current or former patients—it is generally viewed as unethical and should be avoided.

With regard to confidentiality, psychiatrists owe an ethical obligation not to reveal a patient's personal information without the patient's informed consent, as well as a legal duty to protect a patient's privacy (APA Commentary on Ethics in Practice, Topic 3.2.1 [11]). For example, when discussing cases with colleagues not involved in a patient's care, it is important to maintain privacy by effectively disguising the patient's identity even if the clinical case is somewhat altered in the process. Unlike ethical obligations, there are substantial differences in the legal duty to protect a patient's privacy depending on the jurisdiction a psychiatrist is practicing in, as well as the role the psychiatrist is serving (for example, treating psychiatrist versus forensic psychiatric evaluator). These legal obligations are discussed in greater detail in this text's chapter on confidentiality.

Involuntary treatment or detention is one of psychiatry's most controversial topics, not the least because of the historically rampant abuse of involuntary treatment procedures by psychiatrists.

Psychiatrists recognize that enforced treatment contains an inherent tension among several ethical values: respecting the individual's autonomy, providing care for that individual, and protecting the community (APA Commentary on Ethics in Practice, Topic 3.2.5 [11]). In psychiatric emergencies, such as threats of harm to oneself or others, the psychiatrist has an ethical obligation "to ensure the safety of the public or the care and protection of patients through involuntary psychiatric treatment" (ibid). Making use of involuntary treatment modalities requires sensitivity on the part of the psychiatrist to balance these competing values. When involuntary treatment is imposed, it should "ensure the least restrictive clinically appropriate alternative and, to the extent possible, respect the informed consent process and the

patient's decision-making capacity" (ibid). However, there are several notable psychiatrists who disagree with the concept of involuntary treatment or commitment (Thomas Szasz is a well-known example [13]).

One of the important ethical standards of the APA is the requirement that a psychiatrist may certify a patient for involuntary commitment or treatment only after he or she has personally evaluated the patient [7]. Psychiatry residents, depending on their licensing status and the jurisdiction in which they practice, often have the legal authority to certify a patient for involuntary commitment. Residents can find themselves in clinical situations where other medical staff—even more senior colleagues—sometimes pressure residents to certify a patient for involuntary commitment without a personal examination of the patient. Residents have both a legal and an ethical obligation to resist such pressures.

Psychiatrists' Relationship with Other Providers and Third Parties

The nature of psychiatric practice often requires that psychiatrists work with colleagues from different disciplines who have their own ethical obligations. In addition, an increasing number of psychiatrists do not work directly with patients but with third parties such as insurance companies, the legal system, the military, and medical providers, where psychiatrists serve as consultants in an integrated care setting, and so on. These situations create unique challenges that require psychiatrists to develop clear ethical guidelines to protect patients and society. Important considerations include:

- Referrals to other providers, psychiatric or otherwise, should only be made to persons who are competent to deliver the necessary treatment.
- Consultants should only be given information relevant to the specific situation (the "minimum necessary" information needed to provide competent consultation).
- Information provided to other health providers, employers, insurance companies, or other third parties must be truthful.
- Progress notes should only contain the information necessary to ensure good continuity of care. Including nonessential information in progress notes can put the patient's privacy at risk and make successful continuity of care more difficult.
- A psychiatrist can be reimbursed for providing supervision to other providers (e.g., by charging an hourly rate or a flat fee for the supervision).
- Fee splitting, where other providers pay a percentage of their fees to a referring or consulting psychiatrist, is unethical. The concern with fee splitting is that it could lead to an increase in inappropriate referrals to the provider as the referring psychiatrist would obtain financial benefit with each referral (and thus would be incentivized to increase the number of referrals made).
- If a psychiatrist takes on a supervisory role for non-physician professionals (or medical trainees), the psychiatrist must ensure that he or she spends adequate

time to ensure effective supervision; the psychiatrist cannot act as a mere figurehead. Further, matters requiring professional medical judgment must not be delegated to nonmedical professionals (e.g., delegating the decision about what medication to prescribe to a social worker).

- Psychiatrists are mandated to protect patients from impaired or incompetent physicians and non-physician mental health professionals. If possible, these issues should first be addressed through informal processes. If those efforts are unsuccessful, psychiatrists should address the issue through other appropriate channels such as the state's impaired physician program, the state medical board, the chief of the service/hospital, hospital medical staff procedures, or other available routes. (APA Commentary on Ethics in Practice, Topic 3.3.5 [11]).
- Relationships with pharmaceutical and other industries should be handled with caution. At a minimum, potential conflicts of interests must be disclosed to patients and in public speeches and writings, even if the psychiatrist feels that these are inconsequential [7, 11].

Some of the ethical duties listed earlier provide a unique challenge to medical students and trainees because of the power differential they face relative to their supervisors. A related problem is the case of a supervisor who is intoxicated or otherwise not providing competent care. While the power differential makes it especially difficult for trainees to report unethical and/or incompetent behavior of supervisors, they are nonetheless obligated to do so. Every training program should have procedures in place that encourage trainees to report unethical behavior of supervisors without fear of retribution.

In recognition of these challenges, it is the ethical responsibility of psychiatrists to ensure that trainees are treated with respect in an environment conducive to learning. It is not ethically permissible for a supervisor to sign notes or orders written by trainees absent a supervisory relationship.

Other Duties of the Ethical Psychiatrist

- When working in an organized system of care, the psychiatrist must communicate to the patient certain requirements of the organization such as treatment restrictions or triage protocols. The psychiatrist must also help identify treatment alternatives outside of their own system of care if it is more beneficial (or more affordable) for the patient's treatment.
- It is unethical for a psychiatrist to publicly offer a professional opinion on persons (including public figures) whom the psychiatrist has not personally examined and from whom the psychiatrist has not obtained authorization to disclose a professional opinion about their behavior, including their mental state. This is called the Goldwater Rule (named after Barry Goldwater, U.S. presidential candidate in 1964, whose mental state many psychiatrists publicly opined about without having performed a direct psychiatric examination of Mr. Goldwater).

- Law breaking that bears directly on a psychiatrist's practice, such as falsifying medical records, submitting a false bill, and providing false documents to excuse a patient from obligations, is unethical. However, breaking laws that bar civil protests may not be unethical, even if illegal.
- Psychiatrists should not contribute to discrimination based on ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.
- Psychiatrists should not participate in legally authorized executions.
- Psychiatrists should not participate directly or indirectly in interrogations of those detained by law enforcement or intelligence agencies [7, 11].

Ethical Guidelines for the Practice of Forensic Psychiatry

The American Academy of Psychiatry and the Law's (AAPL) ethical guidelines begin by noting that the unique intersection of psychiatric practice and the law exposes forensic psychiatrists to many potential conflicts. AAPL ethical guidelines define forensic psychiatry as "a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment." These ethical guidelines apply to all psychiatrists practicing in a forensic role. They are intended to "supplement the Annotations Especially Applicable to Psychiatry of the American Psychiatric Association to the Principles of Medical Ethics of the American Medical Association" [8].

The traditional physician–patient relationship is different in a forensic psychiatric context. Consider the case of a forensic psychiatrist hired by a defense attorney or the court to evaluate an individual accused of a criminal offense. Here, the psychiatrist's primary duty is to the hiring attorney or the court and not the defendant. This is very different from traditional psychiatric practice in which the psychiatrist's primary duty is to the patient. However, if the defendant expresses suicidal or homicidal ideation during a forensic evaluation, the psychiatrist must shift focus, put on a doctor–patient hat, and act to protect the defendant and others from harm. This careful balancing of roles highlights the need for additional ethical structures when engaging in forensic psychiatric practice.

One of the paramount issues at play in forensic psychiatry is managing dual agency (serving two agencies or serving in two roles at the same time), given the prominent role of third parties in forensic assessments. Other core ethical principles that are crucial to forensic psychiatric practice and further described in the AAPL guidelines include informed consent, confidentiality, honesty, and striving for objectivity.

Dual Agency

The multiple overlapping roles that forensic psychiatrists serve lead to competing commitments and obligations. Psychiatrists practicing outside of a forensic context have a primary, but not absolute, duty to their patient. However, forensic

psychiatrists do not act within a traditional physician–patient relationship in much of what they do. For example, psychiatrists working in a forensic hospital or correctional facility are often asked to provide reports to the courts and may testify in court in cases involving their patients. Their testimony (and reports) could help or harm their patients. In these complicated circumstances, when a treating psychiatrist provides information in court on a patient's diagnosis, treatment provided, and response to treatment only, the psychiatrist is serving as a fact witness, as they are solely testifying about their past experiences working with the patient in a clinical setting. However, when the same psychiatrist forms an opinion regarding the patient's dangerousness or risk of engaging in criminal behavior based on psychiatric data and the additional collateral information available, the psychiatrist is acting as an expert witness (as they are using their psychiatric expertise to form an opinion about the patient) and, in this case, has now become a dual agent, working both for the patient and the legal system. AAPL ethics recommend that treating psychiatrists should avoid acting as forensic experts in relation to patients they are treating (whenever possible) in order to avoid inherent biases that could influence their opinion. It is, however, not unethical to do so and may be necessary in certain situations (e.g., if the psychiatrist is practicing in a rural area without proximally located colleagues who could perform the forensic evaluation instead). The psychiatrist must carefully balance these competing roles without acting unethically. Similar role conflicts often arise with psychiatrists working in correctional and military settings where there are limits on what kind of information can be kept confidential between the psychiatrist and the patient.

The most common dual agency issue that occurs in general psychiatric practice involves completing Social Security (or private insurance company) disability forms for patients. Others include Workmen's Compensation forms and fitness for duty evaluations. In these situations, treating psychiatrists are asked to state their professional opinion regarding their patient's ability to perform certain tasks, armed with only that information provided by the patient. The ethical values of honesty and striving for objectivity call for an unbiased assessment of the patient's ability, a very difficult task indeed, especially if the psychiatrist's opinion conflicts with the patient's desire. The risk of rupturing the therapeutic alliance is high.

Informed Consent and Confidentiality

Unlike traditional psychiatric practice, what is discussed between a forensic psychiatrist and an evaluee is generally not protected by traditional physician–patient confidentiality. If the psychiatrist is hired by the evaluee's own attorney, their discussions may be protected by an extension of the attorney–client privilege referred to as the "work product rule," but this does not keep the information private from the hiring attorney or his/her co-workers. In addition, whatever information the evaluee presents may be discussed in open court or at deposition (a legal process where sworn testimony is provided to attorneys without a judge or jury present. Such testimony may or may not be subsequently presented at a court

hearing). The evaluee may be unaware of these potential disclosures before agreeing to a forensic evaluation. It is, therefore, the duty of the forensic evaluator to ensure the evaluee understands the limited nature of confidentiality in these assessments. The psychiatrist must inform the evaluee that the psychiatrist performing the evaluation is hired by a named third party (e.g., an attorney), the reason for the evaluation, and the limits of confidentiality described earlier. This should be done at the beginning of any forensic evaluation, with reminders during the assessment as necessary. Without these warnings, any consent given to the psychiatrist would not be considered an informed consent.

Honesty and Striving for Objectivity

The unique adversarial nature of the US legal system which pits two opposing sides against one another creates inherent tensions for a psychiatrist hired by one side in a legal dispute. The desire to "win" the case increases the potential for unintended bias in psychiatrists practicing in US court systems, different from other countries without an adversarial judicial process [14]. Several of the ethical rules described earlier are meant to protect the forensic psychiatrist from becoming a "hired gun"—an expert who will say whatever is helpful to the party who hired him/her. However, some unconscious bias is inevitable in any forensic evaluation. The US legal system attempts to balance this by allowing experts to be retained by both sides and by holding forensic experts to ethical standards such as those described by the APA and AAPL.

A psychiatrist who strives for objectivity would render an honest opinion based on a personal examination of an individual, interview of all collateral sources as available and necessary, and review of all pertinent data related to the case. In addition, the psychiatrist should not alter or distort his/her professional opinion in support of the retaining attorney and should not agree to payment that is contingent on the outcome of the case. Further, the psychiatrist should state the limits of his/her opinion as necessary. For example, if the evaluee (or collateral sources) could not be interviewed after an "earnest effort" [8] to do so, it should be stated in the report because the absence of this information could limit the conclusions drawn from the evaluation.

Other Ethical Issues Pertinent to Forensic Psychiatry

- It is unethical to conduct a psychiatric evaluation of an individual charged with a crime before the person has had access to legal counsel, except in medical emergencies for the purposes of treatment.
- Forensic psychiatrists may not bully, be rude, or use name-calling to obtain information from evaluees. However, persistent questioning about inconsistencies and the exploration of areas that make the evaluee uncomfortable are ethical and often warranted in forensic evaluations.

- In cases where a psychiatrist is asked to assess material relevant to a legal case (such as medical records, correspondence, or police interrogation videos) but has not examined the evaluee in person, any opinion rendered must be qualified, indicating in reports and testimony that there was no personal examination.
- It is unethical to change diagnoses or other major findings in a forensic report upon the request of an attorney in order to strengthen a case. It is permissible, however, to accept requests for changes in phrasing that make the expressed opinion clearer or more easily understandable to a nonpsychiatric audience.
- It is unethical to claim expertise in areas where one does not have actual knowledge, skills, and experience [7, 8].

Take Home Messages

– Professional bodies such as the AMA, APA, and AAPL set forth ethical codes of conduct. They do not carry the direct force of law, but nonadherence to them can lead to severe professional and legal consequences including loss of medical licensure and board certification. These potential sanctions may be imposed even if one is not a member of any of these professional organizations, so it is important for all psychiatrists to familiarize themselves with these guidelines.
– All psychiatrists are physicians first and all forensic psychiatrists are psychiatrists. That is why multiple codes of ethics often apply simultaneously to the same individual.
– Tread carefully when you observe unethical behavior of others as you are obligated to address it and to report it if the problem persists. It is advisable to familiarize yourself with the reporting procedures of your training program and institution.
– Forensic psychiatrists, especially when acting as forensic evaluators, face unique ethical challenges arising from their special role and the lack of a typical physician–patient relationship. Forensic psychiatrists should strive for honesty and objectivity and resist pressures to sway their opinion in favor of the hiring party.

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Malpractice

10

Scott Walmer

The Scenario

You are the attending psychiatrist on an adult inpatient psychiatric treatment unit in a community hospital. One of the patients currently on your unit is Ms. Smith, a 53-year-old woman with a 30-year history of schizophrenia who was admitted following a suicide attempt in the context of symptoms of psychosis. You are familiar with Ms. Smith's history, having cared for her during each of her three previous admissions in the past year. You consider her history and previous response to treatment and elect to place her on suicide precautions and start an atypical antipsychotic to treat the psychosis.

During the first few days of the hospitalization, Ms. Smith shows progress with treatment. However, 1 week after admission, there is evidence of inadequate symptom reduction. You are concerned that Ms. Smith is regressing and you increase the dose of her antipsychotic.

Over the next few days, your interactions with Ms. Smith lead you to consider discharge. Eleven days after admission to the unit, you ask Ms. Smith whether she would hurt herself if discharged. She replies, "I hope not." In discussing discharge with her, Ms. Smith expresses anxiety about being discharged the following day. Based on your evaluation, you see evidence for paranoia and significant fear related to her family; however, you also see evidence for clinical improvement since admission.

You arrive to work on day 12 of Ms. Smith's hospitalization. Based on her progress since admission, you feel she is ready for discharge. You consider her history of hospital readmissions and set up a discharge plan that includes several safeguards that were not in place during previous admissions. These include a follow-up

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appointment with her outpatient therapist the morning after discharge, daily visits by a home health psychiatric nurse to check on her mental state and to monitor for medication adherence, and increased family involvement.

Three days after discharge, you receive a call learning that Ms. Smith was found dead in her apartment after committing suicide.

What went wrong? Should you have seen this coming? Was there anything you could have done differently? Could you be found liable for her death?

What Really Happened

Thompson v. Patton, Supreme Court of Alabama, 2008 [1]

On November 11, 1999, Peggy Sue Ellis, a 53-year-old woman with a 30-year history of schizophrenia, suicide attempts, and multiple hospitalizations, was admitted to Baptist Medical Center Montclair in Birmingham, Alabama following a suicide attempt. The psychiatrist treating her was Dr. Rita W. Patton, who had cared for her during three prior admissions the same year. On admission to the hospital, Ms. Ellis was placed on a suicide watch and was started on quetiapine to treat the symptoms of schizophrenia.

Ms. Ellis' hospital course was marked by a waxing and waning of her clinical symptoms; however, by day 11 of the hospitalization, she was progressing toward discharge. Dr. Patton queried Ms. Ellis as to whether or not she would hurt herself if discharged. Ms. Ellis replied, "I hope not." She expressed fear about discharge and demonstrated evidence for anxiety and paranoia that seemed to be related to her family. The following day, Dr. Patton discharged Ms. Ellis from the hospital. The discharge plan included all of the elements described above in the example scenario.

Ms. Ellis presented to her outpatient follow-up therapy appointment the day after discharge. During that encounter, her therapist noted that Ms. Ellis had not filled her prescription for quetiapine, was frightened, confused about her medications, obsessed with psychotic thoughts, and demonstrated an inappropriate and blunted affect. Dr. Patton was not aware that Ms. Ellis had failed to fill her prescription for quetiapine. Two days later, Ms. Ellis was found dead in her apartment secondary to a drug overdose, deemed to be suicide by the coroner.

After the suicide, Marty Thompson, the administrator of Ms. Ellis' estate, filed a lawsuit in the Jefferson Circuit Court (Alabama) against Dr. Patton and her employer ("the Clinic") on grounds of wrongful death under the Alabama Medical Liability Act. The basis for the wrongful death claim was that Dr. Patton deviated from the standard of care by prematurely discharging Ms. Ellis from the hospital, failing to formulate an appropriate outpatient treatment plan, failing to readmit Ms. Ellis to a psychiatric unit, and for failing to implement proper suicide precautions.

At trial, expert witnesses specializing in psychiatry testified for each side. The expert witness for Ms. Ellis' estate opined that based on the facts in the case, there was a probability that Ms. Ellis might possibly attempt suicide if discharged from the hospital on the day that she was released. The jury deadlocked and the trial court declared a mistrial. Dr. Patton and the Clinic then appealed to the Alabama Supreme Court.

In its ruling, the Alabama Supreme Court opined that the trial court "blurred the distinction between the different elements necessary to establish medical malpractice" by conflating proximate causation (the event occurred directly because of the preceding act and would not have occurred but for the act) with the foreseeability of suicide. The Court emphasized that breaching the relevant standard of care is not sufficient for a medical malpractice claim to be successful. A second required element is that the deviation must be a proximate cause of the wrongful death. Because the "proximate cause" issue was not addressed by the trial court, the Alabama Supreme Court remanded the case back to the lower court for it to be answered.

In rehearing the case, the trial court entered judgment in favor of Dr. Patton and the Clinic. Mr. Thompson then appealed to the Alabama Supreme Court, which heard the case a second time and affirmed the judgment of the lower court. In its ruling, the Court held that the testimony of Mr. Thompson's expert witness, while establishing that there was some possibility that Ms. Ellis would attempt suicide, was insufficient to establish proximate causation, as causation requires proof "that the alleged negligence **probably** caused, rather than only possibly caused, the plaintiff's injury." The Court concluded "evidence that a health-care provider's alleged negligence possibly caused an injury is not substantial evidence of proximate causation under Alabama law."

The Court also held that in cases of wrongful death suicide malpractice, expert witness testimony is required to establish a proximate causation link between negligence and suicide, as the relevant factors are beyond the knowledge of lay jurors. In the death of Ms. Ellis, the Court observed that there were several variables in play, and all testifying psychiatrists felt that the discharge plan adequately met the standard of care. As Mr. Thompson's expert failed to testify as to the issue of proximate causation, the Court entered judgment in favor of Dr. Patton and the Clinic.

Discussion

Practicing psychiatry, as with any area of medicine, is fraught with numerous challenges relating to patient care. What is the diagnosis and how should it be treated? Is the patient safe to be treated in the community? Questions such as these routinely confront treating psychiatrists, yet it is axiomatic that the practice of medicine involves decision-making based on imperfect knowledge. There will always be some portion of patients who experience bad outcomes as a result of clinical decision-making, be they common, rare, or unforeseen.

In the law, a tort is when a person suffers harm due to a wrong. According to the law, the wronged person (the plaintiff) can then bring a legal action in civil (non-criminal) court against the individual who wronged them (the defendant), asking for compensation for the harm suffered. There are many types of torts. One such category is called negligence, in which an individual fails to perform an action that another reasonable person would have done if in the same circumstances. When a tort claim of negligence is applied to the practice of medicine and legal action is sought against a physician, we typically call this being sued for "malpractice."

Requirements for Malpractice

For a plaintiff to be successful in a malpractice claim, four basic elements are required, commonly called the "Four D's." These are:

1. Duty
2. Dereliction of duty
3. Damages or harm
4. Direct causation

The plaintiff (the aggrieved party) must prove the presence of these four elements by a "preponderance of the evidence," which translates roughly as "more likely than not." This is a less stringent standard than the "beyond reasonable doubt" standard used in criminal cases. If even one of the above four components is not proven, then the malpractice claim fails.

Duty

The first required element for a malpractice suit to be successful is a duty to the patient. Psychiatrists cannot be held liable to the harm suffered by a person if there is no doctor–patient relationship established. A doctor-patient relationship is established explicitly when the physician agrees to treat a given patient for his or her condition. However, a doctor–patient relationship can exist implicitly as well if, on the basis of the conduct of the physician, the patient might reasonably be led to assume that a doctor–patient relationship has been established [2]. For example, a community physician might encounter an individual in a grocery store, listen to that individual's medical concerns, and then provide medical recommendations. In that individual's mind, he/she just received medical advice from a person known to be a physician, and thus he/she might reasonably assume that a doctor–patient relationship was established. Once a doctor–patient relationship exists (or is believed to exist by the patient), the physician owes the patient (at a minimum) a duty to diagnose and treat to the level of the average physician. A patient or physician may terminate the relationship (and therefore the duty) at any point; however, abandoning the patient without appropriate referrals, notice, or the opportunity to provide continuity of care places the terminating physician at an increased risk of malpractice [3]. Strategies such as developing a policy for providing advanced written notification along with a reasonable duration of medication to ensure that the patient does not run out while finding a new provider will help to lessen the risk of malpractice liability [2].

Dereliction of Duty

Once it is established that a physician owes a duty to the patient, this duty may be negligently breached if the physician deviates from the "standard of care." What is the standard of care? The simplest answer is: what a physician, possessing "that reasonable degree of knowledge and skill that is ordinarily possessed by other members" practicing in the same specialty would do for the same type of patient, in similar circumstances [4].

Although there are statutory differences between jurisdictions that directly impact the way in which psychiatrists are able to practice (e.g., different laws relating to emergency involuntary commitment or involuntary medication), in general, in most jurisdictions, the generally accepted standard of good medical practice crosses state lines. In other words, a patient with bipolar disorder in Louisiana ought to be worked-up, diagnosed, and treated similarly to how that same patient would receive care in San Francisco. Some jurisdictions make exception to the national standard of care rule, which is outlined in the respective state statute.

There is no single authority that provides the definitive answer as to what constitutes the usual behavior of ordinary members of the profession. Good starting references include published journal articles, textbooks, pharmaceutical package inserts, and practice guidelines, such as the American Psychiatric Association's Practice Guidelines [5].

In addition to the standard of care, some jurisdictions utilize the "reasonably prudent practitioner standard," which states that "a physician could be held liable if he failed to provide reasonable and prudent care in light of all the circumstances, even though the physician did adhere to the customary practice of the average physician in the field" [3]. Two different psychiatrists can approach the same patient differently. As long as the differing approach is reasonable and one that at least some minority (usually at least five percent or more) of other reasonable practicing psychiatrists use in their practice, the approach could be considered to fall within the standard of care [3].

For example, the decision to use bupropion (a norepinephrine-dopamine reuptake inhibitor) over fluoxetine (a selective serotonin reuptake inhibitor) as the initial choice of medication treatment for depression would constitute an ordinary difference that falls within the spectrum of common psychiatric practice. However, the decision to place a patient on bupropion as a first-line agent for the treatment of depression would be negligent if it were known that this patient has a severe eating disorder with a history of purging and seizures, as bupropion is known to lower the seizure threshold. Without knowledge of the relevant history, the decision to choose bupropion over fluoxetine would seem innocuous. However, it would still be negligent.

Despite accepted differences within the field, psychiatrists can and do make mistakes. In the above example, the psychiatrist may have made what he considered to be a reasoned decision about the treatment of a patient, but by failing to obtain all of the relevant information necessary to make an informed decision, an "error of fact" has occurred. Without adequate information, the psychiatrist is acting blind and the ultimate judgment is flawed. For this reason, errors of fact may be considered negligent conduct and result in liability for the physician [6].

Errors can also occur when doctors make well-informed decisions that turn out to be wrong, with a good faith belief that the intervention will be helpful to the patient. This is called an error of judgment. In contrast to errors of fact, errors of judgment are less likely to result in liability for the physician [6]. Both errors of fact and judgment can be due to acts of commission (due to taking action) or omission (failing to take action).

Case law, as seen in *Thompson* and other cases, illustrates that expert witness testimony is required to establish deviation from the standard of care [1, 7]. Physicians are held to the standard of their average peer, not that of the exceptional provider who follows the latest, most up-to-date and not yet widely disseminated or practiced evidence-based treatments. As in *Thompson*, courts have held that jurors do not possess the specialized knowledge needed to establish deviation from the standard of care, as by definition the medical standard of care requires specialized medical knowledge that an average lay juror is unlikely to possess [1].

One exception to the requirement for expert witness testimony is the doctrine of *Res Ipsa Loquitur*, translated as "the thing speaks for itself" [2]. There are occasionally malpractice cases where the facts are particularly egregious. While most lay people would acknowledge that they lack the expertise to form an education opinion about the best surgical approach to the repair of a leaking ventricular shunt, even someone who knows nothing about medicine would be able to find fault with a surgeon who leaves a piece of surgical equipment inside the abdomen of their patient. This example illustrates several of the elements required for *Res Ipsa Loquitur*. The harm suffered by this patient would be unlikely to have occurred but for the actions of the doctor. Forgetting to remove the tool from the abdomen was a mistake made by the physician and not influenced by the patient, who could do nothing to prevent it. Additionally, because the patient was under anesthesia, the physician carries special knowledge of the harm that occurred. For these reasons, in cases of *Res Ipsa Loquitur*, the burden shifts to the defendant (i.e., the physician) to prove that the harm *did not* occur. Fortunately, such *Res Ipsa* cases are rare in psychiatry [3].

Damages

Patients suffer adverse effects as a result of everyday medical decision-making. For a malpractice claim to be successful, the plaintiff must prove harm (physical or emotional). What separates the harm that is the basis for malpractice suits from the bad outcomes that are a risk of all medical interventions is the relationship of the harm to negligent medical care. If the patient suffers harm, but no negligence is demonstrated, the malpractice claim is unlikely to be successful. Common claims of negligence in psychiatry include failure to treat, failure to diagnose, failure to hospitalize, and failure to warn. In each of these examples, the physician has a responsibility to act to the standard of care within his or her scope of practice. A prudent psychiatrist who practices at or above the level of the average psychiatrist is not likely to be found liable if his or her patient suffers harm.

Imagine, for example, a patient with a history of depression but no prior suicide attempts who presents to a follow-up medication management appointment with her outpatient psychiatrist. At the visit, the patient endorsed no symptoms of depression or suicidal thoughts of any kind and demonstrated objective evidence of clinical response to the treatment, and there were no obvious acute modifiable risk factors for suicide. In this situation, in a vacuum, most psychiatrists would consider it reasonable to keep that patient on her current medication and to continue treating her in the community. This same patient may go on to attempt or complete suicide,

despite the above presentation. Retrospectively, claims can be made of negligence on the basis of failure to treat or to hospitalize. However, if a psychiatrist can demonstrate through their documentation that he or she reasonably followed the standard of care and acted responsibly in light of the duties owed to the patient, the malpractice suit will have weak legs to stand on.

When an injured party wins a malpractice suit, the financial damages can be either compensatory or punitive. Compensatory damages provide the injured party financial reimbursement for elements directly related to the harm suffered, which may include lost wages, loss of earning capacity, past and future medical expenses, physical or mental pain and suffering, reduced quality of life, and permanent disability. Punitive damages are what they sound like—a punishment for the defendant because of particularly egregious, careless, or malicious behavior. Compensatory damages are the usual type of damages awarded in malpractice cases. However, occasionally situations arise in which the conduct of the defendant is viewed as warranting the additional punitive damages, such as with a sexual misconduct malpractice claim against a psychiatrist.

Causation

The fourth required element for successful malpractice claims relates to proximate causation. Psychiatrists who deviate from the standard of care and whose patients suffer harm are not necessarily liable if there is no relationship between the deviation from the usual care and the harm suffered. That is, there must be a causal relationship between the negligence and the harm. When a compelling argument can be made that the harm is related to the action of the physician, a successful malpractice claim nevertheless requires the causation to be proximate. It is not sufficient that the physician's action played *some role* or that it *possibly* contributed to the harm. Proximate causation requires a "but for" relationship in that the harm would not have occurred *but for* the action of the physician (i.e., the harm wouldn't have happened had the physician acted differently).

In addition, malpractice cases often hinge on the concept of foreseeability as it applies to proximate causation. Foreseeability can be defined as "the reasonable anticipation that harm or injury is likely to result from certain acts or omissions." [8] Case law, as in *Thompson*, has established that the intervening event must be a *substantial* factor in bringing about the injury. *Thompson* illustrates how courts may look at adjudicating the actions of a physician. The mere *possibility* of harm is insufficient; a *substantial probability* is required for a finding of negligence [1].

Common Claims of Malpractice in Psychiatry

Recently published literature suggests that psychiatrists face a yearly risk of malpractice suits of 2.6% [9]. Although this is less frequent than other medical specialties, psychiatrists are unfortunately more likely to face state board discipline than other specialists [10]. In addition, when psychiatrists do face civil action, the mean defense costs of both paid and unpaid malpractice claims are higher than nearly

every other medical specialty [11]. The published literature suggests that psychiatric malpractice claims are more common with male-gendered psychiatrists and are less common when the psychiatrist holds board certification [12].

Psychiatrists may be found liable for any number of reasons. As the case described in this chapter illustrates, malpractice suits are often multilayered and involve assertion of multiple, interrelated claims of negligence; it is rare for a suit to contain just a single allegation [2]. As of 2009, the most common claims that result in a finding of liability against a psychiatrist are incorrect treatment, suicide, drug reaction, and incorrect diagnosis [3]. However, only 10% or so of cases get to trial [2]. The following are brief examples or important points to remember about some of the more common types of psychiatric malpractice cases.

Suicide Malpractice

Viewed retrospectively by plaintiffs who have lost a loved one, suicide can be seen as something that should have been predictable. However, the "I should have seen it coming" does not reflect the currently published literature in psychiatry with regard to suicide risk. With well-informed risk assessments that take into account both known risk factors and the specific patient being evaluated, a risk of suicide, but *not the act itself*, can be reasonably predicted [13].

Given that the act of suicide is inherently difficult to predict, the foreseeability of the actual act of suicide is less germane than the foreseeability of the *risk of suicide*. Psychiatrists are expected to consider the static risk factors (factors that do not change), such as previous suicide attempts, male sex, older age, and family history of suicide, as well as dynamic risk factors (factors that can change) and other modifiable clinical variables that may converge in an individual case to convey a risk of suicide [14]. Examples of dynamic variables include insomnia, anxiety, depression, psychosis, substance use, impaired attention, and access to firearms. Once the psychiatrist has made a determination that there is a foreseeable risk that a patient could be in an acute suicidal crisis, the psychiatrist must take precautionary steps. The focus is on reasonable assessment and mitigation of suicide risk.

One issue that complicates suicide malpractice is the issue of proximate causation. Because the ultimate act of suicide, by definition, requires that the patient take his or her own life, the claim that the suicide occurred proximately *because of* the actions of the psychiatrist, would on its face seem to make malpractice impossible. However, there is an assumption that suicidal individuals lack an ability to appreciate the impact of their behaviors. Thus, despite the patient engaging in the suicidal behavior, psychiatrists may nevertheless be held liable for contributory negligence, which is defined as negligence in which the party harmed played some role in the harm suffered.

Medication Malpractice

Two of the more common types of psychiatric malpractice are claims of negligence for failure to diagnose and failure to treat. In both of these cases, malpractice claims may be challenging on account of the fact that two reasonably prudent practitioners may differ in their selection of drug to treat a given condition. However, liability

may be found if the psychiatrist should have diagnosed a condition that would have altered the rational selection of one drug over another, but failed to do so.

Take, for example, a patient with a history of manic episodes who is placed on a stimulant medication for the treatment of poor focus, distractibility, and increased energy. Although stimulant medications are a common and rational approach for the treatment of attention-deficit/hyperactivity disorder, the failure to obtain the relevant history of manic episodes could result in a finding of liability if the patient goes on to become manic and suffers harm as a consequence. Similarly, medical consequences of prescription drug use, as well as issues related to informed consent, are important areas of risk for treating psychiatrists.

Sexual Misconduct Malpractice

It may be surprising that in one study, 5–10% of therapists admitted to sexual activity with their patients [2]. Mental health professionals are in positions of power over their patients, who often seek out treatment in moments of vulnerability. It goes without saying that sexual contact with patients violates every published ethics guideline by every organizing body and association in medicine and mental health. Because of the intentional nature of the conduct, which is perceived to be wanton and exploitative, punitive damages can be awarded, in addition to the compensatory damages of unintentional tort cases. In addition to civil action, sexual misconduct is a primary reason for disciplinary action by state medical boards and can result in criminal charges in some states.

Suicide, medication, and sexual misconduct represent just three of the many possible reasons that a psychiatrist could face a malpractice suit. A comprehensive review of the different types of psychiatric malpractice and a complete discussion of each is beyond the scope of this chapter, so psychiatrists involved in malpractice cases may want to consider reviewing the relevant case law and statutory language in their jurisdiction.

Malpractice Defense

A psychiatrist's best defense against malpractice is to practice good psychiatry and to strive for excellent care. By staying on top of the latest published literature and being aware of published ethics and practice guidelines, psychiatrists can reduce the risk that they are falling below the standard of care. Physicians should remember that prudent care of patients includes a treatment approach favored by a respectable minority of similar providers. When in doubt about how to proceed in a clinical scenario, consider supervision and/or consultation with a colleague. If the case is ambiguous or if malpractice concerns are present, you should also consider speaking with legal counsel.

An adage exists that "if it isn't documented, it didn't occur." While this is an oversimplification, physicians who take documentation seriously and not only reflect the diagnosis and treatment, but the *rationale* for how they arrived at their decisions, will be better protected should a malpractice claim be brought against

them. The constraint of daily clinical practice places real-life limitations on documentation. Nevertheless, some documentation is better than none, and well-thought-out and reasoned documentation is even better yet.

Should a malpractice claim be brought, testimony at deposition may be required (testimony provided by a witness outside of court for the purposes of establishing what will be presented if the case goes to trial). If a deposition is required, it is imperative to prepare beforehand, both individually, as well as with the defense attorney. Psychiatrists should review the DSM criteria for the relevant diagnoses, as well as be prepared to describe the diagnoses and treatments to a lay audience without use of scientific jargon. Memorizing key dates, clinical thinking, and interventions in the time leading up to the adverse outcome is particularly important. Ultimately, the ability to demonstrate reasoned thinking behind the clinical decision-making, as well as consideration of foreseeable harm and steps taken to prevent it, will go a long way toward the success or failure of the malpractice claim. It is impossible to be over-prepared for a deposition.

Considerations for the Forensic Expert Witness

There is case law requiring expert witnesses testifying to the conduct of a physician to be from the same specialty of medicine as the physician being sued [15]. Expert witnesses practicing in different fields of medicine are unlikely to be allowed to opine about the standard of care in a different field [16].

In court, to encourage testimony, there is a witness immunity doctrine that prohibits lawsuits against witnesses based on testimony given in court. Even when an opinion is reached negligently, the immunity holds. This does not protect against criminal liability from perjury. However, although far less common than claims against clinical psychiatrists, forensic psychiatrists are not immune from claims of malpractice. Examples of claims that may be brought include defamation, invasion of privacy, breach of contract, failure to deliver a timely report, and failure to properly diagnose. As with clinical medicine, practicing above the standard of care applies.

Conclusions

There are many different varieties of psychiatric malpractice and most suits involve multiple simultaneous claims. Liability against the psychiatrist may be found when there is negligent dereliction of a duty owed to the patient, directly resulting in harm. Psychiatrists wishing to minimize the risk of malpractice will strive to practice not just to the level of the ordinary practitioner, but instead to that of the exceptional provider. Rational, evidenced-based, and informed psychiatry that is clearly thought-out and articulated in the documentation will go a long way toward reducing malpractice risk.

Take-Home PEARLS

- Review all relevant history and labs.
- Base clinical decision-making on rational diagnosis and treatment.
- Strive to achieve the level of an exceptional provider.
- Document clearly with justification for clinical interventions and sdecision-making.

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Suicide Risk Assessment

11

Ish P. Bhalla and Kevin V. Trueblood

Case Vignette

You are working as a hospital psychiatrist when you get a consult from the emergency department at 9:30 pm about a patient that presented for suicidal statements. The verbal sign-out from the emergency medicine doctor was that the patient is a 42-year-old man who presented as clinically intoxicated at 12 pm with a Breathalyzer of 0.16. He was cleared medically, and psychiatry was consulted for a suicide safety assessment before discharging him back to his home.

After coming down to the emergency department, you open the chart and discover that the patient was brought to the hospital by law enforcement with documentation stating that the patient was "making suicidal statements to his wife by phone. The wife called 911 concerned for his safety."

You read the electronic chart on the patient and learn that the patient has had a history of a prior suicide attempt 6 years ago. At that time, he overdosed on his prescribed antidepressants after losing his job and was hospitalized on a medical ward for 2 days of observation. After medical clearance, he was hospitalized for 2 weeks on an inpatient psychiatric unit and was then discharged home with outpatient psychiatric follow-up. He currently is prescribed sertraline 50 mg daily and aripiprazole 5 mg daily.

On exam, the patient explains that he recently discovered that he may lose his house because of missed mortgage payments and has chronic back pain from a herniated disk. He states that 3 weeks ago he started drinking four beers daily to help with his back pain, and while it helps somewhat, he still can't exercise as much as he used to. He plans to see his primary care doctor next week to evaluate the pain. He said that he does not take any other drugs. The patient says that he has been going to psychotherapy weekly for the past several months and was prescribed the

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aripiprazole last week as an adjunct to the sertraline for worsening depressive symptoms. He denies owning or having access to firearms. He requests to go home so he can continue looking for a new job to pay his mortgage payments. He states "I don't want to kill myself—I just said that because I was drunk."

You call the patient's ex-wife. She reports that she has had a limited relationship with the patient since their divorce 2 years ago, but he called her today while intoxicated and said that if he can't be with her, he may as well take all of his pills and die. She immediately hung up and called the police. She says she is worried about the patient because he has been having a difficult time with the divorce and seems depressed. He has mentioned to her thoughts of committing suicide recently, and based on her years of knowing him, she is worried that he might act on these thoughts. The patient is unable to identify any friends or family members that could provide additional collateral.

Pertinent data from the mental status exam includes soft speech, constricted affect, organized thoughts, a denial of auditory, and visual hallucinations without evidence of responding to internal stimuli.

Case Analysis and Example Risk Assessment

The above vignette describes a typical patient in the psychiatric emergency setting. A suicide risk assessment should be performed as a component of any psychiatric evaluation, though it is particularly important for this case since it was the reason psychiatry was consulted. Below is an example of the type of risk assessment documentation one would want to complete for such a case.

Risk Factors

Static risk factors in this case include divorced marital status, male sex, history of a suicide attempt, previous psychiatric inpatient hospitalization, and chronic back pain resulting in functional impairment.

Dynamic risk factors include recent suicidal thoughts with plan, current alcohol use, unemployment, financial problems, possibly losing his housing, current symptoms of depression, and poor social support.

Protective Factors

No known access to firearms, involved in weekly psychotherapy, has children.

Suicide Risk Categorization: High

Based on this case presentation and suicide risk assessment, the patient is currently at high risk for suicide and should be admitted to the inpatient psychiatric ward for safety and stabilization. Although he has several protective factors listed above, there are also many worrisome risk factors that support a high-risk classification in addition to components of his presentation. First, he was brought to the hospital involuntarily after making a suicidal statement with a plan to overdose on

his medication. Further, the patient is dealing with current financial stressors that are similar to the circumstances which preceded his previous suicide attempt. While the patient has no known access to firearms, he has the means to carry out the potentially lethal plan he described to his ex-wife by phone. Another impairing stressor is his back pain leading to functional impairment and inability to exercise, which might have been a positive coping mechanism for him during times of stress.

Introduction

Suicide risk assessment can be quite an anxiety-provoking task for any psychiatrist. When a patient commits suicide, in addition to the sense of loss and perceived failure of psychiatric treatment, the mental health provider is often wary of lawsuits for medical malpractice or negligence in preventing suicide. Despite suicide being exceedingly rare with an annual prevalence of about 13 per 100,000 people or 113 suicides per day [1], suicide is the most common reason psychiatrists get sued and results in the highest number of malpractice claims [2]. In malpractice litigation, a well-documented suicide risk assessment will often mitigate a psychiatrist's risk of being found liable for medical malpractice (for more information on malpractice, please refer to the Malpractice chapter in this text).

The goal of suicide risk assessment is not to "predict" suicide per se, but rather to perform a thorough, systematic evaluation of the available data to determine the current level of risk. This is an important distinction, as several studies have shown how poor psychiatrists are at predicting behavior [3]. Since suicide is a rare event with a low base rate, studies that investigate suicide are often quite limited and usually retrospective in nature, further limiting psychiatrist's ability to use this information to predict who will commit suicide. Still, there is an expectation that a psychiatrist will take reasonable steps to gather data and conduct an informed risk assessment as a part of any psychiatric evaluation and use this risk assessment to inform and guide management of the patient.

While the potential consequences of underestimating suicide risk are fairly obvious (that the patient may attempt or complete suicide if not given the appropriate level of care), it is important to also be cognizant of the potential detriments of overestimating suicide risk and unnecessarily hospitalizing a patient, especially on an involuntary basis. These can include a disruption of the patient's life (e.g., consequences from missed work), misallocation of economic and hospital resources, weakened therapeutic alliance, and possibly propagating a dependent and potentially counter-therapeutic relationship between the patient and the healthcare system.

This chapter is meant to outline the components of a suicide risk assessment, discuss the impact of various settings on risk assessment and the role of formal risk assessment instruments, and provide recommendations on documentation of a suicide risk assessment.

Psychiatric Evaluation

A thorough suicide risk assessment is a critical component of a comprehensive psychiatric evaluation and involves gathering information from the patient in an interview, performing a chart review, and contacting people that may have additional information, also known as collateral sources. One of the goals of such an evaluation, and the main objective of this chapter, is to conduct a suicide risk assessment which helps to triage the patient to an appropriate level of care. Here the primary decision at hand is whether there is enough of an emergent crisis to require hospitalizing the patient on a voluntary or involuntary basis. As part of this assessment, the psychiatrist should carefully weigh risk and protective factors gathered from the evaluation. Other goals of the initial psychiatric evaluation are to formulate preliminary diagnoses and to create an initial treatment plan. Of note, suicide prevention or no-harm contracts cannot take the place of a suicide risk assessment [4].

When performing a psychiatric interview in any setting, a psychiatrist should maintain a nonjudgmental approach. If the psychiatrist feels that there is a substantial risk for suicide based on clinical data gathered in the interview, if at all possible, he or she should try to incorporate questions about suicidal thoughts naturally in the interview. Questions should start broad and then become more focused based on the specific answers provided by the patient. For example, an initial question might be "I understand that you have been feeling depressed lately. Has it ever gotten so bad that you have thought about hurting yourself?" Depending on the answers to such questions and the other risk factors listed below, the provider can then ask about passive suicidal thoughts with questions such as "Do you ever think it would be better if you were not living anymore?" Importantly, a psychiatrist should pay attention to facial expressions when asking about suicide, rather than taking notes, as you may miss important clinical data about the patient's affective state and level of risk [5].

According to the American Psychiatric Association Practice Guidelines [6], characteristics that a psychiatrist should consider during a suicide risk assessment which may increase or decrease risk include current presentation of suicidality, psychiatric disorders, personal and family history of suicide attempts, psychosocial factors, and psychological strengths and vulnerabilities. In this chapter, we organize these characteristics a bit differently in order to provide a framework for clinical assessment. Assessment of suicide risk is a clinical decision and should be considered on a case-by-case basis, though epidemiological studies have identified a set of characteristics that can increase or decrease a patient's perceived level of suicide risk. As part of a suicide risk assessment, a psychiatrist should carefully appraise these risk and protective factors as part of a systematic framework for understanding and assessing suicide risk.

Risk Factors

Risk factors for suicide are known factors that may increase the likelihood of suicide and are divided into static and dynamic categories. Empirical epidemiological studies on suicide factors often use an index called the standardized mortality ratio

Table 11.1 Risk factors for suicide

Suicide risk factors	
Static	*Dynamic*
History of suicidality	Current suicidality
Sociodemographic	Suicidal thoughts
Male	Presence of a plan
White race	Intent
Age > 65 or teens	Substance use
Rural residence	Current psychiatric symptoms
LGBT	Hopelessness
Psychiatric history	Insomnia
Affective disorders	Anxiety
Psychotic disorders	Poor coping skills
Eating disorders	Psychosocial
Personality disorders	Unemployment
History of hospitalizations	Homelessness
Medical comorbidities	Lack of social support
Life-threatening	Access to care
Functional impairments	Access to lethal means
Pain	Firearms
Family history of suicide	Prescription medication

(SMR). The SMR is a measure of the relative risk of a particular risk factor after matching for age and sex. A comprehensive literature review of suicide risk factors is beyond the scope of this chapter, though some main considerations are discussed below. Table 11.1 lists static and dynamic risk factors for suicide.

Static Risk Factors

Static, or chronic, risk factors for suicide are defined as various sociodemographic and diagnostic elements that generally do not or cannot be easily changed over time or by intervention. These factors mostly involve historical data. It is important to make this distinction for treatment planning purposes, as static factors are not a potential target for treatment.

- *History of Suicidality*. Perhaps one of the most robust predictors of suicide is a history of a suicide attempt [7]. However, this relationship is more complex, as it has been found that up to two-thirds of completed suicides were on the first attempt [8]. It has been estimated that for every completed suicide, a patient attempts 10–20 times [9]. Still, patients with a history of suicide attempts or other types of impulsivity [10] should be considered at elevated risk for suicide. When assessing for a past history of suicide attempts, it is important to ascertain the motivations and intentions of the attempt in addition to the means of the attempt and intoxication status. More lethal motivations and means should be considered a higher risk factor.

- *Sociodemographics*. There are many confounding variables that influence the association between various sociodemographic characteristics and rates of suicide. Nonetheless, these static factors are generally considered to elevate suicide risk: male gender (have higher completed suicides but fewer attempts than females [11]), lesbian/gay/bisexual/transgender (LGBT) orientation, those living in rural or isolated areas [12], white race [13], age greater than 65 or 10–24 years old [1], and single marital status (including widowed or divorced).
- *Psychiatric History*. While suicide is often thought of as an impulsive action, a vast majority of patients who commit suicide had a diagnosable psychiatric disorder. A history of certain psychiatric disorders is particularly associated with suicide including depression, anxiety, bipolar disorder, anorexia nervosa, and schizophrenia [14]. Having a history of hospitalization for a psychiatric disorder has also been found to be a risk factor [15]. Patients with personality disorders, especially borderline personality disorder, are at an increased risk for suicidal and self-injurious behaviors.
- *Medical Comorbidities*. Individuals with a history of medical diagnoses are at an elevated risk of suicide, particularly those recently diagnosed with serious medical conditions with poor prognosis such as cancer [16]. Medical conditions leading to functional impairment such as severe pain are also risk factors for suicide [17]. Other types of acute stress can also be associated with suicide, likely with a similar mechanism as a serious medical diagnosis [18].
- *Family History of Suicide*. A genetic link for suicide has been proposed [19]. Studies have found that those whose relatives have committed suicide [20, 21], have psychiatric diagnoses [22], or are impulsive as a personality trait [21] are at an increased risk for suicide themselves.

Dynamic Risk Factors

Dynamic, or modifiable, risk factors are defined as elements that have the potential to change over time and may be susceptible to psychosocial treatment. These factors deal with current symptoms. Since these risk factors change, they should be addressed on an ongoing basis.

- *Current Suicidality*. An obvious dynamic suicide risk factor is when a patient reveals to the clinician that he or she is thinking about suicide; this self-disclosure has been found to be a risk factor for suicide [23]. The presence of a lethal suicide plan has been particularly linked to increased suicide risk. However, feigning thoughts about suicide is also an easy and common method for malingering. When evaluating a patient who states that he or she is feeling like hurting or killing themselves, the psychiatrist should also consider potential secondary gains.
- *Substance Use*. Alcohol and other drugs have been found to be a risk factor for suicide [24]. This includes current intoxication as well as diagnosed substance use disorders. One theory is that increased substance use can be a signal of worsening psychiatric symptoms. Another is that substances, particularly alcohol, can

lead to disinhibition, poor decision-making, and impulsivity, putting the patient at an increased risk for suicide.

- *Current Psychiatric Symptoms*. In addition to the current suicidal intent mentioned above, there are specific psychiatric symptoms that have been associated with suicide. Hopelessness and a patient's inability to list reasons for living are traits that are especially worrisome [25]. Shame, low self-esteem, impulsivity, aggression, psychological turmoil, and severe or unremitting anxiety are among other factors that are associated with suicide.
- *Psychosocial Circumstances*. Living and working situations are important to consider, especially a recent or abrupt change in status. Risk factors include unemployment, homelessness, and lack of social support including a poor relationship with family [26]. In addition, it has been found that a recent discharge from an inpatient psychiatric hospitalization is a strong risk factor for suicide [27].
- *Access to Means*. With the understanding that suicide is mostly considered an impulsive act, ready access to lethal means is a risk factor for suicide. Firearms in particular have been regarded as the weapon with the highest association with suicide risk [28]. Other dangerous and common means include overdosing on prescription medication.

Protective Factors

Equally important in suicide risk assessment is to consider protective factors or data that lessens the perceived risk for suicide. For several of the above risk factors for suicide, the absence of a risk factor is thought to be a protective factor. However, this is not always the case. For instance, a denial of suicide ideation should not be considered a protective factor because while patients with suicidal ideation are at a higher risk for suicide, available empirical data does not support the lack of suicidal ideation as a protective factor. One study found that in patients who had seen their psychiatrists on the day of their eventual suicide, suicidal intent was reported in only 22% of cases [29]. Another study found that 78% of patients who later suicided on an inpatient ward were documented to have denied suicidal ideation immediately prior to death [30]. Some patients may deny suicidal thoughts to mental health providers after they have already decided to commit suicide to prevent clinical intervention. Table 11.2 lists protective factors against suicide.

Table 11.2 Protective factors for suicide

Protective factors
Social supports
Religious or cultural beliefs opposing suicide
Reasons for living
Ability to cite these reasons
Dependent children
Pregnancy
Psychological state
Future orientation
Positive coping skills

- *Social Support*. The perceived presence and availability of a person's social network including family can be a protective factor. Patients can often utilize this support network in times of crisis before attempting suicide. There is also the sense of responsibility toward social contacts that can deter such behavior.
- *Religious Beliefs Opposing Suicide*. Religious beliefs are generally considered a protective factor for suicide. Many religions believe that suicide is morally wrong with consequences in the afterlife, thus deterring a suicidal patient from attempting or committing suicide. In addition, religion usually offers social support in the form of pastors or other religious leaders and a sense of community among others of the same faith. However, there are some religions and cultures that do not view suicide with the same moral objection and can even honor suicide; thus religion in and of itself is not necessarily a protective factor.
- *Reasons for Living*. Patients who are able to cite subjective reasons for living are considered to be at lower risk for suicide. Also, those who have children, particularly dependent children at home, are less likely to commit suicide. This phenomenon has been found more in women, though there is some evidence to support a similar relationship in men. Pregnancy is also a protective factor.
- *Psychological State*. Patients who have positive and reasonable nonviolent future plans, so-called "future-orientation," are at a lower risk for suicide [31]. Positive coping skills in the setting of stressful life events are also a protective factor.

Setting

Emergency Department

Suicidality is a common reason for presentation to the emergency setting. Patients in crisis can be referred by family or friends, brought in by police, or self-present to the hospital. The method of presentation is useful data when assessing risk. It is thought that patients who self-present are themselves seeking treatment and have insight into their illness, therefore lowering their risk for suicide.

Patients in the emergency setting should be screened for drug use by a urine toxicity test and for alcohol by a Breathalyzer, as patients are not always open about their substance use. A comprehensive suicide assessment may not be possible or advisable when a patient is acutely intoxicated from alcohol or another substance. For example, the patient may not be sober enough to answer questions, or immediate medical intervention may be the priority, depending on the severity of intoxication. If the patient makes statements about suicide, however, it may be necessary to increase supervision while in the emergency room. A formal psychiatric evaluation can begin after a period of sobriety.

Collateral information is especially important in the emergency setting, as patients may not be forthcoming regarding suicidality. Data from an outside

source is useful to corroborate a patient's story or may also call into question information provided by the patient, who may be exaggerating or minimizing symptoms.

Inpatient Setting

Suicidal emergencies are often a reason that patients are admitted to inpatient psychiatric wards, and suicide risk assessments in this setting should be conducted often. In addition to daily assessments, the inpatient treatment team should conduct suicide risk assessments upon admission, after periods where the patient's clinical condition has changed and when the patient has new psychological stressors. Risk and protective factors during inpatient hospitalization are generally the same as other settings, though severe anxiety is one additional factor associated with an acute risk in the inpatient setting. Inpatient suicides have not been found to be associated with any particular admission diagnoses [30].

Suicides on inpatient psychiatric wards are relatively rare and, when they do occur, are considered a sentinel event (a reportable and unanticipated adverse event not related to the natural course of illness). That being said, inpatient suicide accounts for 16.3% of sentinel events reported to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) [32].

Outpatient Setting

Psychiatrists often complete formal suicide risk assessments early in the course of outpatient treatment but can easily forgo this process in subsequent appointments especially when the patient was considered low risk from the beginning. Like other psychiatric symptoms, suicide risk can wax and wane, and assessment should be conducted not only at treatment onset but also during periods of clinical status change including an increase in psychosocial stressors and loss of social support. A positive therapeutic alliance can be a protective factor in the outpatient setting. When suspecting an increase in suicide risk, the provider should consider performing a formal risk assessment including contacting collateral sources and consider sending a patient to the emergency department for safety.

Correctional Settings

Psychiatrists are often asked to evaluate the suicidality of inmates transported from correctional settings to the emergency room or as part of a team working with the correctional facility itself. People in jails commit suicide at a rate more than ten

times that of the general population [33]. Further, suicide is the most common cause of death in jails, accounting for a third of deaths in 2013 and is a leading cause of death in state prisons [34]. This trend is likely associated with psychosocial dysfunction of inmates, lack of sufficient mental healthcare, a sense of hopelessness, and the psychological stress of being incarcerated. Studies have found that 63% of people who suicide in jail did so on their first day [33]; therefore, recently incarcerated inmates should be considered at higher risk for suicide. Other specific factors that may increase the risk of suicide while incarcerated include young age and male sex.

Approaches to Suicide Risk Assessment

Clinical vs. Actuarial Methods The clinical approach to suicide risk assessment values the provider's judgment during the evaluation. This method takes into account the psychiatrist's general impression and feelings after sitting with the patient but is considered subjective and not based on evidence. That being said, there is some data to support the patient's subjective degree of psychological pain as a clinically useful indicator of current suicidality [35]. Traditionally in the field of forensic psychiatry, psychiatrists have used actuarial methods to assign risk to patients based on particular patient characteristics. There is practical value in this approach because it allows an evaluator to assign a percent risk that a subject with similar characteristics will commit suicide in a specified amount of time, which can help to determine risk for longer-term placements. However, this approach does not have much clinical value, as the factors provide limited information about the imminence of such acts.

Structured Professional Judgment Bouch and Marshall proposed a novel approach to risk assessment that combines the clinical and actuarial methods [36], which allows a clinician to use evidence gathered from an interview to evaluate risk in a transparent and structured way. This method is called structured professional judgment. The advantage of this approach is that it provides both imminent and long-term risk for disposition planning and can help inform decisions about monitoring plans for patients. Using this approach, psychiatrists should take into account various risk and protective factors when assessing suicide risk as part of the evaluation. A higher number of risk factors are thought to increase risk in synergistic fashion, meaning that two risk factors together are considered more dangerous than each in isolation [6].

The Limited Role of Suicide Risk Instruments There have been many suicide risk assessment tools developed for research purposes and to assist in clinical decision-making. These instruments should not be substituted for clinical reasoning, though it can be used for adjunctive purposes or as a screening tool in

Table 11.3 Selected suicide risk assessment instruments

Risk assessment instruments
Modified SAD PERSONS scale
Beck depression inventory
Beck anxiety inventory
Beck hopelessness scale
Beck scale for suicidal ideation
High-risk construct scale

both psychiatric and nonpsychiatric settings [37]. In fact, one study assessed the sensitivity and specificity of such a tool as a screening test for inpatient admission [38]. Table 11.3 lists some of the suicide risk assessment instruments which have been found to correlate with the decision to admit a patient to the psychiatric ward. Like other useful screening tests, these instruments had high sensitivity but often low specificity.

Documentation and Legal Considerations

A thoroughly documented suicide risk assessment is not only meant to prevent malpractice litigation but also to improve the quality of patient care. Including suicide risk assessment as part of clinical documentation is particularly important when a patient's care is to be transferred to another provider. It can also be a useful tool for a psychiatrist in any setting to organize a large amount of data and think critically about whether he or she has completely evaluated the patient's risk and made an appropriate disposition recommendation commensurate with the degree of risk posed.

The standard of care for a psychiatrist when making a suicide risk assessment is beyond the scope of this chapter [39]. Malpractice has been discussed earlier in this book, and documentation is critical in court when a psychiatrist is sued for malpractice. Documenting a suicide risk assessment is clearly important in cases when a patient later attempts or commits suicide and also when the patient is admitted to the hospital, especially on an involuntary basis. Courts may interpret the lack of any suicide risk assessment documentation as a failure to complete the risk assessment at all. Documentation should be completed as soon as possible after the evaluation and should generally allow the reader to understand the psychiatrist's thought process and rationale for decision-making, which may include considering the risks and benefits of a higher level of care. Suicide risk assessment is a nuanced and complex process, and one's documentation should reflect this complexity.

The documented level of risk should match the clinical decision. For example, a patient found to be at high risk for suicide should not be discharged from the emergency room. On the other hand, a patient who is at low risk should not be involuntarily admitted to an inpatient psychiatric unit on 1:1 observation status.

Conclusion

Patient suicide is a serious clinical concern and is a common reason for lawsuits against psychiatrists (though the absolute number of lawsuits against psychiatrists is low compared to other medical specialties). An integral part of a psychiatric evaluation is a suicide risk assessment. Suicide risk assessments should be completed and documented in a timely fashion after evaluating a patient. Factors associated with suicide risk are categorized as static or dynamic. In determining a patient's level of risk, these risk factors should be weighed against protective factors, as well as other components of the psychiatric evaluation which influence risk, such as setting and clinical context. After assessing a patient's overall level of risk, a risk management plan should be implemented in which treatment decisions are based on mitigating dynamic risk factors and making use of available protective factors.

- As part of a psychiatric evaluation, a suicide risk assessment should be completed and documented after each clinical encounter.
- Risk factors are empirically tested characteristics that are associated with suicide and should be carefully weighed against protective factors when determining the level of risk.
- The category of assigned risk (low, moderate, or high risk) should match the level of care recommendation (inpatient psychiatry with or without 1:1 observation, outpatient follow-up).
- The setting in which the evaluation was conducted plays an important part in the determination of risk.
- Suicide risk assessment scales can sometimes be an adjunct to a psychiatric evaluation but should not be used as a stand-alone risk assessment measure to guide a clinical decision.
- Legally, a psychiatrist is not expected to "predict" suicide or other self-injurious behavior but is expected to have documented evidence of having carefully considered risk and protective factors before making a decision on disposition.

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Violence Risk Assessment

12

Alexander Westphal

Clinical Vignette

You are a psychiatrist on an inpatient unit at a state mental hospital. A middle-aged man with schizophrenia has been held at the hospital for over a decade after being found not guilty by reason of insanity for the murder of a police officer. He is being considered for a reduction in oversight, an "increase in his privilege level," so that he can walk unaccompanied from his unit to group and individual therapy sessions, a 5-min walk. The hospital campus is not contained, so theoretically he would have the opportunity to leave the campus during this walk. He would be required to call the unit upon reaching the therapist's office. With this arrangement if he did leave without permission, the hospital should be aware of the situation in less than 10 min.

The patient is currently restricted to the unit, unless accompanied by staff. There are several concerns with reducing his oversight. First, he has a history of extensive violence beyond the index offense, including numerous assaults directed against hospital staff. However, he has not been violent in over a year. Second, during individual therapy, he has described fantasies of shooting his wife, a woman who was previously a patient at the hospital but has now been discharged and is living in a nearby community.

He denies any intention of acting on these fantasies. The psychologist to whom he disclosed the fantasies, while alarmed by what the patient described, points out that he has never been violent with women and that his pattern of violence is explosive and oppositional and, in the past, has arisen only during interactions with authority figures or during the commission of another crime. As far as anyone knows, he has never planned a violent act. She also emphasizes that he identifies the thoughts as fantasies rather than a plan.

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You conduct a mental status examination as part of your assessment. The exam is unremarkable other than for mild irritability, evident in curt, dismissive answers to several of your questions. He has no signs or symptoms of active psychosis. He categorically denies any intention of harming anyone, even while he acknowledges the fantasies described by the psychologist. He says that the reason he brought them up to the psychologist was because they bother him and wanted help getting rid of them and points out that if he were planning to act on them, he would not have told anyone about them. He feels that it is unfair that they are being considered as a factor in the decision whether to reduce his level of oversight. He says that he just wants to get back to his normal life and has spent enough time in the hospital.

Would you support this relaxing of oversight? If so, assuming no setbacks, how rapidly would you allow the patient to progress to longer periods without supervision? Should the patient be allowed to visit his wife? And should his wife be warned about the fantasies?

History of the Real Case and Its Significance

On December 7, 1979, Dwayne White, a patient confined to St. Elizabeth's Hospital in Washington DC, left the grounds and stabbed his wife, Genoa White, more than fifty times with a pair of scissors [1]. At the time of the attack, Dwayne White had "grounds privileges" which required that he stays on the hospital campus but only required that he checks in to the unit twice a day at 9 AM and 9 PM and permitting him to go anywhere on the hospital premises between 9 AM and 9 PM without supervision. The hospital, while maintaining some security measures, had an open campus.

Mr. White had been admitted to St. Elizabeth's 10 years earlier on a court order after he had been acquitted of the murder of a police officer by reason of insanity, otherwise known as not guilty by reason of insanity (NGRI). The murder occurred when five police officers attempted to arrest Mr. White's father. Since then, Mr. White remained violent at the hospital, with numerous assaults on staff and the hospital's law enforcement. He escaped from the hospital once and assaulted a cab driver in an attempt to rob him. But over the years, Mr. White became less violent. He became involved in a relationship with Mrs. White, who at the time was also a patient at the hospital, and they married.

The hospital began to ease the restrictions on Mr. White, and over the course of a year, he progressed from passes to walk across campus to attend therapy to complete freedom on the campus during the day. He had been on this status for 6 months when he left the campus without permission and attacked his wife.

During the year preceding the assault, Mr. White had told his therapist that he had fantasies about shooting his wife. Because of a hospital policy designed to encourage the therapeutic alliance between patients and their providers, his therapist did not participate in administrative decisions regarding his status and did not notify the hospital about the fantasies, and Mrs. White was not notified. The psychologist felt that his risk level for acting on the fantasies was low

because Mr. White had no history of assaulting women and had not assaulted anyone for more than a year.

Mr. White was criminally charged for assaulting his wife and in the legal case against him he again used the insanity defense, but this time it was unsuccessful and he was convicted of assault with intent to kill. Mrs. White brought a Federal Tort Claims Act action against the hospital claiming that the hospital should have warned her of this threat and, by failing to do so, had breached a duty to her. Furthermore, she claimed that the hospital was negligent by not taking reasonable precautions to ensure that he did not leave hospital grounds.

The District Court found that Mr. White's psychotherapist was acting within professional standards of competence and that St. Elizabeth's had not been negligent in granting Mr. White unsupervised access to the hospital grounds because it was not foreseeable that he would leave and attack his wife. The decision was appealed, and the Court of Appeals affirmed that the psychotherapist was not negligent, referencing Tarasoff:

> In defining the duty to warn, the courts have made it clear that the duty is not triggered by the mere existence of a threatening statement by a patient to his psychotherapist. Such statements are commonly expressed to psychiatrists and merely pose but do not answer the difficult question of whether or not danger is actually present. Before a hospital or psychotherapist incurs an obligation to warn, the patient must present a 'serious danger of violence' to a 'foreseeable victim of that danger.' [2]

The Court of Appeals found, however, that St. Elizabeth's Hospital was negligent, overturning the previous court's decision. They cited evidence that the hospital had minimized Mr. White's potential for elopement and violence to support this decision. This case has several implications, not the least of which is that institutions, rather than individual clinicians, bear the brunt of the liability for risk assessment.

Core Principles of the Topic

The vignette case, described above, highlights some of the challenges of assessing whether someone poses a risk for violence. The patient had several risk factors for violence, including a history of violence, a major mental illness, and fantasies about violence. While the fantasies he described to his psychotherapist were alarming, she balanced this against the fact that they were fantasies rather than a plan, and while they were about violence, it seemed to be qualitatively different than his personal past history of violence (e.g., he had never acted violently toward women nor had he been violent other than while committing a crime or responding to a perceived threat). She also considered the facts that he had not acted violently recently. She decided not to take measures to contain the risk. She made a clinical judgment of the type that people involved in mental health care make so frequently. In this case, her assessment was incorrect, but the court did not find that she was negligent, illustrating that they recognized that a degree of error is inevitable in this sort of assessment.

As the court recognized, there is no simple formula for risk assessment for violence.

However, it is one of psychiatry's most important tasks, and while it is frequently encountered in emergency psychiatric evaluations, it is also something clinicians need for day-to-day management of stable patients. Risk assessment is, in many ways, unlike other aspects of psychiatry in which the primary duty is to the patient. While a psychiatrist conducting a risk assessment certainly has a duty to the patient they are assessing, they must balance this against a duty to the public. These distinct tasks can cause competing interests, which can lead to very complex situations.

Approaches to Risk Assessment

Clinicians frequently approach risk assessment on a case-by-case basis, tailoring their approach to the individual. This is sometimes described as a "clinical judgment" approach and, when done well, allows the clinician to create a detailed, dynamic, and qualitative portrait of the individual and their risk [3]. In this approach, the clinician integrates what they know about the patient's personality, symptoms, and environment with their understanding of the likely causes of violence. As a sole approach, it is limited. It is, by definition, idiosyncratic and thus not reproducible or transparent; it cannot be compared across time or populations.

Clinical judgment approaches are contrasted with "actuarial" approaches. Actuarial approaches refer to a body of research that has identified risk factors across groups of subjects and use the results to make predictions about the risk of individuals. The results are quantitative and so can be compared over time and populations. An example of an actuarial risk assessment tool, the VRAG is discussed below. There are various problems with actuarial approaches as the sole tool for risk assessment, mostly related to applying facts derived from aggregate data to the individual.

One of the most fundamental problems with actuarial approaches is a consequence of the rarity of violence. In principle, the more rarely an event occurs the more difficult it is to predict; the occasional true predictions get lost in the noise of false positives. This creates a clinical predicament. If a positive prediction of violence very likely represents a false positive, treating everyone who tests positive (e.g., securing them in psychiatric hospitals) would be completely unreasonable. Furthermore, even if this approach were taken, it would inevitably miss people from lower risk categories who are going to act violently.

Structured professional judgment (SPJ) approaches are intended to address the weaknesses of clinical judgment and actuarial approaches when used in isolation. SPJ combines both clinical and actuarial approaches into a predetermined interview structure that incorporates what is known about actuarial risk factors while also considering the specific, dynamic aspects of the case. Some risk assessment instruments are designed to accomplish this task. An example is the HCR-20, discussed below [4].

A thorough consideration of the risk factors in any psychiatric interview is clearly central to reducing risk and the responsibility of anyone involved in psychiatric decision-making. Risk assessments conducted by independent clinicians (not directly involved in patient care) with specialized training in risk assessment can be an important resource. However, when this is not available, clinicians should still do their best to consider actuarial risk factors, to combine them with the dynamic risk factors of the case, and to link all of the risk factors to a management plan directed at reducing the identifiable and malleable risks. When there is any concern for risk, it is simply not enough to ask someone whether they have violent intentions or access to weapons and call it a day.

Risk Factors for Violence

The American Psychiatric Association Resource Document on Psychiatric Violence Risk Assessment [3] identifies several risk factors as the most important in determining violence risk:

1. Prior violence
2. Prior arrest
3. Young age at time of first arrest
4. Drug and/or alcohol abuse
5. Cruelty to animals and people
6. Fire setting
7. Risk taking
8. Behavior suggesting loss of control or impulsivity
9. Present circumstances and mental state
10. Male under 40
11. Noncompliance with treatment
12. Access to weapons
13. Role of significant other and/or caretaker (either provocative or not protective)
14. Sees self as victim
15. Lack of compassion/empathy
16. Intention to harm
17. Lack of concern over consequences of violent acts

The most authoritative study of risk factors to date, the MacArthur Violence Risk Assessment Study followed 1136 subjects from civil admissions in inpatient hospitals [5]. The subjects were interviewed in the hospital and then twice more after discharge over a 20-week period. Information was gathered from interviews with the patient, interviews with collateral sources, and official records, e.g., hospital or arrest records. The outcome measure, violence, included threats made with a weapon in hand, even in the absence of physical assault.

About 20% of the subjects went on to act violently within the time period. Among the major risk factors identified by the MacArthur study were psychopathy

(the most powerful predictor of violence) and a mental health diagnosis. These are discussed in more detail below. They confirmed several well-established risk factors, including gender, prior violence, childhood experiences of physical abuse, and socioeconomic status.

They also clarified several risk factors related to the symptoms of mental illness. The presence of delusions, whatever the content, was not related to violence, even though a "suspicious attitude" was. Neither hallucinations in general nor even "command" hallucinations increased the risk of violence. However, command hallucinations in which the subject was commanded to act violently did increase the risk. So too did daydreaming or thinking about harming others. Anger, measured by a scale, was also strongly associated with violence.

Risk factors for violence fall broadly into two categories that in some ways mirror the distinction between clinical and actuarial approaches. Static risk factors are those that do not change over time and are captured by actuarial approaches. An example is a history of a prior violent act. Once a person has acted violently, they are at higher risk for acting violently again, even if there are substantial changes in their situation, and the likelihood of this can be quantified. Dynamic risk factors, on the other hand, are amenable to change. These are often best communicated by qualitative descriptions. An example is alcohol intoxication. The level of risk for violence for that particular individual varies according to whether he or she is intoxicated.

As discussed above, mental illness has been identified as a risk factor for violence. The relationship between mental illness and violence is complex. Early papers indicated that mental illness increases the risk for violence (e.g., [6, 7]). As research evolved, it was apparent that subtypes of mental illness had very different risk profiles. In addition, there are many types of violence. For example, the kind of planned violence perpetrated by someone robbing a bank to support a drug habit is very different than the confused violence of a dementia patient who misperceives that they are being attacked. Furthermore, mental health diagnoses appear to alter conventional risk factors. The APA resource document briefly reviews the literature on this topic:

> The tendency for violent acts to be conducted by men is still present but less strong, first offenses occur later and the likelihood of acting violently does not fall off so rapidly with advancing age. The protective effect of stable relationships may also be less, particularly where someone's social and occupational functioning is poor. In other respects, however, the correlates of violent offending in the general population apply also to people who suffer from mental disorders. (Buchanan et al. 2012)

The concept of psychopathy has played an important role in understanding violence. It has been repeatedly described as the single greatest risk factor for violence [8, 9]. In *The Mask of Sanity*, Cleckley described a group of symptoms, including superficial charm, lack of remorse, and affective poverty, all in the absence of delusions or irrational thinking that he defined as psychopathy [10]. The concept has been forwarded by Hare, the author of the Psychopathy Checklist-Revised (PCL-R), an instrument commonly used during risk assessments [11]. Psychopathy is

most closely related to the mental health diagnosis of antisocial personality disorder, described in the Diagnostic and Statistical Manual 5 (DSM-5) [12]. The term psychopathy is also frequently used interchangeably with sociopathy.

Most commonly psychopathy and sociopathy are distinguished on the basis of the causal ingredients. Psychopaths are thought to be hardwired that way, their behaviors a reflection of intrinsic factors. There are many contexts in which traits of psychopathy are adaptive, promoting survival. As such a stable percentage of any population, whatever their background, would be expected to have psychopathy. Sociopathy, on the other hand, is used to describe people with psychopathic-like behaviors that are the result of adverse life experiences, e.g., witnessing violence. The more difficult the environment, the more frequently the traits emerge. Both psychopathy and sociopathy are manifest in the behaviors that define antisocial personality disorder, and so antisocial personality disorder is the broadest category, encompassing both psychopathy and sociopathy.

There are polarized opinions on whether to conceive of antisocial personality disorder as a mental illness, particularly in the legal setting. The nature and source of the disorder is often a central issue in criminal cases, where it may be introduced as a mitigating condition (evidence that there were factors beyond the individuals control at play in their behavior). But it also may be introduced as an aggravating condition (evidence that the defendant cannot be rehabilitated).

Skeem et al. [13], in a study of 165 high-risk patients, described three subtypes of violent individuals. The first two subtypes were similar in that they included depression or dysphoria and used substances heavily. The first and most violent subtype had psychopathic traits, antisocial lifestyles, and extensive legal involvement. The second had higher levels of baseline function and less legal involvement and did not have antisocial traits but were generally highly reactive and sensitive to personal problems. The third and least violent group had very low levels of baseline function, suffered from delusions, and were the least likely to use substances.

The constructs in the Skeem paper are more complex and rich than diagnostic categories. But when they are considered along with the results of the MacArthur study described above, several clear themes emerge. Cluster B personality disorders, in particular psychopathic (antisocial) and reactive (borderline) traits, are associated with violence. To a lesser degree psychotic illness that includes command hallucinations to act violently is also associated with violence.

For patients with mental illness, several other important risk factors have been identified—active substance abuse and treatment noncompliance increase the risk dramatically [14].

Risk Assessment Instruments

The Violence Risk Appraisal Guide (VRAG) is a tool that weighs actuarial risk factors [15]. It is available for free online and is recommended as a guide to clinicians without specialized training who want to be sure that they are addressing risk factors appropriately. It is a 12-item risk assessment tool that weights various factors

and places people in broad risk categories. The 12 items are all actuarial factors, e.g., criminal history. It does not factor in dynamic or clinical variables such as the strength of the individual's support system. The Sexual Offender Risk Appraisal Guide (SORAG), a 14-item sexual offender version, is similar but also factors in history of sexual offenses and phallometric test results (involves the measurement of changes in penile circumference in response to sexual and nonsexual stimuli as a measure of sexual arousal to both appropriate and deviant sexual material).

A number of structured risk assessment instruments exist that are designed to incorporate both actuarial information and clinical judgment. These structured risk assessment instruments are used less commonly in general clinical work and are more often used in high-risk cases, forensic assessments, or research and require specialized training to administer.

Singh et al. [16] conducted a survey of 2135 mental health professionals from 44 countries who had conducted at least one risk assessment during their careers. They found that 58% of risk assessments used some sort of structured instrument, and over 400 instruments were described. Half of these instruments were commercially available. The rest were developed for individual or within institution use. The VRAG (discussed above) was one such instrument. Some of the other most commonly used, empirically validated instruments are described below.

HCR-20

The Historical Clinical Risk Management-20 (*HCR-20*) is a 20-item assessment tool for violence risk prediction that includes three domains: historical, clinical, and risk management [17]. The historical domain includes an inventory of risk factors, such as a history of violence and the presence of psychopathy (incorporating a PCL-R score). The clinical domain captures current symptoms, attitudes and insight, and related factors. The risk management domain captures variables related to future risk, including things like the strength of the person's support system and the likelihood that they will be exposed to destabilizing forces. According to Singh et al. [16], the HCR-20 is the most commonly used instrument globally for risk assessment, management, and monitoring.

PCL-R

The *PCL-R* is a 20-item inventory of personality traits associated with psychopathy obtained from a direct interview and a review of collateral information [11]. While the PCL-R is not explicitly designed to measure violence risk, it is designed to identify psychopathy, the diagnostic construct most associated with violence. It does not factor in other diagnoses (e.g., schizophrenia) that may be related to violence risk. It requires specialized training to administer. The PCL-R generates a score and has an established cutoff for psychopathy. According to Singh et al. [16], the PCL-R is the second most common instrument used in risk assessment, management, and monitoring.

LSI-R

The Level of Service Inventory-Revised (LSI-R) is a 54-item risk and need assessment tool used most extensively in correctional settings. It blends static and dynamic risk factors, and identifies target areas for intervention, and predicts the likelihood that the offender will return to prison [18].

ICT

The iterative classification tree (ICT) is an actuarial tool intended to assess violence risk by people discharged from psychiatric facilities [19]. As with the other instruments, it assigns risk based on actuarial information. However, it is based on the idea that risk factors interact with one other, rather than being additive. Questions are asked on the basis of answers to previous questions. Different combinations of factors produce different profiles of risk.

Reconsideration of the Clinical Vignette and Actual Case

Going back to the case of the patient who stabbed his wife described above, the important question is whether the risk was preventable. Based on the details in the clinical vignette, a number of risk factors were present. These included broad risk factors (e.g., male gender) as well as very specific ones (that the subject had murdered a police officer). Several of the factors weighed heavily make complete clinical sense (e.g., the nature of the subject's previous violence) but are not factors identified by risk assessment research at this point. A factor that was downplayed was the subject's violent fantasies. However, the MacArthur study discussed above as well as other studies, linked violent fantasies to future violence. It is not clear from the information how the risk factors were weighed. In the actual case, the breakdown may have been one of communication between the clinician and the hospital: a well-intended policy to foster therapeutic alliances impeded the process of risk containment. This argues for the value of independent risk assessments (i.e., conducted by clinicians who are not part of the direct care of the patient) as part of any management plan of people who have substantial risk factors, including those found NGRI.

Summary and Recommendations

In summary, no matter the experience of the provider or the quality of the instrument, risk of violence cannot be predicted with enough accuracy to justify any single approach. Unstructured approaches are unreliable, and data-based approaches do not capture the whole picture and are limited in what they can say about individuals. While risk factors may continue to be identified as society changes (e.g.,

the effects of violent video game exposure) and as science develops (e.g., research on the brain processes underlying empathy), there are fundamental limitations to what aggregate data can tell us about the individual. The science of risk assessment, at least as it stands, will never be able to give categorical or even satisfying answers about individuals.

What is very clear is that a thorough consideration of the risk factors in any psychiatric interview can reduce risk. Independent risk assessments of high-risk patients may contribute valuable information. Risk assessment tools, such as the)HCR-20, allow clinicians to make a structured assessment and be sure that they have covered all of the important risk ingredients. For the busy clinician who may not have training on a specialized risk assessment instrument, it is important to rationalize any decision clearly, referencing current knowledge on risk. This means that they should be aware of the static risk factors identified in the literature (and can use the VRAG, which is available for free online) to help guide this, spend enough time with the individual they are evaluating to be able to describe the dynamic risk factors, and directly link the identified risk factors to a risk management plan which aims to reduce the individual's risk of acting violently in the future.

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Substance Abuse and the Law

13

Lindsay Oberleitner

Synthesized Clinical Vignette

You are a psychiatrist with a specialty in the treatment of substance use disorders. You are sitting at your desk when your phone rings. The voice on the other end is Attorney Marco from the local public defenders' office. He requests an evaluation of substance use history, substance use symptoms and severity, and substance use treatment recommendations for his client, Mr. James Zimmerman. Attorney Marco lets you know that Mr. Zimmerman reported that he has used substances for the past year and denied any use in the week preceding his arrest, but Attorney Marco believes that his client is minimizing his use. Mr. Zimmerman is facing charges for possession of narcotic paraphernalia, and he could receive an option for treatment in lieu of stricter punishments if he is considered "drug dependent" at the time of his offense. You schedule Mr. Zimmerman for an evaluation.

Mr. Zimmerman knocks on the door to your office the next day for his scheduled appointment. Mr. Zimmerman walks slowly into your office without making eye contact, and quietly sits down in the chair across from you. He has a slight build and dark circles under his eyes. You observe a slight tremor in his hands as he wipes sweat from his forehead. Before you begin to speak, you observe other notable features signifying his serious pattern of drug use. There are track marks and dried scabs up and down both of his arms which paint the picture of a steady intravenous use pattern. You begin with a developmental history that is notable for multiple family members who he believes have had problems with alcohol and other drugs. He reports that outside of his family history of substance use, his upbringing was "average." He initially denies ever having problems with substance use prior to the past year but when you probe deeper, he reports an early onset of marijuana use. However, he denies any problems related to his use and states that he rarely used

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marijuana or drank alcohol through his 20s. Mr. Zimmerman is now 32 years old and reports that he has been using heroin for the past year intravenously but has been able to go for a week or more at a time without use on rare occasions. When you ask Mr. Zimmerman to describe when he first started using heroin, he explains that he was a successful general contractor who owned his own business for many years but 5 years ago had an unexpected fall from a ladder while on the job which led to chronic lower back pain. After the accident, he went to the emergency room where he was prescribed opioids to manage the acute pain. Mr. Zimmerman never sought care from a pain management specialist but would have "flare-ups" of his back pain every 2–3 months which would lead him back to the emergency room where he would be given another prescription for opioid pain medications.

Mr. Zimmerman described that he felt the pain was intolerable, and after 2 years of his recurrent pattern of going to the emergency room to obtain opioid medications, he started noticing that he would feel nauseous and irritable when he would run out of pills. After being out of work for several years, Mr. Zimmerman lost his medical insurance and began buying prescription opioids on the street. After a year and a half of buying prescription opioids, he could no longer afford the quantity he needed to prevent withdrawal and began buying heroin. He has used approximately a bundle (ten bags) of heroin daily, intravenously for the past year.

The next day you receive a call from Attorney Marco asking you to testify in court regarding Mr. Zimmerman's case. He wants you to explain to the judge your findings regarding Mr. Zimmerman's diagnosis and to recommend a strategy to the court for how to maximize Mr. Zimmerman's chances of remaining abstinent in the community.

What would you do?

What Really Happened: Robinson v. California, US Supreme Court [1]

Mr. Robinson was arrested in California for being addicted to narcotics. At the time of Mr. Robinson's arrest, being addicted to narcotics was a misdemeanor which carried a mandatory incarceration period, even if the individual charged was not intoxicated at the time of the offense. In the case of Mr. Robinson, he was arrested after police noticed track marks from injection drug use, described as scabs more than 1 week old. The police did not find any substances or paraphernalia on him at the time of the arrest, but Mr. Robinson reported to arresting officers that he had used opioids a week prior to his arrest. In the trial, Mr. Robinson denied that he had ever used heroin and stated that he was not addicted to heroin, describing the track marks as resulting from a medical condition he acquired in the military. Mr. Robinson was convicted of being addicted to narcotics through a jury trial, based on the police testimony of both the observed scabs consistent with injection drug use and his self-reported use days prior to the arrest.

The justification for the California Statute at that time was at threefold: (1) that the state of being addicted to narcotics (in this case heroin) suggests that illegal drug

use had occurred in the state at some point and it was unnecessary to prove where this use occurred, (2) that the state of being addicted to substances was a risk to society that needed to be controlled (e.g., increasing crime through drug trade, increasing rates of crime to obtain drugs), and (3) that convictions and imprisonment provided a period of forced abstinence which could be enforced more easily than the longer standard drug treatment programs, suggesting imprisonment was a safer alternative for both the defendant and society. The statute was unique as compared to other crimes in that the state of addiction is chronic and does not need to be directly tied to a behavior at the time of the alleged crime (in comparison to charges for possession of drugs in which the person must have the drugs on them or in their possession at the time of the arrest or charges such as driving under the influence of alcohol or drugs which requires active intoxication by a substance while operating a vehicle).

The case was first appealed to the Los Angeles County Superior Court and that court supported the conviction of Mr. Robinson, in sum because it was believed to be the duty of states, in the interest of public health, to do anything in their power to regulate any "habit-forming" drugs. It was decided that there should be policing power to reduce substance availability by any means that the state government saw fit given the severity of the problem of illicit drugs.

The US Supreme Court then overturned the conviction and ruled that although states have the power to punish individuals for the use, purchase, or sale of drugs or for drug-related criminal behavior, it could not be considered to be a criminal offense to simply have a "narcotic addiction." The court determined that like other medical or psychiatric illnesses, convicting a person for the state of being addicted and requiring a mandatory period of incarceration are considered cruel and unusual punishment. The court argued that in a court of law, addiction should be treated just as other disease states would be treated. The court also referred to an earlier case of Linder v. United States [2] in which it was determined that individuals with addiction have a disease warranting treatment. Issues that were raised for consideration through the court were: the first exposure to substances may be innocent (e.g., medical reasons, in utero exposure), that the physical need (i.e., withdrawal) may last longer than generally accepted in the field of medicine at the time, and that despite conflict over whether addiction is a disease in its own right or merely a result of other psychiatric conditions that imprisonment could interfere with effective treatment.

Core Principles

Addiction as a Disease

The societal acceptance of substance use disorders (SUDs) as a disease with clear neurobiological factors has long lagged behind the understanding of other psychiatric diagnoses, and this leads to a direct influence on the treatment of SUDs in the criminal justice system. Our diagnostic manual, The Diagnostic and Statistical

Manual of Mental Disorders—Fifth Edition (DSM-5; [3]), provides the same attention to SUDs as other psychiatric diagnoses, yet in common practice the medical field often differentiates "substance use" and "co-occurring mental disorders." This linguistic distinction between primary mental health and SUDs alone implies a dissimilarity in conceptualization of the disorders that does a disservice to the many individuals suffering from primary SUDs. Even with the recent improvements in mental health parity, many individuals struggle to receive insurance approval for access to appropriate and effective substance use treatments, and only approximately one out of ten individuals in the United States with a substance use disorder enters treatment [4]. Further, for individuals with both "primary" psychiatric diagnoses and SUDs, active use of substances often excludes individuals from needed psychiatric treatments. The medical professions have some accountability in the criminality of substance use, as our history in formally defining SUDs as a psychiatric diagnosis or disease has been a historically contentious one within the field. As SUDs are now clearly accepted by the medical professions as a primary clinical disorder, we must ensure that the messages we provide as medical professionals to the criminal justice system are consistent with our fields' model of SUDs as a disease. Over half of those individuals in a criminal justice setting meet criteria for a SUD [5].

Considering that most individuals meeting criteria for a SUD will not receive appropriate assessment and treatment in the community, and that the number of individuals in the criminal justice system with mental health diagnoses and SUDs is growing, there is a high likelihood that all mental health professionals will provide assessment or treatment to a client involved with the criminal justice system at some point during their career. When providing care to someone with a primary SUD diagnosis, because the mere act of purchasing or using most substances is illegal, as providers we should be well aware of the potential interaction our clients may have with the criminal justice system and our potential roles. I will briefly review our history of understanding of SUDs, the current state of accepted knowledge in our field, and review practical diagnostic information that should be considered.

History of Addiction in Medicine

Addiction and alcoholism have been discussed in the popular literature for centuries; however, I will focus here on the conceptualization of addiction within the United States. Understanding the history of addiction within medicine is key to understanding how the definitions within our own fields may have influenced the legal treatment of substance use. Anthony Benezet published the "Mighty Destroyer Displayed" in 1774 [6] and within this text describes the many physical deleterious effects of alcohol observed by Dr. Hoffman, a physician: "that they rot, the entrails, (s)uch as the liver, (s)tomach, and bowels; as it is evident, not only by opening the bodies of tho(s)e who are killed by drinking them…." Despite these early descriptions of the serious and potentially deadly harm that could result from the habitual use of alcohol, there was little recognition of the actual "habituation" to alcohol as a disorder in and of itself. At that time, it was the physical effects of alcohol and not the "habituation" of alcohol that was considered a problem. It was not until the late

1800s that Dr. Leslie Keeley described alcoholism as a disease itself that can be cured. This recognition did not spread to greater medical acceptance until the 1950s; at which time the availability of treatment programs for SUDs began to grow. Our understanding of how neurobiology, genetics, and psychological and environmental factors all interact in the development, course, and treatment of SUDs has expanded rapidly since that time. Unfortunately, there continues to be substantial barriers to access for SUD programs both because of program shortages and cost to client.

Current State of Accepted Knowledge

In 2016 we saw the release of "Facing Addiction in America: Surgeon General's Report on Drugs, Alcohol, and Health" [7]. The report provides a review of the accepted knowledge in the field of addiction to date and provides the clear guideline that there is ample research evidence that substance use disorders are "a chronic brain disease that has the potential for recurrence and recovery" (p. 2). The report describes in detail the changes that occur with prolonged use of substances and describes the persistence of these substances even after substance use cessation. These guidelines should reverberate through our assessment of individuals in the criminal justice system and our description of SUDs to nonmedical professionals in the criminal justice system.

The shift that has occurred over time, from the effects of alcohol being deleterious as evident in the early writings of Benezet to the 2016 Surgeon General's Report on SUDs as a disease in and of itself, is a dramatic one when considering the implications for the criminality of the behavior. In the early descriptions from Benezet, the impact on criminality of use is not clear. If we only consider the intersection of substance use and the medical field at the point of physical impairments resulting from substance use, we ignore the vast majority of individuals who use substances problematically without medical problems. This early description would suggest that individuals without medical complications of substance use are not within the realm of the medical field, and thus medicine did not have a role in the treatment of SUDs nor could medicine speak to the potentially mitigating effect of the psychological "addiction" to those drugs within the criminal justice system. Take in contrast our current understanding of SUDs as a disorder deserving of medical attention with or without deleterious physical effects. This present definition of SUDs gives the framework for an intersection of medicine and substance use much earlier in the course of addiction. In thinking about the Robinson v. California, our current definition of SUDs opens the door to the idea that medical professionals have valuable insight into the behaviors of individuals who have been diagnosed with SUDs whether or not there was intoxication or use at the time of an offense.

However, the dissenting views in the Robinson v. California case do bring to light an important distinction in our field. There is strong evidence for the existence of a biologically driven process of addiction, but not all individuals who use substances are "addicted." The formal diagnoses of substance use disorders as defined by the DSM-5 (mild, moderate, or severe) or substance abuse or substance dependence as defined by the ICD-10 capture only a portion of individuals who use

substances. The ability to *accurately* diagnose SUDs and explain that diagnosis to a lay audience is an essential part of the medical profession's intersection with the community more broadly and especially within the legal system.

Practical Diagnostic Considerations

First we must consider the important distinction of addiction versus use of a substance. This may seem on first glance to be a simple one. In the medical fields, we are all trained to consider symptoms when diagnosing other psychiatric diagnoses such as major depressive disorder. We can all recite the symptoms of major depressive disorder with ease if we have spent any of our time working with a psychiatric population. Now consider the last time you encountered a patient who was using substances. Consider how seriously you or your colleagues evaluated each symptom of a SUD. For many, the answer is that you talked with the client about the frequency and quantity of their use, considered the impact of the use (e.g., were they coming into an emergency room because of an injury during intoxication?), and asked about how long they have been using. These questions are of high importance and can help us to quickly identify those individuals who are engaging in hazardous or risky substance use. Should the motivation of your evaluation be purely a decision for whether or not someone should receive a referral for a more in-depth substance use evaluation and/or treatment (e.g., when evaluating in the emergency room or primary care), this line of questioning may be a sufficient screen. Now consider the legal perspective. Imagine as described in the case of Mr. Zimmerman that you are called into court to testify regarding the presence of an opioid use disorder for your client. The typical screening of substance use patterns and consequences of use is not sufficient to answer that important diagnostic and legal questions. As with any other psychiatric diagnosis, we should hold close the standards of our field for diagnosing and ensure we know which SUD symptoms that individual does and does not meet. In fact, with the transition from DSM-IV-TR to the DSM-5, it is no longer the discretion of the evaluating clinician as to whether an individual has a mild, moderate, or severe SUD but instead the number of symptoms met directly translates to the severity level. It is also important to note in this transition to DSM-5 that repeated legal involvement as a result of substance use is no longer a criterion for a SUD nor does a single symptom lead to a diagnosis (as was previously the case with abuse diagnoses). The removal of legal problems as a symptom has a very real impact on how we talk about diagnoses when evaluating an individual facing criminal charges related to their use.

To consider substance use patterns a little further, all practitioners should hold clearly in their mind that heavy use, even a regular or daily use pattern, does not directly equate to a SUD. Substance use or misuse in the absence of a SUD can have devastating effects that should be fully addressed in a medical context. Substance use or misuse can lead to serious physical consequences up to and including accidental death, and it can directly contribute to mental and physical impairments during periods of intoxication or withdrawal that contribute to possible harm (including criminal) to others. In fact, the Surgeon General's report directly defines substance misuse as "use (of) substances in a manner that causes harm to the user or those

around them." In considering that definition, it is clear that substance misuse, in the absence of a SUD, can lead to legal consequences. It is important that we work toward a standard in the field of summarizing substance use patterns that may be hazardous or risky in our patients, especially when consulting on a legal case. At a minimum, description should include the current use pattern (*frequency of use*: # times a day, # times a week/month; *quantity*: how much is used in each episode, how much is used in a day, potency of the drug (if applicable), and whether or not the drug is combined with other drugs when used; *deleterious effects*: arrests, violence, psychological effects, work performance, etc.).

The importance of substance misuse is clear; however, it is essential that medical professionals can distinguish misuse from SUDs and describe the contrast when consulting with or for other disciplines such as the law. In reviewing Robinson v. California, it is clear that the courts have for many years placed a greater emphasis on the term "addiction" than regular use of substances in the absence of a disorder. The medical field is the definer of "addiction" and as medical professionals, medical researchers, and medical consultants we must be able to translate each of the DSM-5 symptoms into easily understood and defendable pieces of information. For example, if you were to testify regarding the evaluation of someone with a SUD, you should have clear, simple language to explain the experience of craving and what evidence you have used from collateral, other records, and patient experiences. To a nonmedical professional, cravings may seem like nothing more than a statement of "I really want to use" or "using is fun so I want to keep doing it." Cravings are clearly much more than that Friday night desire to have a drink and let go of stress, and it is our duty when questioned by individuals outside of our field to provide the new framework for describing this symptom. Beyond having clear definitions of each symptom readily available in our minds, it is advisable in a legal evaluation to seek evidence of every single symptoms presence or absence in the case of a SUD. For example, if you are describing the symptom of recurrent difficulty fulfilling obligations, a work record that shows repeated tardy arrivals or absences from work could provide support to your decision to count that criterion. Given that many individuals use more than one substance, it is important to know this breakdown for SUD symptoms for each and every one.

After determining a diagnosis of SUD, we must consider the specifiers of SUDs which include factors relevant to the criminal justice system. Possible specifiers include: in a controlled environment, on maintenance therapy, and early/sustained partial/full remission. Let us think for a moment back to the original case and the importance placed on the "active" aspect of the diagnosis, as it is a point that deserves some legal clarity. There was much made of the time of Robinson's last use of heroin, and he initially described his last use as more than 1 week prior to the arrest. Let us think then about Mr. Zimmerman's case to place this in context. If you believe that Mr. Zimmerman has met criteria for SUDs at any point in his life, even though he was not using substances immediately prior to the arrest, you would next determine the specifiers of the diagnosis to decide if his SUD was "current." Mr. Zimmerman would not have been in full remission (requiring at least 3 months of not meeting criteria for a use disorder—early—or more than 12 months of not

meeting criteria, sustained) if you believe that prior to his week of abstinence he was meeting any criteria for a SUD. In your assessment you directly observed continued withdrawal, and he reported continued impairment in his major obligations; therefore, we would diagnostically consider Mr. Zimmerman to have an opioid use disorder, current.

There are a few final trending issues that mental health professionals should be aware of in regard to diagnosing SUDs in a forensic population. (1) Because of the recent change in language in our diagnostic manual from substance abuse or dependence to substance use disorders of mild, moderate, or severe classifications, the language within the courts has not caught up in all cases. For example, in the State of Connecticut, to qualify for the "drug intervention program" in which successful completion of regular court dates and negative urine drug screens over the course of 12–15 months may lead to a favorable case outcome (e.g., charges dropped, sentenced to a conditional discharge, etc.) for the defendant requires that a person is "drug-dependent" and defined by "a psychoactive substance dependence on drugs as that condition is defined in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" of the American Psychiatric Association" [8]. At the time this definition was written, it was likely assumed to be able to adapt to any changes in nomenclature within our diagnostic manual, but none as dramatic as we have experienced with the transition to DSM-5 in regard to SUDs. We as professionals must feel comfortable in, and able to justify, our own translation of "drug dependence" to our present diagnostic manual which no longer uses the term. Although all professionals would agree that a mild SUD would not hold the same essence as drug dependence used to, it is not as clear whether or not both moderate and severe or only severe should translate back to the "drug-dependent" nomenclature still used in many courts across the United States. (2) The rate of prescription opioid misuse has grown rapidly in the last couple of decades in the United States, and our diagnostic system is just beginning to catch up with that growth. Individuals who are using long-term, daily opioids (or other prescribed medications like amphetamines or sedatives) as prescribed will develop a physical dependence to those medications. Although current practice is to not use the symptoms of tolerance and withdrawal when evaluating someone who is taking opioids as prescribed, this results in a complicated diagnostic picture and potential masking of a SUD for those individuals who are misusing prescribed opioids.

What Does This Mean for Your Assessment of Mr. Zimmerman?

Mr. Zimmerman is before the court charged with possession of paraphernalia. He was not accused of intoxication at the time of his arrest nor of possession of drug. Mr. Zimmerman reported to the arresting officers that he had not used heroin for the past week; however, mere possession of paraphernalia is a misdemeanor charge in most states (a few states may charge as a felony depending upon the circumstances and type of possession). Mr. Zimmerman reported only a brief use history with sporadic periods of nonuse in the couple of months preceding the arrest to the arresting officers; however, he had opened up more about his substantial history of substance use to his attorney which prompted the referral for evaluation of substance

use disorder to you. His attorney is requesting a diversionary/pretrial intervention program for Mr. Zimmerman. The diversionary program requires that the arrest was non-violent (it was) and that Mr. Zimmerman was considered drug dependent at the time of the arrest. The prosecution is arguing that Mr. Zimmerman seems to only have a pattern of opioid misuse without an actual opioid use disorder, which would disqualify him from this program.

In considering the diagnosis of an opioid use disorder for Mr. Zimmerman, there are key factors that you should address. First, you must accurately determine the substance use history from Mr. Zimmerman and gather any collateral that you can regarding the length and severity of his use. For example, work records may indicate lost positions because of substance use. Former partners or friends might be able to describe the time at which his substance use began to spiral out of his control. Second, you must consider every SUD symptom and determine the accurate count. Consider if Mr. Zimmermant meets 4–5 criteria for a SUD, a level of SUD symptom endorsement that is consistent with a "moderate" severity specifier. The next clinical judgement that needs to be made is whether you may describe this moderate severity SUD as consistent with the essence of substance dependence described in previous versions of the DSM [19]. Third, in considering the chronology of his SUD, you must consider the point at which Mr. Zimmerman's medical use of opioids transitioned to a use disorder. Finally, you must consider whether the SUD was of a "current" specifier at the time of the offense and now or if he meets a controlled environment, on maintenance therapy, or remission specifier.

Choice Versus Compulsion

A common concept in the understanding of substance use as it intersects with the legal system is whether or not each episode of use is a result of free choice or a compulsion. In fact, one could be asked to speak to the level of choice a defendant had at any specific time point of use. This is challenging concept to speak to in regard to substance use, especially when someone is diagnosed with a SUD. This argument is often broken into three parts: the "first" use, episodes of use between the "first" and the development of a SUD, and episodes of use in the course of a SUD.

The "First" Use

Much is made about the process of how an addiction began. This is likely based in the idea that many of us have unrealized vulnerabilities to substance use disorders but if we are never exposed to a drug that we are vulnerable to, we will obviously not develop a SUD. In this strictest of senses, most individuals had some choice as to whether or not they used that first substance. However, let's return briefly to Robinson v. California. In the review of the case, there are descriptions that provide exceptions to the idea that the first use of a drug is always a choice, for example, in the case of in utero exposure or medically administered exposure. Further, even if we ignore those specific exceptions, there is much more gray area than not in the degree of choice that we associate with that first use of a substance. For example,

substantial bodies of research have shown that growing up in a family with someone who has a SUD can increase the chances of exposure to substances early in life and that the experience of childhood trauma and/or the later development of other psychiatric diagnoses can lead to earlier onset of use. Though we could not argue that those situations set an individual up to be without choice, many would argue that those increased (unchosen) vulnerabilities can decrease one's ability to resist that first exposure.

Additionally, the problem of origin of the substance use (and ultimately what can be considered fault for that use in the legal system) has grown in importance rapidly in the past two decades. Since the rise of pain as the fifth vital sign, along with a myriad of other cultural factors that increased our prioritization of providing effective treatment for pain, the rates of opioid prescriptions have increased rapidly and subsequently the rates of opioid use disorders. As was raised in Robinson v. California, the medical-based onset of substance use may often carry with it (even in the absence of medical evidence that a SUD that began out of an exposure to an appropriate prescription is any different in symptomology than one that began out of illegal use) a more sympathetic view within the criminal justice system.

Choice in the Course of Continued Use

There are various points in the course of use that we may consider the idea of choice versus compulsion. Earlier in this chapter, the distinction between substance use and SUDs was made. In considering the concept of choice, there could be arguments made that in terms of gradients, substance misuse in the absence of SUD carries with it more degree of choice than a formal SUD diagnosis. In fact, symptoms of SUDs directly address a sense of loss of control over the use of a substance. For example, the symptom of being unable to stop using despite a strong desire to quit directly relates to the concept of choice. The existence of this symptom for an individual suggests that the individual has had numerous instances where they were making an active effort to stop using but did not feel or exhibit the ability to enact that cessation of substances. Thus, if we are asked in a legal setting to explain the level of choice an individual with a SUD had over their use while his or her SUD is active, then we as a professional have decided this symptom was endorsed, and we should be ready and able to explain what this inability to cease substances means and how it relates to control/choice in the moment.

Conceptualizing Treatment and Remission

As medical professionals, we also know that many (but not all) individuals experience "recovery" from SUDs. This can raise the theoretical question then that if treatment can work and recovery is real, individuals who are not in remission must be making a choice to continue their active use patterns. This is yet another area for which we must consider how much more gray area exists. Although we hear of the cases of individuals with serious SUDs who are able at some point in their lives to stop their use without clinical intervention, what we also know is that for most people evidenced-based psychotherapy and medication-assisted treatments are a key to successful recovery. Even with our best evidenced-based care, our effect size,

or the number of people who successfully recover during that course of treatment, is relatively small. Does this mean that the majority of individuals are making an active, conscious choice to continue their use? Does it mean that our treatments are not effective? Or does this imply that the degree to which an individual can succeed in treatment and abstain from substance use is influenced at any point in time by a multitude of factors, only part of which is the strong desire to stop use and the availability of effective care? The latter of which is hardest to quantify and assess but the most realistic view.

Many factors can increase the chances that a person can abstain from substances, not limited to: effective treatment for other co-occurring psychiatric conditions, effective management of medical needs (e.g., chronic pain), stable living (e.g., housing, employment, relationships), and an environment with decreased exposure to common triggers for substance use. As a field, we should also be able to speak to, at least generally, the brain changes that can occur throughout the course of substance use (see [7]), some of which revert after extended periods of abstinence and some of which do not. Thus, although the easy and short answer to whether or not someone with a SUD is making a choice to use could be "yes," the longer and scientifically supported answer is that the degree of choice an individual has changes depending upon where he or she is in his or her course of use (e.g., the influence of neurobiological changes), life circumstances (e.g., stability, support, etc.), and availability of effective care.

What Does This Mean for Your Assessment of Mr. Zimmerman?

In your assessment, Mr. Zimmerman met criteria for an opioid use disorder, moderate. You assessed that despite not using opioids in the week before his arrest (a key concern raised by the police and likely to be brought up as proof that he can make a choice to not use) that he met for a current use disorder. He had continued to exhibit symptoms of his SUD during your evaluation (i.e., withdrawal symptoms, cravings, work impairment because of his withdrawal, inability to stop use, etc.). He reported a strong desire to stop using opioids but reported that he has never been able to make it more than 2 weeks without relapsing to opioid use since he first met criteria for a SUD. You are asked to consider the factors that increase or decrease the degree of choice in his current opioid use. Relatedly, you are asked to consider what may increase or decrease the chances of success in substance use treatment and/or what would be the most effective treatment to increase Mr. Zimmerman's chance of remission.

Substance Use Disorder as Gateway to "Other" Crime

The term "gateway" is used in many ways with regard to substance use. The idea that certain drugs provide a "gateway" to more serious or riskier substances has been a frequently cited (though debated) notion throughout the study of addiction. In regard to our understanding of psychiatry and the law with respect to SUDs is the idea of substance use as a gateway to other more serious crimes. This argument

arises because if one could prove that substance use equates with other behaviors that are a risk to others in society, one would be able to more easily bypass the difficulties with criminalizing a psychiatric diagnosis.

If we consider the evidence, the findings are quite mixed. Research is beginning to parcel out the effects of the relationship of crime and substance use. Within the criminal justice system, the majority of individuals have a history of substance misuse or SUDs. We know that substance use can increase rates of violence (see [9]) and that for some individuals as the severity of a SUD increases so does the likelihood of engaging in crimes to fund the increasing substance use. Despite these increased odds, we do not have any evidence that *most* individuals with SUDs will progress in their criminal activities.

Relationship of Criminal Behavior and Substance Use

Should one be able to prove that a clear relationship exists between the presence of a SUD and future nondrug-specific crime, it would suggest that criminalizing substance use is not just a moral statement on drugs but an actual risk prevention strategy. As stated above, one cannot deny that substance use is extraordinarily common for individuals in the criminal justice system, but what if we consider that idea from a different perspective. The National Survey on Drug Use and Health [10] has found that past month use of illicit substances was 10.2% and past month use of alcohol was 23.0% for individuals aged 12 and over in the United States. According to the US Bureau of Justice Statistics [11] reports, 0.87% of adults were incarcerated and just under 2% were on parole or probation in 2015. Criminal penalties do not equate to the rate of criminal offenses as most illegal behavior does not even result in an arrest. However, the difference in rate of those who are actively using substances and the rate of those who are currently serving some form of sentence for a crime are dramatically different. It seems from these numbers that the reverse does not hold and that the most who engage in substance use do not face criminal charges.

Complicating this matter further are some of the reasons why there is a high co-occurrence of criminal justice involvement and substance use. The US Bureau of Justice Statistics [12] has described three primary paths by which substance use can lead to arrest: (1) "drug-defined" crimes (e.g., DUIs, possession of narcotics, etc.), (2) "drug-related" crimes (e.g., stealing to fund use, violence facilitated by drug effects), and (3) "drug-using lifestyle" (e.g., "deviant lifestyle," most consistent of the three with true antisocial traits). It is clear that substance use can be a contributor to criminal behavior. However, given the criminalization of substance use itself, we must think deeply about what we mean by substance use leading to criminal behavior. In this assessment, we would be most concerned about preventing the occurrence of "drug-related" crimes and "drug-using lifestyle." It is hard to assess how many individuals with SUDs commit crimes resultant to (but not "drug-defined") their use. One way to examine the data is to consider the proportion of individuals in our prisons because of direct "drug-defined" crimes, which turns out to be staggeringly high with 48% of federal prisoners and 16% of state prisoners having a drug-defined charge as their most serious charge [20].

What Does This Mean for Your Assessment of Mr. Zimmerman?
You reviewed Mr. Zimmerman's criminal history. He has been arrested numerous times in the last 2 years for possession charges. If merely looking at his risk of relapse to substances and thus criminal possession of opioids based upon his repeated arrest, his risk would be extraordinarily high. However, Mr. Zimmerman has not been arrested for "drug-related" offenses nor does he have a violent history. In addition to your assessment of his risk for relapse, you consider whether he is a risk toward himself or others. You have assessed no signs of risk from Mr. Zimmerman and report this. You also can consider speaking to the factors that could decrease his risk of continued arrest which would be appropriate psychiatric treatment which includes medication-assisted treatment such as methadone or buprenorphine, treatments he has never been offered despite his many interactions with the legal system.

Punishment Versus Rehabilitation

Directly related to our views of whether or not we see SUDs as a diagnosis on equal playing field with other psychiatric diagnoses and the role of "choice" is the judgment of whether punishment or rehabilitation is more valued in our culture. As a medical profession, there is much that can be offered to this dialog within our country. Going back to the early writings of Benezet, he writes of a call to action for the world's governments to invest efforts into the reduction of alcohol use. Benezet states that in regard to alcohol "it behooves all, who have any bowels of pity for their fellow-creatures, more especially the governors of the nations, as guardians and tender fathers, to guard the people committee to their charge from this mighty destroyer." Reducing the rates of substance use in the United States continues to baffle our society, and we must continue to try to intervene at all phases by focusing on (1) reducing the exposure to substances, (2) early intervention in those who do use to prevent transition to a SUD, and (3) effective treatment for SUDs. Medical professionals have an important role and voice at each of these stages of substance use reduction. Our history in the United States is full of regulations that have not led to the elimination of substance misuse nor the end of SUDs. In our short history as a country, we have gone through prohibitions, the War on Drugs (with mandatory minimums for drug crimes) and the growth of substance-related charges (e.g., development of drug-free zones, increased penalties for nondrug-dependent possession of drugs, the multiplicative effect of possession of narcotics, possession of paraphernalia, and possession within a drug-free zone, and additional penalties for repeat drug offenders). Despite these legal and governmental restrictions, we have not seen a substantial decrease in exposure (i.e., rates of use) nor in the rates of SUDs over time (i.e., reducing transition from misuse to SUD; [13]). There is a clear role for the law in reducing availability of drugs, for example, the prosecution of medical doctors with "prescription mills" for opioids could decrease access and first exposures to prescription opioids. Also, the criminal justice system has a role in increasing

treatment exposure and providing structure to increase quit attempts without incarceration.

Medical evidence has shown that individuals with substance use are more likely to be re-incarcerated as a result of parole or probation violations following release from incarceration as compared to those who do not use substances, and further the rates of relapse on the first day of release from incarceration are incredibly high (Bennett, Holloway, & Farrington 2008; [14–17]. Taken together, these findings suggest that incarceration (as one of our strictest punishments) does not reduce the chances of continued criminal behavior. We also know that there are effective treatments for SUDs (e.g., evidence-based psychotherapy, medication-assisted treatment, community supports, etc.), and when those treatments are provided immediately upon release from incarceration, the rates of relapse to substances and also recidivism are significantly decreased [18].

If we consider two other forms of community-based legal oversight, probation and drug court, the results are more promising. In the short-term, strict monitoring (e.g., drug courts) and suspended sentences (when one is only incarcerated after a violation of the terms for release to the community) can serve to reduce substance use for some individuals. If we think about someone who is misusing substances, but not exhibiting characteristic symptoms of SUDs, it would make sense that increased structure in the form of possible punishments (e.g., immediate incarcerations upon positive drug screens, suspended sentences, risks of violating probation, etc.) or rewards (e.g., negative drug screen leads to getting hired at a new, desirable job) can provide enough motivation during the period of time that those limits are in place. However, there are individuals who are repeatedly arrested for substance use crimes even while on probation, and those individuals more likely than not are suffering from serious SUDs requiring more intensive intervention.

What Does This Mean for Your Assessment of Mr. Zimmerman?

A common question that can arise in a court-based evaluation of substance use is your belief as a professional of the likelihood of relapse. You should understand the potential penalties that Mr. Zimmerman could be facing before discussing his potential for relapse or alternatively his potential to remain abstinent in the future. In the case of Mr. Zimmerman, imagine that a minimum length of incarceration is 3 months. You know as a medical professional that he will be at high-risk of relapse upon his release, and it would be important to be able to speak to the services that may increase his chances of preventing relapse following his release from incarceration.

Conclusion

Addiction or substance use disorders, have long received differential treatment as compared to other psychiatric and medical disorders by the community, the legal system, and our own medical system. Research and evidence from the medical community had an impact in Robinson v. California on the overturning of addiction to narcotics as a misdemeanor punishable with a mandatory

imprisonment. As a result of this case, it is no longer allowable to criminally penalize someone for having a substance use disorder. There are many potential criminal consequences of SUDs and those with more serious SUDs are more likely to be involved in the criminal justice system. It is our role in the medical profession to be able to translate the medical evidence of SUDs so as to inform a legal audience regarding the issues of choice, recovery, and relapse as they pertain to SUDs. It is also our role to speak to the elements that increase chances of success in recovery/abstinence (e.g., medication-assisted treatments, stable living, evidence-based psychotherapy to address co-occurring disorders, etc.). If you are in the position of evaluating an individual for a SUD as it relates to criminal charges, you should:

1. Know the medical evidence for SUDs as a disease and be able to provide support
2. Know the symptoms of SUDs and be sure to have clear descriptions of what is meant by each symptom in lay terms
3. Support your diagnosis with evidence, every symptom if possible (especially if you observe physical evidence, such as withdrawal)
4. Know the course of the SUD and other substances used, including detailed information on the onset of the use and periods of abstinence/relapse
5. Be able to speak knowledgeably to the course and recovery from SUDs broadly and what strategies could be implemented for the individual you are evaluating to increase his or her chance of success

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Child and Adolescent Forensic Psychiatry

14

Carlos A. Salgado

Clinical Vignette

You are a resident working in an outpatient Child-Adolescent Psychiatry Clinic. You are about to see a 17-year-old boy that was referred by his pediatrician for "ADHD and aggression." As you walk into the room, you are immediately struck by the young man's appearance. He is tall and muscular and could easily be mistaken for someone in their 20s. He is sitting down and casually leaning back in his chair; however upon your entering in the room, he quickly hunches over, elbows on knees, and begins nervously biting his nails. He eyes you somewhat suspiciously. He is accompanied by his father, a burly man in his late 40s, with a worried look on his face.

You introduce yourself and begin the interview: "Tell me what brings you in?" The young man shrugs his shoulders and looks away toward the corner of the room. His father quickly nudges him and sternly adds: "Hey, the doctor asked you a question." The young man sighs, looks up at you, and says: "I dunno, they told me to come here." You ask, "Who is they? "He explains, "My doctor, she thinks my ADHD is really bad." He ruffles his hair and stares off into the corner again.

His father sighs, rolls his eyes, and begins, "You see doc, he's been getting into trouble. Constantly fights at school. He's repeating ninth grade now. Not doing well, not doing well at all. Constantly skipping classes. Even fights with kids in the neighborhood." You nod appreciatively at the father and turn to the patient, offering: "Sounds like things aren't going very well…what can you tell me about that?" The patient looks up reluctantly: "Yeah, I got into some fights…gotta stand up for yourself you know."

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You proceed to ask him to describe a typical school day, and the patient replies, "I hang out with my friends mostly." He adds, "School is boring, classes don't make sense, and I can't pay attention anyway." The father clarifies that his son had been diagnosed with ADHD in elementary school and started on a stimulant medication. The patient's father and mother would not routinely require the patient to take the prescribed medication, and the patient would not always make it to follow-up appointments. His father added that his own personal history of cocaine use at that time contributed to some of the chaotic upbringing the patient had been exposed to and poor compliance with treatment.

The patient's father also added that he was concerned about his son's ongoing association with "the wrong crowd," especially considering his criminal history and current probation. His father wondered whether medication or treatment of some kind might be helpful to keep the young man out of trouble.

You turn to the patient in an effort to clarify a few things and ask: "Can you tell me more about the probation and the conditions of it?" He answers: "I got into trouble with some kids at school; they sort of dared me to take something from the store so I did it. We burglarized a store, basically. I went to jail for a year. Now I am on probation." He described that the conditions of his probation are "now, I have to stay out of trouble basically, not use drugs or anything like that. I get random urine tests as part of the probation."

You inquire about his previous medication trial: "When you were on a medication in elementary school, do you remember if it was helpful to you?" The patient answers that he thinks so but could not be completely sure. He does however recall not getting into trouble as much. "Do you think the meds might help me now as well? Or do you think this is just how I am now, how I'll always be?" he asks.

How do you respond?

Graham v. Florida, US Supreme Court, 2010 [1]

Terrance Jamar Graham was born on January 6, 1987 to cocaine-addicted parents. He was diagnosed with attention deficit hyperactivity disorder (ADHD) in grade school, began using alcohol and tobacco by age 9, and was smoking marijuana by age 13. When he was 16 years old, Mr. Graham was involved in an attempted robbery at a restaurant in Jacksonville, Florida, along with three other school-aged boys. One of the boys struck and injured the restaurant manager. As the manager yelled, the boys decided to flee, and no money was taken.

At the time of his arrest, under Florida law, it was up to the discretion of the prosecutor whether to charge 16 and 17 year olds as adults or juveniles. Mr. Graham was ultimately charged as an adult with armed burglary with assault or battery (carrying a maximum possible sentence of life without parole) and attempted armed robbery (carrying a maximum possible sentence of 15 years imprisonment). Mr. Graham pled guilty to both charges under a plea agreement. He was sentenced to

3 years of probation and received credit for the 12 months that he spent in jail awaiting trial. He was 17 years old when he was released from jail in June 2004.

Approximately 6 months later, when he was 17 years and 11 months old, Mr. Graham was arrested for his role in a home invasion along with two male accomplices who were 20 years old. After leaving the home, the assailants attempted another robbery, at which time one of the men sustained a gunshot wound. Mr. Graham drove his accomplices to the hospital and dropped them off in the car he had borrowed from his father. The police attempted to stop Mr. Graham which resulted in a high-speed chase, a crash, and his eventual arrest. Firearms were found in the vehicle. Mr. Graham was found to have violated the terms of his probation due to associating with individuals engaged in criminal activity, possession of firearms, and committing crimes. He was found guilty of the initial crime committed in 2003 (armed burglary and attempted armed robbery charges) and was sentenced to life imprisonment without the possibility of parole.

Mr. Graham filed a motion challenging his sentence as cruel and unusual punishment under the Eighth Amendment given that he was a minor at the time he committed the crime, which was denied. The First District Court of Appeals of Florida affirmed the trial court's decision, stating that the sentence was "not grossly disproportionate to his crimes." The Florida Supreme Court denied review of the case; however the US Supreme Court agreed to review it.

The US Supreme Court reversed the judgment regarding Mr. Graham's sentencing. The Court stated that a sentence of life without parole for a non-homicide offense was rare and did not accomplish the goals of judicial punishment, which included retribution, deterrence, incapacitation, and rehabilitation. The Court added that since Mr. Graham was a juvenile, it could not be determined whether he would be a danger to society for the rest of his life, and such a sentence denied "the juvenile offender a chance to demonstrate growth, maturity and rehabilitation." As a result, the US Supreme Court decided that imposition of such a stringent sentence for a crime committed by a minor was inappropriate due to the future potential that a juvenile could exhibit. This decision further cemented that juveniles have the right to be treated differently when punishments for criminal acts are imposed.

Introduction

To understand the forensic issues that arise within the realm of child and adolescent psychiatry, it is important to recognize that the special place juveniles occupy within the legal system has evolved through the centuries. This has included the development of the juvenile court system and the ongoing reform that has taken place within that system, how the concept of culpability plays a role when determining the appropriate punishment for a crime, and the US Supreme Court's review of cases that have contributed to the evolving place of juveniles within the courts and the extent to which minors should be punished. There are also several factors unique to children that have contributed to the Court's decisions that will be reviewed.

The Differences Between Children and Adults in the Court Were Not Always Clear

Treating children is not the same as merely treating miniature adults. Children are significantly different than a fully developed adult; biologically, socially, and psychologically. This may be considered by some readers as an obvious concept, and with ongoing developments in the areas of neural imaging, functional imaging, and physiology, there is greater appreciation of the neuropsychological aspects of child and adolescent development that continues even into adulthood. While this is not a new concept in modern day society, laws differentiating adults and children were not always clearly delineated, especially when it came to civil liberties and protections. For example, prior to 1875 there was no formal organization that was dedicated to the prevention of abuse toward children [2], and it was not until 1938 that there was a federal act delineating fair child labor practices [3]. By the same token, when considering the expanse of our country's legal history, it was not until relatively recently that a judicial jurisdiction was developed to be focused solely on the adjudication of juveniles (i.e., juvenile court).

The first juvenile court was established in Illinois in 1899. Before that, children 14 years of age and older were tried in adult court and were presumed to be fully culpable as adults. The juvenile courts' jurisdiction was meant to handle more minor offenses of children under the age of 16. The idea was to transition their sentencing and experience within the juvenile justice system to be more of a rehabilitative one versus the more punitive model in place at that time in the adult criminal court system [4]. By 1935, all states had established juvenile courts. The theory of *parens patriae* (idea that the State has the power to intervene in the best interest of children) also contributed to the change as the State was seen as bearing the responsibility for its youth rather than solely to punish them. [5] Judge Julian Mack described the philosophy in his 1909 article as:

"Why is it not just and proper to treat these juvenile offenders, as we deal with the neglected children, as a wise and merciful father handles his own child whose errors are not discovered by the authorities? Why is it not the duty of the state, instead of asking merely whether a boy or a girl has committed a specific offense, to find out what he is, physically, mentally, morally, and then if it learns that he is treading the path that leads to criminality, to take him in charge, not so much to punish as to reform, not to degrade but to uplift, not to crush but to develop, not to make him a criminal but a worthy citizen [6]."

With time, the juvenile court system was perceived to have adopted a relaxed posture. This included the informal and inconsistent process of juvenile waiver and transfer to adult court (the process by which certain juvenile cases were deemed to be more appropriately handled in and transferred to adult court). The lax posture stemmed from the idea that formal proceedings in juvenile court would lead to an adversarial environment [7]. However, as stated by Justice Fortas in 1966, "…there may be cause for concern that the child receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children [8]." This inconsistent

process directly impeded the due process protections which guarantee that all legal proceedings are fair and that the defendant will be given appropriate notice of the proceedings and have an opportunity for a hearing prior to any decision by the court. In the following year, the Supreme Court ensured additional due process protections were granted for juveniles engaged with the juvenile court system [9]. Thus, when presented with the possibility of requesting waivers of juveniles from juvenile court to adult court, juveniles were assured a hearing, representation by legal counsel, access to information for the basis of the waiver decision, and a statement justifying the reason for the waiver [10]. Despite the reformation that occurred, there was eventually a swing in the pendulum that brought with it pessimism and skepticism about the lenient nature of the juvenile court system. This was also paired with an increase in violent offenses that were being committed by juvenile offenders [11].

Culpability is a legal concept related to having committed an act or fault [12], which also adds the aspect of moral blame associated with a particular act [11]. Additionally, for a "crime" to have been committed, there must exist both the act itself (*actus rea*) and a person's understanding that the act is criminal (*mens rea*). In the legal system, children are considered to not be capable of being blamed for their actions. The lessened culpability in children has been documented as far back as the sixteenth century BCE where Hebrew Scriptures referenced offenses where you could or could not impose blame and stated that offenses committed by children were blameless as children could not weigh the moral implications of their behavior. This can also be seen in the *doli incapax* doctrine of the seventeenth century, which holds that children under the age of seven are incapable of committing a crime since they do not have the criminal intent or malice needed for a crime to have been committed [12]. Thus, when the offender is a young child, the question of culpability becomes easier in the sense that it is an obvious decision. However, between ages 7 and 13, this notion of capacity to form criminal intent or malice could be challenged in court, [13] and thus in adolescence the concept of partial culpability came into question.

The Supreme Court and Sentencing of Juveniles

The first juvenile offender that was executed in the United States was Thomas Graunger who in 1642 was convicted of bestiality in Plymouth Colony, Massachusetts [10]. Although not a common place phenomenon, youth offenders tried in court as adults had the potential of receiving adult sentences. Although the juvenile court's focus was on rehabilitation, with greater concerns regarding the leniency of the juvenile court, there was an accompanied increase in juvenile transfers to adult court. In the adult criminal court system, youthful offenders were held as fully responsible for their crimes and allowed the possibility of their being sentenced to death. During the 1990s, the United States was one of only six nations that were executing individuals that had committed crimes as juveniles. The other countries included Pakistan, Iran, Yemen, Nigeria, and Saudi Arabia [10, 14].

Table 14.1 Supreme Court cases regarding juvenile sentencing

Year	Case	Significance of decision
1988	Thompson v. Oklahoma	The death sentence for juveniles under the age of 16 is unconstitutional
1989	Stanford v. Kentucky	The death sentence is not cruel and unusual punishment for 16 and 17 year olds
2005	Roper v. Simmons	The death sentence for anyone under the age of 18 is cruel and unusual
2010	Graham v. Florida	Life without possibility of parole is unconstitutional for anyone under the age of 18

The US Supreme Court (the Court) has dealt with the concept of death sentences for juveniles in various ways (Table 14.1). In 1982, the Court laid the groundwork for the consideration of age and upbringing as a mitigating factor that should be considered at the sentencing phase of a death penalty case. Monty Lee Eddings was 16 when convicted of murder and sentenced to death. Although his age was a mitigating factor, the other aspects of his family life, exposure to violence, and emotional problems were not considered as mitigating factors independently. When the decision was eventually overturned by the Court, Justice Powell's opinion stated, "so must the background and mental and emotional development be duly considered [15]."

In the Court's review of Thomson v. Oklahoma (1988) [16], the question that was raised was whether the execution of an offender that was 15 years old at the time he committed the offense violated the Eighth Amendment right against cruel and unusual punishment. In the Court's opinion, they pointed out that the death penalty is supposed to serve the purpose of retribution and deterrence. In the case of a juvenile offender, they acknowledged the lesser culpability that youth retains, adding that given "the teenager's capacity for growth, and society's fiduciary obligations to its children, this conclusion is simply inapplicable to the execution of a 15-year-old offender." In the Court's opinion sentencing someone under the age of 16 would not achieve the intended purpose of capital punishment. Thus, this sentence would cause "purposeless and needless imposition of pain and suffering." They added that there were several laws that all states had enacted that included prohibitions against 15 year olds: voting, serving on a jury, driving without parental consent, marrying without parental consent, purchasing pornographic material, or participating in legalized gambling. These factors aided in their conceptualization that 15 year olds were not prepared to assume the same level of responsibility as adults.

In the following year, the Court was faced with a similar question regarding whether it was cruel and unusual punishment under the Eighth Amendment to impose the death penalty for all juvenile offenders. However, the sentences in question in the case of Stanford v. Kentucky (1989) [17] involved juvenile offenders that were 16 and 17 years old at the time they committed murder. The Court's ultimate opinion was supported by a lack of consensus in State and Federal decisions, which the Court stated did allow for the imposition of death for 16 and 17 year olds. Thus, the Court held that the Eighth Amendment's prohibition of cruel and unusual punishment did not prevent states from imposing the death penalty to juvenile offenders over the age of 15.

The same question again arose in 2005 when the Court reviewed the case of Christopher Simmons (Roper v. Simmons) [18], in which a 17-year-old had been convicted of murder and sentenced to death. Since the Court's decision in 1989 (Stanford v. Kentucky), the Roper Court opined that there had been a change in the national consensus. At that time in 2005, 30 states prohibited juvenile death penalty; 12 states had abolished the death penalty completely; and 18 had specific prohibitions against the death sentence for juvenile offenders. Additionally, the Court stated that executing juveniles had become a rare practice even in states where it was legally allowed, as there had only been six states that had carried out executions of juvenile offenders since the 1989 decision of the Court. Thus, all these factors were considered evidence of a national consensus that American society viewed youthful offenders as less culpable as a class. The Court opined that at the time, there was also international consensus on the issue as the United States was one of the few remaining countries in the world that had not yet banned the practice of sentencing juveniles to death. In its opinion, the Court provided three reasons as to why juveniles were less culpable as a class: [1] lack of maturity and underdeveloped sense of responsibility could result in poorly thought-out decisions; [2] juveniles are more vulnerable to negative influences, such as peer pressure; and [3] their character and personality traits are not as well formed as adults. As a result, the Court held that the Eighth Amendment forbids the imposition of the death penalty on juvenile offenders under 18. As mentioned above, the Court then addressed additional developmental considerations that made juvenile offenders' culpability different as a class when they reviewed the case of Graham v. Florida in 2010, providing further evidence that the Court has recognized biological, psychological, and social differences that must be considered when dealing with the sentencing of juvenile offenders.

Factors Considered in Determining Partial Culpability

The Supreme Court cases referenced above begin to shed light on the factors and rationale that contribute to the partial or lessened culpability that juveniles as a class are privileged to in our legal system. The Thompson Court (1989) made specific reference to "the teenagers capacity for growth" which is related to the ongoing development and maturation that adolescents undergo. The Court also referred to the concept of *parens patriae*, stating that it was "societies fiduciary obligation to its children." In our society, a line has been drawn at the age of 18 as being the age of majority. Prior to this, there are certain civil liberties that juveniles are not permitted to engage in, which served as evidence of the adolescent's inability to assume the full responsibilities of adulthood. The Supreme Court has also considered other factors that contribute to juveniles' lesser culpability, including a lack of maturity, greater vulnerability to negative influences, and incomplete character and personality development. As a result, in the eyes of the Court, adolescents thus do not merit the death penalty [18], nor do they merit penalties in which there is an eradication of hope that the individual may demonstrate growth and maturity, thus forbidding a juvenile from being sentenced to life without the possibility of parole [1].

Other factors that contribute to this reduced culpability included a heightened degree of impulsivity, an inability to refrain from wrongful actions, and that they may be in a developmental stage of increased aggression [11]. The surgeon general's report on youth violence indicates that violent offenses are more common in adolescents, citing that 30–40% of boys under the age of 17 had already committed a serious violent offense. The report also mentions that only 20% of those adolescents continue displaying violent offenses into adulthood [19], indicating these behaviors may be more reflective of their developmental stage rather than life-long ingrained personality traits. It has also been shown that the peak age of onset for violent offending occurs between 15 and 16 years of age [20]. Thus, during adolescence there is greater aggression, less ability to refrain from engaging in aggressive behaviors, and more likelihood for violent offending. However, this appears to be a relatively time-limited phenomenon, which may reflect the individual's increased ability to control aggressive impulses as they transition into adulthood.

As opposed to adult offenders, juvenile offenders tend to commit violent offenses in groups rather than acting independently [20]. This is further evidence of the vulnerability to be negatively influenced by peer groups. Peer influence, through social comparison and conformity, makes adolescents more likely to conform their behavior to that of others and to measure their own behavior against that of others [21]. Of note, several of the cases referenced above included crimes that were committed as a group. Immaturity is also another factor to consider, specifically, the cognitive limitations inherent to adolescents as they lack the ability to completely weigh the potential consequences of their choices. In addition, psychosocial immaturity (the underdeveloped social and emotional awareness displayed by children as they transition to adulthood) is another reason juvenile offenders engage in criminal behavior and another reason they are susceptible to peer influence [11].

There are also neurocognitive considerations. In the brain, the socio-emotional system develops before the cognitive control system. The cognitive control system relies on the frontal cortex and is involved in impulse control, planning, assessment of risk and rewards, and reasoning. Thus, since the development of the socio-emotional system, controlled by the limbic system, precedes the development of the brain structures which control these emotions, this discrepancy can lead to an increased tendency in adolescence to engage in impulsive and higher-risk behaviors [22].

Finally, it is important to consider the concept of unfinished character development that was mentioned in Roper v. Simmons, whereby the Court specifically cited the American Psychiatric Association's Diagnostic and Statistical Manual's (DSM) provision that antisocial personality disorder should not be diagnosed before the age of 18 [23]. This is further reinforced by the idea that as character development progresses into adulthood, violent offending often does not continue [11, 19]. The Court in Roper stated that due to this transient character development, "a heinous crime committed by a juvenile is not evidence of irretrievably depraved character [18]." Thus, with ongoing development of the juvenile's character, there is the hope that adolescents would be able to eventually demonstrate their "growth and maturity [1]."

Conclusion

Legal protections were not always granted to children as we understand them now. Although there has been a long history in our country's legal system of understanding the lessened culpability of children, adolescent offenders continue to pose a gray area when it comes to considering how culpable they are for their criminal actions. There have been several instances where additional understanding of child and adolescent development has begun to inform case law and has been considered in the US Supreme Court decisions.

In general, juvenile courts were developed so as to deal with juvenile matters but were established nationwide by the 1920s, which is a relatively recent phenomenon. Following their initial development, there was a period of increased frustration with the court's lessened punitive power, leading to an increase in transfers of juveniles to adult courts. This subsequently led to an increase in adult sentencing for juveniles, including the death sentence and life without the possibility of parole. In more recent decisions by the Court, these practices have been deemed to be unconstitutional, further emphasizing the special category children and adolescents hold as a class in our current legal system.

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Special Topics in Forensic Psychiatry: The Insanity Defense and Competence to Stand Trial

15

Hassan M. Minhas

Not Guilty by Reason of Insanity

Clinical Vignette

On your day off from your busy medical practice, you read the headlines in the newspaper—"Top ranking government official shot! Suspect may have a mental illness." On reading the story, you learn that an individual shot a government official, whom he believed was the President of the country. As you follow the story developed over the next few days, you read that the government official eventually passed away from the injuries he sustained, and the defendant is charged with murder.

The defendant's legal team files for a plea of Not Guilty by Reason of Insanity (NGRI); realizing the national importance this case holds, and its relevance to your field, you closely follow the trial proceedings and the public discussion that ensues. At trial, witnesses testify that the defendant was suffering from persecutory delusions at the time of the offense, and the defense team argues that he should therefore be found Not Guilty by Reason of Insanity (NGRI).

At a faculty meeting shortly after the trial, some of your colleagues ask your general opinion on the matter of legal insanity, and several interesting questions are raised: How does mental illness impact culpability? What is the legal standard of "insanity"? If a delusional individual acts criminally under the influence of a delusion, should he be found NGRI? What about an alcoholic with no control over his drinking who commits a crime when drunk? What about an individual with mental illness who would not have committed the crime but for his mental illness? What about an individual with an impulse control disorder, who causes bodily harm to someone else in a state of impulsivity? The questions continue…

How would you respond to your colleagues' questions?

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What Really Happened

M'Naghten's Case, Eng. Rep. 718 [1]

In 1843, Mr. Daniel M'Naghten fired a gun at the Prime Minister's private secretary, civil servant Edward Drummond, at point-blank range (believing him to be the Prime Minister himself). Mr. Drummond passed away five days later. On appearing at the magistrates' court the next day, Mr. M'Naghten stated that persecution by the Tories had driven him to act.

M'Naghten's trial took place before Chief Justice Tindal, Justice Williams and Justice Coleridge. At the trial, M'Naghten plead Not Guilty by Reason of Insanity. Evidence was provided, and witnesses were called to attest to the fact that he was not in a sound state of mind at the time of committing the act. Both prosecution and defense based their cases on what constituted a legal defense of insanity. The prosecution argued that in spite of his "partial insanity" Mr. M'Naghten was capable of distinguishing right from wrong, and conscious that he was committing a crime. The defense, on the other hand, argued that Mr. M'Naghten's delusions had led to a breakdown in his moral sense of right and wrong and loss of self-control, which had left him in a state where he was no longer a "reasonable and responsible being." After hearing both sides of the case, the jury returned a verdict of Not Guilty by Reason of Insanity.

Following the ruling, due to public outcry, Queen Victoria appealed to the judges of the House of Lords to answer general questions about the standard for legal insanity. In response to these questions, the judges formulated the M'Naghten rule which states that: "the jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong (DANIEL M'NAGHTEN'S CASE. May 26, June 19, 1843. In: United Kingdom House of Lords Decisions, British and Irish Legal Information Institute.)."

Core Principles of the Topic

Actus non facit reum nisi mens sit rea—this legal principle was put forward in the 1600s by English jurist Sir Edward Coke, and is literally translated to "an act does not make a person guilty unless (their) mind is also guilty." This principle underlines the importance of *mens rea*, or "guilty mind" and highlights the interplay between mental state and culpability.

Prior to the M'Naghten case, there had been several attempts to define a test for insanity. For example, the "wild beast test" stated that to be found insane, a defendant must be "totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, a brute, or a wild beast [2]." This standard

continued to evolve; in the early 1800s, Mr. James Hadley attempted to assassinate King George III. The court trying the case decided that a crime committed under some delusion would be excused only if it would have been excusable had the delusion been true. This would apply in a situation when, for example, the accused imagines he is cutting through a loaf of bread, whereas in fact he is cutting through a person's neck.

The M'Naghten case raised a lot of controversy and public outrage; the Queen, concerned with the outcome of the case, asked the justices of the House of Lords to clarify the test of legal insanity, and this led to the M'Naghten rule. The justices stated that in order to qualify for the Insanity Defense, two main components were required: (1) the presence of a mental illness, which results in (2) either an inability to know the nature and quality of the act; or in an impairment in one's ability to know the wrongfulness of the conduct. The wording "nature and quality" refers to the physical quality of the act as opposed to the moral quality; for example, someone who had the delusional belief that they were slicing a cake when they were actually cutting off someone's limb would not know the "nature and quality of their act." Conversely, if the same individual did know that they were cutting off a limb (but believed that the limb being severed was Satan's and thus it was morally correct to do so), he or she would be aware of the "nature and quality" of the act, though his/her ability to know the wrongfulness of the act would be impaired.

The M'Naghten rule began to be adopted by states in the United States of America in the mid-1800s, and was eventually adopted by most states. Over time, criticism of the M'Naghten rule grew, and some argued that it was too strict, viz. it too narrowly limited cases in which it could be applied. In response to this growing criticism, the Product Rule (also known as the Durham rule) was developed around the 1950s. This rule proposed that: "No man shall be held accountable, criminally, for an act which was the offspring and *product* of mental disease." [3]. In a 1954 [4] case from The United States Court of Appeals District of Columbia Circuit (The "Durham case"), the court reviewed the trial court's conviction of Mr. Monte Durham. Mr. Durham had a long history of psychiatric illness, several past inpatient psychiatric hospitalizations, and past diagnoses of "psychosis" and "psychopathic personality without mental disorder." The trial court had found him guilty of a housebreaking charge; the court of appeals, however, overturned the conviction, and in doing so stated: "An accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect." This test was more inclusive than the M'Naghten rule.

Another test that has been used to determine insanity is the irresistible impulse test. Although this test has been argued since the late 1800s, it gained acceptance around the 1950s. The test is based on the inability of an individual to conform their behavior to the requirements of the law. That is, even though they appreciated that their actions were morally wrong, they were unable to control their conduct due to their mental illness [5]. A well-known case utilizing this defense was the case of Lorena Bobbitt, who was charged for cutting off her husband's penis with a kitchen knife while he slept. Ms. Bobbit's defense team presented evidence to demonstrate that her husband had abused and raped her in the past. Using this evidence, they

argued that even though she knew the action itself was wrong, she was unable to curtail her impulse. The jury found Ms. Bobbitt not guilty due to insanity causing an irresistible impulse to sexually wound her husband.

In 1962 [6], the American Law Institute (ALI) formulated the Model Penal Code, providing a compromise between the stricter M'Naghten, and broader Durham rules. After being introduced, the Model Penal Code defense for insanity became widely adopted by most states in the United States. The test states that: "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law." This test essentially combines the M'Naughten and the irresistible impulse defenses, with some modifications. It is important to note that the wording "appreciate" is broader than "knowing" wrongfulness—a defendant may "know" that shooting somebody is unlawful, but may not "appreciate" the wrongfulness if he believed that he acted on orders from the FBI (as part of a delusion), and that it was therefore the morally righteous thing to do.

The Insanity Defense attracted the public spotlight and criticism in 1982, when Mr. John W. Hinckley attempted to assassinate President Ronald Reagan. At his trial in 1981, Mr. Hinckley was found NGRI. The verdict resulted in public outcry, and this led several states to drop the insanity defense entirely (Montana, Utah, Idaho, and later Kansas). Other states enacted a number of measures to increase the difficulty of defendants obtaining an NGRI defense, including:

1. Adopting the stricter M'Naghten standard over the Model Penal Code standard (as noted above, the Model Penal Code standard was a compromise between the stricter M'Naghten and more lax Durham Standard. After the Hinkley trial some states reverted from the Model Penal Code to M'Naghten).
2. Increasing the stringency of the state's civil commitment procedures.
3. Adopting a "Guilty but Mentally Ill" defense (where the defendant is found guilty but also in need of mental health treatment while incarcerated).

On the Federal level, in response to the Hinckley trial, the Insanity Reform act of 1984 was introduced which amended the United States Federal Law. Prior to the enactment of the Act, if the insanity defense was raised in federal court, the prosecution was required to prove the defendant's sanity "beyond a reasonable doubt." The Act amended this, and shifted the burden of proof from the prosecution to the defense. This meant that now the defendant was required to prove insanity by "clear and convincing evidence." Although "clear and convincing" is a lesser standard than "beyond reasonable doubt," shifting the burden from the prosecution to the defense made the defense more difficult to successfully obtain.

Presently each state has a different insanity test, and it is important that the forensic psychiatrist performing an insanity evaluation be knowledgeable regarding the specific insanity statute in the state in which they practice. This can best be obtained by asking the attorney for the relevant portion of the statute in the state where the

case is being tried. For a comprehensive list of state insanity defense statutes, the reader can refer to the American Academy of Psychiatry and the Law's Practice Guideline for forensic psychiatric evaluation of defendants raising the insanity defense [7].

The Insanity Defense is an affirmative defense, meaning that the burden of proving that they were legally "insane" at the time of the act is on the defendant. This differs from most criminal cases in which the burden is on the prosecutor to prove the defendant is guilty of the alleged acts beyond a reasonable doubt. However, the defendant need only prove they were "insane" at the time by *clear and convincing evidence* (a lesser standard than the typical beyond a reasonable doubt standard). Once the defense decides to enter a plea of Not Guilty by Reason of Insanity, they almost always provide the court with evidence from a psychiatric expert. The prosecution may choose to get an evaluation of their own by their own psychiatric expert, whose evaluation may or may not come to the same conclusion as that of the defense.

An NGRI evaluation performed by a forensic psychiatrist typically begins with clarifying the specific NGRI statute applicable to the jurisdiction of the court, and understanding the legal charges and the state's version of the offense. Then the defendant is interviewed (often several times) and psychological testing may be obtained if appropriate. A thorough examination includes gathering further corroborating information such as past medical and treatment records, school records, employment history, etc. Since an NGRI evaluation is a retrospective examination of the defendant's mental state at the time of the alleged conduct, collateral records and reports around the period of time the act allegedly took place become extremely important.

If a defendant is found NGRI, the defendant is not released from custody, but is instead committed to a psychiatric hospital. Many times the confinement at the psychiatric hospital can be for a period of time longer than what they would have served in prison had they been found guilty of the crime, though specific procedures for managing individuals found NGRI vary state by state.

Conclusion

- The Insanity Defense has a long and often controversial history. States have changed the relevant statutes based on evolving jurisprudence (theory and philosophy of law), and highly publicized events involving the defense (such as the Hinckley Trial).
- Currently there are several different versions of the Insanity Defense statute, with some states having no provision for the Insanity Defense at all (Montana, Utah, Idaho, Kansas), and most states using some modified version of a M'Naghten or Model Penal Code standard. It is important for the forensic evaluator to familiarize him/herself with the specific statute of the state or jurisdiction the evaluation is being performed in.

– The most common versions of the Insanity Defense include the M'Naghten standard, the Durham Rule (also known as the Product Rule), the Irresistible Impulse Test, and the Model Penal Code Test.
– After being found Not Guilty by Reason of Insanity, defendants are generally committed to psychiatric hospitals, though specific procedures for confining and managing these individuals vary state by state.

Competence to Stand Trial

Clinical Vignette

You are an outpatient psychiatrist, and have been taking care of Mr. John Smith, a 38-year-old male with a long history of schizophrenia, and of significant treatment noncompliance. You get a call from Mr. Smith's mother, who informs you that he has recently been arrested for an alleged assault. She states that she is in the process of hiring an attorney for him, but that she is worried that he will have a difficult time working with one, as he has been very psychotic over the past week because he stopped taking his clozapine. You understand her concerns, as you know that when Mr. Smith is off of his medication, he gets extremely disorganized, and is usually unable to have a linear, goal-oriented discussion. His mother is concerned that Mr. Smith would not be able to provide his attorney with the relevant information required to assist in his defense.

What would you recommend to Mr. Smith's mother to address her concerns?

What Really Happened

Dusky v. United States, 362 U.S. 402 [8]

Mr. Milton Dusky was a 33-year-old man and was charged with assisting in the kidnapping and rape of an underage female. Mr. Dusky had a history of mental illness, and a psychiatrist testified that as a result of mental illness, he was "unable to properly understand the proceedings against him and unable to adequately assist counsel in his defense." Despite this testimony, Mr. Dusky was ruled to be competent to stand trial because he was oriented and able to provide some details regarding the kidnapping incident. He was eventually sentenced to 45 years in prison.

The case was reviewed by the United States Supreme Court. After reviewing the evidence, the Court ruled that to be competent to stand trial the defendant must have a "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him." The court stated that a brief mental status exam was insufficient. Mr. Dusky's case was remanded for retrial, and eventually his sentence was reduced to 20 years in prison.

Core Principles of the Topic

Competency evaluations are one of the most common type of evaluations that forensic psychiatrists perform. The nature of competency evaluations is similar to "capacity evaluations" that are performed in a clinical context. Just like a consult-liaison psychiatrist may be asked to assess whether a patient has "capacity" to make decisions about his/her treatment, a forensic psychiatrist may be asked to assess whether a patient is "competent" to assist in his/her defense. Defendants have a right to understand the proceedings against them and to be able to aid in their own defense. If they lack the capacity to do either, they are not legally competent to stand trial. It is important to note that competency to stand trial relates to the defendant's state of mind during criminal proceedings, not during the commission of the alleged crime (the latter is an issue of criminal responsibility—see prior section on the insanity defense).

The concept of competency to stand trial dates back to England in the seventeenth century. At that time, in an attempt to avoid entering a plea, some defendants would stand mute. In these situations, the court would decide whether the defendant was "obstinately mute" or "dumb by visitation of God." Defendants found to be "obstinately mute" had increasingly heavy weights placed on their chests until they responded. Defendants found "dumb by visitation of God" on the other hand, did not have to go through this ordeal.

Since then, the concept of competency has evolved and matured. The major landmark case that set a clear standard for competency to stand trial in the United States was Dusky v. United States. In the case, the Court ruled that competency required a "rational" and "factual" understanding of the proceedings, and the ability to consult with an attorney to aid in defense. It is important to note that the ruling separated "rational" from "factual" understanding—while a defendant may have a factual understanding of how the court works, if this understanding is based on an underlying delusional belief (for example that the judge is an alien out to destroy the world), the defendant does not have a "rational" understanding. The Dusky Standard has now been adopted by every state in the U.S. and is an integral part of criminal proceedings. A subsequent case, Drope v. Missouri, 420 U.S. 162 [9], further emphasized the Dusky ruling, and stated that a criminal defendant must be able "to assist in preparing his defense".

Although the Dusky case did not specify what conditions may make a person incompetent to stand trial, most states require the presence of a psychiatric illness. It is important to note that the presence of a psychiatric illness, although necessary, is not sufficient to demonstrate a lack of competency. In order to demonstrate a lack of competency, it must be demonstrated that the psychiatric illness is causing an inability to understand the proceedings of the court, or an inability to participate in one's own defense. As an example, a defendant may have severe schizophrenia, but still be able to understand the workings of the court, the charges against him, and be able to provide his attorney with relevant details pertinent to his defense.

The issue of competency may be raised at any point during the adjudication process, and it may be raised by the defense, prosecution, or the court (i.e., the judge).

Concern regarding competency is often raised when the defendant is demonstrating symptoms of mental illness, seems to be making decisions which are irrational, or is having difficulties interacting with his own attorney and/or the court. Once the question of competency is raised, the court issues an order for a psychiatric evaluation to assist in determining whether the defendant is legally competent for the trial to proceed. No further action can be taking on the case until the question regarding the defendant's competency is answered. If after an evaluation the defendant is deemed not competent by the court, the case cannot proceed until the defendant's competence is "restored" (his illness treated sufficiently that he is able to understand the proceedings and assist in his defense).

Prior to performing a competency evaluation, the psychiatrist should learn about the charges that the state has levied against the defendant. During the evaluation, the psychiatrist will complete a psychiatric assessment, including obtaining information pertaining to past psychiatric and medical history, family history, social history, etc. In addition, the psychiatrist will assess the defendant's knowledge and understanding of the various components involved in a legal proceeding—this would include an understanding of the roles of the judge, prosecutor, defense attorney, and of other key personnel and procedures. Also, it is important to assess the defendant's knowledge of the charges and an understanding of the allegations that have been made. Other important aspects to assess include the defendant's ability to behave properly during court proceedings and at trial, understanding of available pleas and their implications, knowledge of and capacity to understand and engage in a plea-bargaining process capacity to engage in appropriate, self-protective behavior, and the defendant's ability to retain and apply new information effectively. Obtaining collateral data (records and interviewing family/treatment providers) may also provide useful information that may assist in forming a more complete understanding of the defendant's psychiatric status [10].

After the evaluation is complete, the psychiatrist will summarize the findings in the form of a report in which he or she will reach an opinion as to the defendant's competence to a reasonable degree of medical certainty. If it is the doctor's opinion that the defendant is not competent, then it must be further clarified whether or not the defendant is "restorable"—viz., whether or not psychiatric treatment and/or education is likely to return the defendant's to a state of competence, and what would be the least restrictive setting needed to achieve this restoration (e.g., inpatient vs. outpatient). It is important to note that the evaluating psychiatrist presents his/her opinion to the court, but the final decision is made by the judge (who takes into consideration the report, and if needed, the doctor's testimony).

Most states have "restoration programs" for defendant's found to be not competent but restorable. This largely includes educating them about court personnel and procedures, and about the specific charges against them. Also, mental health treatment is provided to treat any active psychiatric symptoms which may be contributing to a lack of competency. In the situation where a defendant is found to be not competent but is refusing psychiatric medication, there is a provision to forcibly administer medications if the defendant meets certain criteria commonly referred to as the "Sell" criteria.

Sell v. United States, 539 U.S. 166 [11] was a landmark decision in which the Supreme Court imposed stringent limits on the forcible administration of psychotropic medication (solely for the purpose of restoring competency) to a defendant who has been determined to be incompetent to stand trial. In the case, the Court held that medication could be administered against the defendant's will only when: (1) An important government issue is at stake; (2) There is a substantial probability that the medication will enable the defendant to become competent without exposing them to substantially undermining side effects; (3) The medication is necessary to restore the defendant's competency, with no alternative and less intrusive procedures available that would produce the same results. These criteria are what are now known as the Sell criteria and in all states represent the threshold one must reach in order to forcibly medicate a defendant solely for the purpose of competence restoration.

Conclusion

- Defendants have a right to understand the proceedings against them and to be able to assist in their own defense. If they are unable to do so, then they are not competent to stand trial.
- Either party or the court can raise a concern about competence; once the concern is raised, the judge issues an order for a psychiatric evaluation and proceedings in the case halt until a determination regarding the defendant's competence is made.
- A competency evaluation includes a typical psychiatric assessment and a determination of the defendant's factual and rational understanding of the legal system as it applies to his/her case. The evaluation also determines whether the defendant is able to work with an attorney and participate in his/her own defense.
- If the defendant is found to be not competent, an assessment must be made regarding whether there is a substantial likelihood that the defendant can be restored to competency—if so, the least restrictive environment to achieve this goal should be used.
- There is a provision for forcible administration of medication solely for the purpose of restoring competency. However, for this to be done, a strict set of criteria (the Sell criteria) must be met.

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Conclusion: How to Learn More About Forensic Psychiatry

16

Tobias Wasser

The authors hope that this text has been a helpful introduction to the intersection of psychiatry and the law across a number of domains and subspecialty areas. Chapter authors have highlighted important core concepts related to the particular focus of their chapter to introduce readers to these topics. However, it would be unrealistic to expect readers to feel completely comfortable with all of these areas simply as a result of reading this text, and thus knowing how and when to refer to an appropriate colleague and how to explore additional educational opportunities in forensic psychiatry may be of interest to readers.

After reading this text, readers' increased understanding of the law will improve their capacity to discern which legal or forensic issues are within the scope of their general psychiatry practice and which are beyond it. For those issues that are beyond the reader's level of comfort or knowledge, it may be beneficial to consult with or refer to a forensic psychiatrist with more specialized expertise and training in these areas. Forensic psychiatrists have specialized knowledge and skill regarding forensic issues and are able to use their training to help clinicians understand and apply the law to their clinical work and to work with policy makers to help inform policies and statutes for legally regulated aspects of psychiatric practice (e.g., civil commitment and involuntary medication). Examples of areas that might benefit from referral to a forensic psychiatrist include requests from attorneys or clinical teams for complex violence or suicide risk assessments or specific types of forensic evaluations (e.g., to answer questions regarding competence to stand trial or criminal responsibility).

For those readers who have an interest in gaining a greater level of expertise in forensic psychiatry, it may be worthwhile to pursue additional training through a forensic psychiatry fellowship. As of 2017, there are 46 Accreditation Council for Graduate Medical Education (ACGME)-accredited forensic psychiatry fellowship programs in the USA and eight programs in Canada (see Table 16.1) [1]. Given the large number of fellowship programs, with significant variability in the didactic

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Table 16.1 List of forensic psychiatry fellowships in the USA and Canada

USA	Canada
Albert Einstein College of Medicine, New York	McMaster University, Ontario
Brown University Fellowship	Queen's University, Ontario
Case Western Reserve University, Ohio	University of Alberta
Columbia/Cornell, New York	University of British Columbia
Emory University, Georgia	University of Montreal Forensic Psychiatry Residency/Fellowship Program
Forensic Psychiatry Fellowship, Saint Louis University (SLU)	University of Ottawa
Harvard Medical School, Massachusetts	University of Toronto
Louisiana State University, Shreveport, LA	Western University
Medical College of Georgia	
Medical College of Wisconsin	
Medical University of South Carolina	
New York University Medical Center	
Northwestern University, Illinois	
Ohio State University	
Oregon Health and Science University	
Rutgers University—Robert Wood Johnson Medical School	
Saint Elizabeth's Hospital/Department of Behavioral Health, Washington, DC	
Saint Louis University, Missouri	
State University of New York (SUNY) Upstate Medical University, Syracuse, New York	
The National Capital Consortium Military Forensic Psychiatry Program, DC	
Tulane University School of Medicine, Louisiana	
University of Arizona Forensic Psychiatry Fellowship Program	
University of Arkansas for Medical Sciences	
University of California, Davis	
University of California, Los Angeles (UCLA)	
University of California, San Francisco	
University of Cincinnati	
University of Colorado	
University of Florida	
University of Maryland School of Medicine	
University of Massachusetts	
University of Miami, Florida	
University of Michigan, Center for Forensic Psychiatry	
University of Minnesota	
University of Missouri, Columbia	
University of North Carolina	

Table 16.1 (continued)

USA	Canada
University of Pennsylvania	
University of Rochester, New York	
University of South Carolina	
University of South Florida, Tampa	
University of Virginia	
University Texas Southwestern Medical School	
University of Southern California (USC) Institute of Psychiatry, Law & Behavioral Medicine, Los Angeles	
West Virginia University	
Western Psychiatric Institute and Clinic, Pennsylvania	
Yale University, Connecticut	

curricula and hands-on experiences of each program, it is not possible to provide a comprehensive overview of the specific learning opportunities that fellows are exposed to at all programs. However, in 2015 the ACGME developed forensic psychiatry milestones, which were designed to provide forensic fellowship programs a framework for the assessment of the forensic psychiatry fellow's development (see Table 16.2 for a summary of these milestones) [2]. For those readers considering forensic fellowship, these milestones also serve as a broad overview of the key elements taught in most forensic fellowships to develop competency in the subspecialty field of forensic psychiatry.

In 2015, in an effort to assist applicants to forensic psychiatry fellowships, the Association of Directors of Forensic Psychiatry Fellowships, a council of the American Academy of Psychiatry and the Law (AAPL), developed a set of guidelines regarding application, interview, and acceptance procedures for fellowship positions [1]. These guidelines recommend that any psychiatry residents interested in pursuing forensic psychiatry specialty training should begin to explore fellowships around the middle of their third postgraduate year (PGY-3). For nonresident applicants, this would mean researching fellowships beginning sometime around January to February of the year prior to the anticipated July 1 start date. Applications typically are screened by programs from the late spring to early fall, and interviews are generally scheduled between the summer and fall of the year prior to the fellowship start date. Programs that still have openings will consider later applications, although some programs fill their positions before the October AAPL annual meeting.

Additional opportunities to learn about forensic psychiatry are available via engagement with professional organizations and scholarly journals. AAPL, the largest American professional organization for forensic psychiatry, hosts a 4-day annual meeting at various sites throughout the country every October [1]. The annual meeting consists of dozens of presentations by the nation's leading experts in the field and provides opportunities for those interested in forensic psychiatry to learn about

Table 16.2 ACGME forensic psychiatry milestones

Sub-competency	Summary of corresponding ACGME forensic psychiatry milestone(s)
Patient care 1	*Provides psychiatric care in a forensic setting* - Provides care that consistently manages security concerns, dual agency, and the potential for conflicts with therapeutic efforts
Patient care 2	*Procedural skills* - Conducts a forensic psychiatric evaluation in criminal and civil settings - Communicates the results of a forensic psychiatric evaluation through written and oral reports
Medical knowledge 1	*Knowledge of the law and ethical principles as related to the practice of forensic psychiatry* - Basic knowledge of the legal system, sources of law, and landmark cases relevant to forensic psychiatry - Basic knowledge of civil law as it relates to forensic psychiatry - Basic knowledge of criminal law as it relates to forensic psychiatry - Knowledge of ethical principles as they relate to forensic psychiatry
Medical knowledge 2	*Knowledge of clinical psychiatry especially relevant to forensic psychiatry* - Knowledge of the particular psychiatric and behavioral presentations commonly encountered in the practice of forensic psychiatry - Knowledge of the assessment of particular psychiatric and behavioral presentations commonly encountered in the practice of forensic psychiatry
Systems-based practice 1	*Patient/evaluee safety and healthcare team* - Medical errors and improvement activities - Communication and patient/evaluee safety/risk - Regulatory and educational activities related to patient/evaluee safety/risk
Systems-based practice 2	*Resource management* - Costs of care and resource management
Systems-based practice 3	*Consultation to medical providers and nonmedical systems (e.g., military, schools, businesses, forensic)* - Provides recommendations as a consultant/collaborator
Practice-based learning 1	*Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence* - Self-assessment and self-improvement - Evidence in the clinical workflow
Practice-based learning 2	*Teaching* - Development as a teacher - Observable teaching skills
Professionalism 1	*Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles* - Compassion, reflection, sensitivity to diversity - Ethics

Table 16.2 (continued)

Sub-competency	Summary of corresponding ACGME forensic psychiatry milestone(s)
Professionalism 2	*Accountability to self, patients, colleagues, legal systems, professionals, and the profession* - Fatigue management and work balance - Professional behavior and participation in professional community - Ownership of patient care and/or responsibility for forensic evaluation
Interpersonal/ communication 1	*Relationship development and conflict management with patients, evaluees, colleagues, members of the healthcare or forensic team, attorneys, and members of the legal system* - Relationship with patients and evaluees - Conflict management - Team-based care or evaluation
Interpersonal/ communication 2	*Information sharing and record keeping* - Accurate and effective communication with team - Effective communications with patients, evaluees, and others - Maintaining professional boundaries in communication

current major issues, update their existing knowledge base, and engage in discussion with peers on the standards governing the profession. Each year, prior to the start of the annual meeting, there is also an intensive 3-day forensic psychiatry review course, which provides an in-depth review of selected topics in forensic psychiatry and relevant landmark cases covering basic concepts as well as recent updates in case law [1]. AAPL also has its own professional journal, entitled the *Journal of the American Academy of Psychiatry and the Law*, which is published quarterly [3].

The International Academy of Law and Mental Health (IALMH) is an international professional society focusing on the interaction of law and mental health through multidisciplinary and cross-national approaches while drawing on law, the health professions, the social sciences, and the humanities [4]. Every 2 years IALMH holds an International Congress on Law and Mental Health, bringing together the international community of researchers, academics, practitioners, and professionals in the field. IALMH also has its own official publication, the *International Journal of Law and Psychiatry*, which is intended to provide a multidisciplinary forum for the exchange of ideas and information among professionals concerned with the interface of law and psychiatry [5]. There are also a number of other scholarly journals related to forensic psychiatry published by other organizations, including the *Journal of Forensic Psychiatry & Psychology* [6], *Law and Human Behavior* [7], and *Behavioral Sciences & the Law* [8], among others.

The authors hope that this text has contributed to readers' interest in the field of forensic psychiatry and will stimulate their enthusiasm for acquiring further knowledge and expertise in this rewarding and exciting field.

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