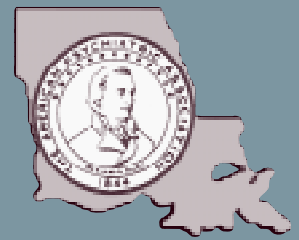


the LOUISIANA PSYCHIATRIC MEDICAL ASSOCIATION Newsletter



LPMA IS A BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

FALL 2004 • Vol. 39 • No. 2

2004 FALL MEETING: SEPT. 16-18 AT SANDESTIN RESORT

We are looking forward to another good meeting at the Hilton Sandestin Beach & Golf Resort located on Florida's Emerald Coast in Destin, Florida, September 16-18. If you have never been to this resort, you have a treat in store. The sand is the whitest anywhere and the water is several beautiful shades of green. Many think it is the best beach in the U.S. The spacious guest suites feature private balconies overlooking the beach.

There are four championship golf courses, 14 tennis courts, two outdoor pools, two whirlpools, a full-service salon and fitness center, a full-service marina and bicycle rentals. They offer a recreation program for children and nightly live entertainment for adults. Both elegant and casual dining options are on site and there are other fine restaurants nearby.

For hotel reservations, call (850) 267-9500. Mention the LPMA program to receive the group rate, which is \$159 single/double plus taxes and a \$14 resort fee. The reservation cut-off date is August 15, 2004. The registration fee for LPMA members is \$175 and covers all educational sessions, materials, continental breakfasts, Friday lunch and coffee breaks. Members-in-Training (MITs) and other residents pay \$75, but only MITs may attend the Friday program. APA medical student members and other students pay \$50, but only APA members may attend the Friday program. If you have not received a meeting brochure, call the LPMA Office at 800-438-6471 or 504-891-1030.

LPMA committee meetings will be on Friday morning and the General Membership meeting and Awards luncheon will be in the afternoon.

The scientific program entitled "Creativity and

Affective Illness" has been planned by the Department of Psychiatry and Neurology at the Tulane Medical School. The faculty includes Jose Artecona, M.D., Assistant Professor of Psychiatry, Tulane; Lori Lynne Davis, M.D., Clinical Associate Professor of Psychiatry & Behavioral Neurobiology, University of Alabama at Birmingham; Janet Johnson, Associate Professor of Psychiatry, Tulane; and Paul Rodenhauer, M.D., Professor Emeritus, Tulane.

Fall Meeting Agenda

Friday, September 17

- 7:30 AM Registration & Continental Breakfast
- 8:00-Noon LPMA Committee Meetings
- Noon-3:30 Awards Luncheon & General Membership Meeting

Saturday, September 18

- 7:30-8:30AM Registration & Continental Breakfast
- 8:30-8:45 Welcome & Introductions
...Patrick T. O'Neill
- 8:45-9:45 "Can Creativity Exist in a State of Euthymia"...Lori Davis
- 9:44-10:00 Questions & Answers
- 10:00-10:15 Coffee break
- 10:15-11:30 "Walter Anderson's Alternative Reality: Bipolar Disorder in Disguise?" ...Paul Rodenhauer
- 11:30-12:15 "Spirituality & Mental Illness"
...Janet Johnson
- 12:15-12:30 Questions & Answers
- 12:30-1:30 Lunch on your own
- 1:30-2:15 "Affective Illness in Rock Stars"
...Jose Artecona
- 2:15-3:45 Workshop Session 1
 - A. "Creativity as It Relates to People with Bipolar Disorder"
...Davis
 - B. "Creativity & Mental Illness"
...Rodenhauser & Artecona
 - C. "Spirituality & Mental Illness"
...Johnson
- 3:45-4:00 Coffee Break
- 4:00-5:15 Workshop 2 (repeat of Workshop 1) □



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REQUEST FOR ACTION

JULIANA FORT, M.D., M.P.H., M.B.A., EDITOR

LEGISLATIVE ADVOCACY:
Child Healthcare Crisis Relief Act needs your support. Visit www.aacap.org to act now.

To help alleviate the critical shortage of child mental healthcare workers, the Child Healthcare Crisis Relief Act was introduced in the 108th Congress (H.R. 5078 from the 107th Congress). This bill will create incentives for young healthcare providers to specialize in treating our young and will strengthen and expand graduate programs in children's mental health.

The children's mental health workforce bill, the Child Healthcare Crisis Relief Act, H.R. 1359, sponsored by Reps. Patrick Kennedy (D-RI) and Ileana Ros-Lehtinen (R-FL), and S. 1223, sponsored by Sens. Jeff Bingaman (D-NM) and Susan Collins (R-ME), is gaining support in both the House and the Senate. The bill aims to address the national shortage of children's mental health professionals, including child and adolescent psychiatrists, by encouraging individuals to enter the field through the creation of education incentives.

For child and adolescent psychiatrists, the bill would set up a loan forgiveness program and would restore Graduate Medical Education (GME) fund-

ing for child psychiatry training programs, which would reduce a significant financial burden on the hospitals and medical schools that operate these medical training programs. Other children's mental health professionals, such as psychologists and school-based professionals, would be eligible for scholarships, loan forgiveness and training grants. H.R. 1359 has been referred to the House Energy and Commerce and Ways and Means committees. S. 1223 has been referred to the Senate Health, Education, Labor and Pensions Committee. Currently, S. 1223 has the bipartisan support of 11 cosponsors, including Health, Education, Labor and Pensions Committee Ranking Member Edward Kennedy (D-MA), but many more supporters are needed for the bill to be passed in 2004. The House bill, H.R. 1359, now has 56 bipartisan cosponsors but it too requires much more support to gain passage.

Visit www.aacap.org and follow the Advocacy link to the Child Mental Health Workforce Bill. You can take immediate action by submitting your zip code to automatically e-mail your senators. □

CONTRIBUTIONS WELCOME

Contributions to the LPMA Newsletter are welcome. Both personal and professional items of interest in written or photograph form are sought. Every effort will be made to preserve the spirit and intent of the author when it is necessary to shorten or edit an article. Author's opinions do not necessarily reflect the official opinion of the Louisiana Psychiatric Medical Association. Letters to the editor and responses to those letters are also welcome.

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BICK AWARD WINNERS

The Bick Award, established in 1970 by LPMA in honor of Dr. John W. Bick, Jr., is awarded each year to the graduating medical student who demonstrates the most promise in psychiatry at each of Louisiana's medical schools.

This year's recipients were **Manon Mashburn, M.D.** at Tulane Medical School and **Matthew Gamble, M.D.** at LSUHSC, New Orleans.

Dr. Matthew Gamble has entered the LSU/Ochsner psychiatry residency program.

Dr. Manon Mashburn grew up in Fairfax, OK, a very rural town on the Osage reservation. She is still very much in touch with her cultural heritage and returns home in June for her tribal dances. She graduated from the University of Tulsa and received a MSPH and a Diploma in Clinical Medicine from Tulane's School of Public Health and Tropical Medicine. She is currently a resident in psychiatry at Tulane. □

INSTITUTE ON PSYCHIATRIC SERVICES: OCT. 6-10

The APA 56th Institute on Psychiatric Services, an interdisciplinary clinical meeting focusing on community psychiatry, will be held Oct. 6-10 in Atlanta, GA. The theme is "Mental Health Disparities in the Community." Registration information is on the APA website, www.psych.org. □

NAMI NEW ORLEANS LOOKING FOR ARTISTS

During the month of October 2004, NAMI New Orleans and Barrister's Gallery will be co-sponsoring an exhibit titled "Altered Perceptions." They are looking for artists who have mental illness. All mediums of art will be considered. All sales will provide income for the artists, promote public awareness and benefit NAMI New Orleans. For additional information, call (504) 896-2345. □



ENJOYING THE 'PRIVILEGE' OF PRACTICING MEDICINE

DAVID EDWARD POST, M.D., LPMA PRESIDENT

I have always believed that practicing medicine (and furthermore psychiatry) is a 'privilege'. When I entered Tulane Medical School in 1984, it was a time when medical school applications were peaking and the scuttlebutt among the pre-med applicants was that the Medical School Admissions Director could 'fill' an entire entering medical class with students that all achieved 'A' averages.

Medical school Admissions Committees certainly had an onerous task to sort through thousands of applications and narrow the field down to an entering class of about 150 'budding' physicians-to-be.

Once in medical school, I recall that much emphasis was on the doctor-patient relationship. There was clearly a mindset that emphasized that there was more to being a physician than just pill pushing. Moral and ethical fiber was equally important. There was more to being a physician than just having scholarly aptitude. Heck, if that was the case, Admissions Officers could have filled the entering medical classes with...engineers!

I love my profession, and it has exceeded my expectations in many ways. I almost became a surgeon like my dad. Perhaps I would have become a specialist in ear ossicles...who knows? Yet, after a

grueling year of General Surgery at Duke University Medical Center, I returned to Tulane to do a rotational internship year and find a better sub-specialty fit.

Rather than 'save the world' via sutures, I almost fell into a field that has brought me many personal and professional rewards. I came to see how helping people cope with psychological trauma rather than physical trauma was in many ways just as important and significant as watching physical wounds heal. Perhaps that is why when I see my psychiatrist colleagues coming down the hall, I'll often ask them (with a wry smile): 'Hey, Have you saved any lives today???' Of course, I knew full well that they had...whether they know it (or not)!

I guess my personal concept of professional, medical 'privilege' differs from that of the Louisiana Legislature and Governor Blanco as reflected in the passage of psychologist prescribing privilege (despite strong opposition from the medical community and beyond).

Good people sometimes do foolish things for misguided reasons...but when the going gets tough..."They always ... "Come Home to Papa!"

Stay tuned ... See you in Sandestin! □

I guess my personal concept of professional, medical 'privilege' differs from that of the Louisiana Legislature and Governor Blanco as reflected in the passage of psychologist prescribing privilege

DEPRESSION CALCULATOR TO HELP RAISE AWARENESS

There is an exciting new tool to help raise awareness about depression in the workplace. Recently, the APA and the American Psychiatric Foundation's National Partnership for Workplace Mental Health joined with the U.S. Chamber of Commerce, the nation's largest business organization, the Pharmaceutical Research and Manufacturers of America, the Institute of Health and Productivity Management and the Mid-America Coalition on Health Care to launch the "depression calculator."

The calculator is an online tool (available free at www.workplacementalhealth.org/depcalc.cfm) that allows employers to estimate the cost and productivity savings they will receive if they provide their employees with coverage for and access to quality health care for mental illnesses, and educate their employees to help raise awareness about depression.

"This depression calculator is an excellent tool

to assist employers in quantifying the cost of depression in their workforce," said Steve Heidel, M.D., a member of APA's Committee on Business Relations who represented the APA at the launch. "Depression is a real medical illness—not just a 'bad day' or a character weakness—and it can be effectively treated. The impact of undiagnosed and untreated depression on the corporate bottom line is clear: the costs in lower productivity, higher absenteeism and higher medical costs significantly exceed the costs of properly diagnosing and treating the depression."

APA believes the business community will have significant interest in the depression calculator, as evidenced by the participation of the U.S. Chamber of Commerce in its launch. APA members who have contacts with the local business community should bring to their attention this new online tool. □

LOUISIANA LAWMAKERS HURRIEDLY PASS PSYCHOLOGIST-PRESCRIBING LAW

JIM ROSACK

Even though the new law calls for no specific medical oversight, state officials apparently didn't believe patient safety was at stake.

GRATITUDE FOR NAY SAYERS

LPMA is very appreciative of votes against the passage of HB 1426 by Senators Adley, Bajoie, Barham, Boasso, Cheek, Dardenne, Ellington, Hainkel, Holden, Hollis, Irons, Jackson, Lentini, Malone, Mount and Theunissen and Representatives Alexander, Bowler, Bruneau, Burns, Crane, Flavin, Gray, Guillory, E., Hunter, Johns, Katz, Kennard, LaBruzzo, LaFleur, Lancaster, Marchand, McVea, Murray, Pinac, Pitre, Powell, T., Richmond, Scalise, Schneider, Strain, Thompson, Toomy, Tucker, White and Winston.

On May 6 the state of Louisiana became the second state in the country to authorize psychologists to prescribe psychotropic medications to people with mental illness. The state joins New Mexico, which enacted psychologist-prescribing legislation in March 2002 (*Psychiatric News*, April 5, 2002).

APA's reaction was swift and condemning. "[Louisiana] HB 1426 is a rush to judgment that puts politics above patients' lives and safety," said APA President Michelle Riba, M.D. "By enacting it, Gov. [Kathleen Babineux] Blanco and the Louisiana legislature have codified a dangerous, substandard level of care as legally acceptable in Louisiana. HB 1426 puts Louisiana well outside the medical mainstream in the United States and will jeopardize patients struggling with mental illnesses."

While "the lessons to be learned from Louisiana are far from clear" at this time, Riba emphasized that APA plans to undertake "a careful review" as a "key part of continuing to block such reckless laws."

Blanco, a Democrat, signed HB 1426 after concerted efforts by APA, the Louisiana Psychiatric Medical Association (LPMA), the American Medical Association, and the Louisiana State Medical Society, along with local chapters of the National Alliance for the Mentally Ill and the Depressive and Bipolar Support Alliance, strongly urged the governor to veto the hastily passed legislation.

The original psychologist-prescribing bill was introduced on April 7, sponsored by Louisiana House Speaker Joe Salter (D). An identical bill was introduced on April 13 by Senate President Donald Hines, M.D. (D), who maintains a family practice while the legislature is not in session. With little discussion or debate and only minor amendments, the bill was passed by the House on April 19 by a vote of 62-31.

The next day the Senate received the House bill, and declaring it to be a duplicate of the Senate version, Hines deftly moved the House bill through the Senate chamber. On April 21 Hines used procedural privileges as Senate president to suspend the normal rules for considering legislation in an orderly manner.

When the president pro tempore, Diana Bajoie (D), attempted to offer an amendment that would have prohibited psychologists from prescribing to children, Hines dismissed the effort. He noted that as a physician himself, he could write prescriptions for children for the very medications in question, and he wasn't

required to have a master's degree in psychopharmacology.

Hines called for a vote, and the measure passed the Senate by a vote of 21-16. In the end, only minor editorial changes and clarifying amendments were passed.

The bill went back to the House immediately, and, again with the rules suspended, representatives voted on it without any conference committee consideration. The House passed the bill by a vote of 68-30.

The final bill was signed by Salter on Thursday, April 22, and by Hines on the following Monday, April 26, starting a 10-day countdown for the governor's action. In Louisiana the governor may sign passed legislation, veto it, or allow it to go into law without a signature.

Lobbyists for the state medical society and LPMA were so dismayed that they left the legislative chambers silently, shaking their heads.

No Regard for Patient Safety

In the ensuing 10 days, efforts were made with "warp speed," noted LPMA legislative representative Dudley Stewart Jr., M.D. The lobbyists, Stewart, and LPMA President Patrick O'Neill M.D., called in AMA President Donald Palmisano, M.D., who is from Louisiana, to advise the governor's office of the significant patient-safety concerns that the legislation raised.

The new Louisiana statute will allow a "medical psychologist" to prescribe and distribute "agents related to the diagnosis and treatment of mental and emotional disorders." A "medical psychologist" is loosely defined as a "psychologist who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the [psychologist examiners'] board and who holds from the board a current certificate of responsibility."

The only medications that the law specifically exempts are narcotics.

Blanco asserted in a prepared statement that she was "assured by the proponents [of the legislation], including the speaker of the House and the president of the Senate," that the new law's "tight

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PRACTICE OF MEDICINE AUTHORIZED FOR BOARD OF PSYCHOLOGY IN LA: HARBINGER FOR CALIFORNIA?

RONALD C. THURSTON, M.D., CALIFORNIA PSYCHIATRIC ASSOCIATION

In April, HB 1426 zipped through the Louisiana Legislature. On May 6, Governor Blanco signed it into law, giving authority to the Louisiana Board of Examiners of Psychologists to establish and implement procedures to grant “a medical psychologist the authority to prescribe and to distribute, without charge, drugs and other procedures directly related thereto within the scope of practice of psychology in accordance with the rules and regulations adopted by the board.” And to clarify: “ ‘Prescription’ shall mean an order for a drug or for a device or test directly related to the drug or to the decision to order or to continue or discontinue the order of the drug.” A “medical psychologist” has a psychology-board-approved master’s degree in psychopharmacology. HB 1426 does require the “medical psychologist” to obtain “consultation and concurrence” from the client’s physician.

HB 1426 is a typical “prescriptive authority” bill. **What can we learn from Louisiana? Here are some take-home lessons:**

1. “Prescription” bills authorize the state board of psychology to invent, elaborate and regulate a practice of medicine for psychologists. This is the radical goal. Details can be left to future elaboration and negotiation.
2. “Prescription” translates to “Practice of Medicine” in all “prescription” bills. Faux safeguards, such as “concurrence,” are details.
3. Yes, legislatures can allow master’s level psychopharmacologists to practice medicine on the mentally ill.
4. Legislation is always politics, but not always rational social policy, and almost never evidence-based science.
5. The mentally ill always get second-rate consideration. Now they will get second-rate medical care.
6. Psychologists lobbied long and hard for April in Louisiana. They’re hard at work in California.
7. Psychologists portray themselves as the mental health (not illness) experts, merely adding medicine (and related procedures, examinations, laboratory tests and nursing orders) to the scope of psychology.
8. Psychologists argue that access to care can be increased by decreasing the standard of care. What can we do in California? We must re-frame

the debate and reveal the consequences. It’s Mental Illness, not health. It’s Practice of Medicine, not prescriptions. It’s Public Policy, not turf war. It’s People at risk, not turf.

Shall California deregulate and downgrade the practice of medicine? Next year, for the fifth time, our Legislature will consider the following social policy: 1) Invest another, non-medical agency with the authority to define and regulate the practice of medicine; 2) Reduce the standard of medical care for the mentally ill.

What about access? There’s no clamor to downgrade the building code in order to improve access to housing. Obviously, if standards were reduced, nobody would build to the higher code. If the Legislature votes to eliminate the requirement for a fundamental medical education, nobody need trouble himself or herself with a medical education. “Prescription” legislation paves the way for future generations of “providers” to take a road less troubled, and creates a permanent, separate and second-class system of medical care for the mentally ill. □

“Prescription” legislation paves the way for future generations of “providers” to take a road less troubled, and creates a permanent, separate and second-class system of medical care for the mentally ill.



Letter of Appreciation to DGR

Nicholas M. Meyers
Director, Division of Government Relations
American Psychiatric Association

Dear Mr. Meyers:

The Louisiana Psychiatric Medical Association is extremely grateful for the help we received from APA and particularly DGR throughout the recent crisis with HB 1426, the bill to give psychologists independent practice of medicine. Paula Johnson's participation in our grassroots workshop at our Spring Meeting in Baton Rouge was very helpful. We appreciated the alerts that you sent that we copied and emailed to our members regarding contacting the representatives and senators in the Louisiana Legislature and later our Governor, Kathleen Blanco. They arrived every day and sometimes twice a day as circumstances changed. You also made it possible for our members to go to the APA website and send messages. LPMA members even received personal calls from APA with regard to actions they might take. In addition you asked other medical specialties and the AMA to issue alerts to their members in Louisiana urging them to oppose the bill.

You provided reams of background materials for our use and issued two press releases from APA President Marcia Goin, M.D. condemning the House and Senate votes. You designed, developed, and conducted a call-in press conference featuring the LPMA president, NAMI representatives from two parts of the state and two psychologists who opposed prescriptive authority. Background information and calls to reporters were instrumental in the largely negative press the bill received.

We did not prevail, but we will long remember the tremendous support that you gave us.

Sincerely,

Patrick T. O'Neill, MD, Immediate Past President and David E. Post, MD, President □

LPMA
ADVOCACY AND
LEGISLATION

Online at:
[www.lpma.net/
legislat.htm](http://www.lpma.net/legislat.htm)

PSYCHOLOGIST-PRESCRIBING LAW PASSED

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controls" and "tough" regulations she expects the board of psychologist examiners to promulgate will protect patients' safety. She noted that those who "do not abide" by the provisions of the law could lose their prescribing privileges and "face misdemeanor charges." Yet no such "tough rules" or any regulations are codified by the statute. In fact, complete oversight of psychologist prescribing is granted to the Board of Psychologist Examiners, and it is that same board that the law entrusts to create regulations and procedures to implement the law.

To be eligible to prescribe, applicants must hold a current license to practice psychology and must have "successfully graduated with a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution or equivalent to the postdoctoral master's degree as approved by the board."

The law's language describing educational requirements is vague, but it appears to be par-

terned after the American Psychological Association's preferred curriculum for prescribing psychopharmacology.

The law requires a prescribing psychologist to "prescribe only in consultation and collaboration with the patient's primary or attending physician and with the concurrence of that physician." However, Riba noted, "Bluntly, the vaguely defined consultative requirements cited by the governor as a safety measure do not pass muster: there is nothing in the law to ensure that a physician will ever lay eyes on the patient."

Patients Opposed Legislation

Riba said that patient advocacy groups and patients themselves were adamantly opposed to the legislation, and she had urged Gov. Blanco to protect them and their loved ones by vetoing the bill.

"[Psychotropic] medications," Riba emphasized, "impact the whole patient, not just the patient's mental or emotional disorder,

as the governor suggests. "These 'potent medications,'" she continued, "may interact with other medications and may impact other medical conditions. As behavioral scientists, psychologists are simply not trained for the medical complexities faced by psychiatrists and other physicians when they prescribe medications."

Riba stressed that APA's focus must be on "action." As part of an action plan, she added, APA must "review how we respond to these assaults. We will undertake this review quickly, but we should not-unlike the Louisiana legislature-rush to judgment without the benefits of the facts."

Such an examination-determining what was successful in some states and what was unsuccessful in Louisiana- "is a key part of continuing to block such reckless laws," she continued.

Reprinted from *Psychiatric News*. □

DUTY TO WARN IN THE POST 9-11 ENVIRONMENT

The Duty to Warn vs. Confidentiality in the 21st Century

HAROLD GINZBURG, M.D., CHAIR, LPMA DISASTER RESPONSE COMMITTEE

When does a health care provider, specifically, a psychiatrist, notify legal authorities, or others, that a patient is dangerous or potentially dangerous? A patient makes a boastful threat against an insurance adjuster, "If she were in the room, I would strangle her!" Is this sufficient justification to warn the adjuster to refrain from visiting my office? What significance does it have if the adjuster is in another state and never has even been to Metairie or New Orleans! A second patient declares, "Sometimes I want to blow up the Worker's Compensation Office, in New Orleans!" He has been in the military and has experience with explosives. He has no history of engaging in any violence, beyond that experienced as a combat veteran during his two tours in Vietnam. Is this sufficient? A third patient, when asked if he wants to harm anyone, answers in the affirmative and identifies his supervisors, by name, and indicates the methods he would use to harm each one. He has recently purchased ammunition for his rifle. Is this sufficient? A fourth patient states, spontaneously, that when his home is sold, his wife is going to take her share of the proceeds, and leave him. When that happens, he intends to harm his former case manager and present workers compensation insurance company's adjuster. He has already found the location of the home of the former case manager and driven through her driveway. He does not know the name or location of his current adjuster; she lives and works in another state. Is this sufficient? A fifth patient states that he knows how to contaminate the city's water supply and is waiting until the right moment to do it. He defines the right moment as when the worker's compensation carrier terminates paying him benefits. Is this sufficient? Who do I notify?

For purposes of simplicity, assume all patients described above have the same two initial diagnoses, rendered according to the current edition of the Diagnostic and Statistical Manual¹: 307.89 Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, orthopedic / neurosurgical injury and 309.28 Adjustment disorder with mixed anxiety and depressed mood. The last two patients have reported auditory hallucinations, but do not meet the diagnostic criteria for schizophrenia; in addition, they both have personality disorders.

These five clinical instances suggest that there

may not be a clear demarcation as to when notice should be made or to whom the notice should be given. Each of these five instances involves a patient receiving mental health treatment as a result of a work related accident or incident which caused them sufficient distress as to render them to no longer be a member of the work force. Each of these five instances involves a patient whose mental health treatment is being paid for by the workers compensation insurance carrier. Each of these five instances provides a different level of threat. The last instance may involve matters of national security and could be thought of as a terrorist threat.

If any one of the insurance companies contacted retains a 'risk consultant' to provide them additional consultation, is patient confidentiality breached if you talk with that individual? The layers of bureaucracy have increased with managed care. The level of concern about dangerousness has increased substantially since Sept. 11, 2001. Medicine has become even more complex, extending well beyond the office walls and hospital fences.

Historical perspective

The physician-psychiatrist has a duty to his or her patient. The physician-psychiatrist has a duty to the insurance company who pays the bills for the psychotherapeutic services rendered. They expect and are entitled to some degree of communication, including a patient evaluation and written progress reports. Record-keeping has changed in recent years as a result of the shift toward managed care, increased legislative and judicial regulations of the practice of medicine, such as Health Information Portability and Accountability Act of 1996 (HIPAA)² and the Patriot Act³ and technology developments. The physician-psychiatrist has a duty to the community and the nation. He has a moral obligation as a citizen of the community and the nation. There is the duty of confidentiality to the patient; there is the duty to protect members of the community and the nation from harm from his or her patient.

A duty is a legal and ethical responsibility. A breach or violation of a duty may result in litigation and legal sanctions. Duties are a reflection of the moral fiber of a community. Public policies are the means for expressing a community's moral impera-



Harold Ginzburg, M.D.

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DUTY TO WARN IN THE POST 9-11 ENVIRONMENT

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tives. Negligence is the breach of a duty owed with that breach causing some resultant quantifiable injury. There must be proof, to a medical degree of certainty, that is, more likely than not, 50.1%, that the action or inaction caused the injury. Once negligence is established, the physician may be liable for unforeseen consequences as well as foreseeable ones to foreseeable and unforeseeable individuals⁴.

New York Supreme Court Justice Cardozo, in 1928, in Palsgraff v. Long Island R.R. Company⁵, stated that a duty is established if his or her act or omission caused foreseeable harm. The facts of Palsgraff are worth reviewing as they set the stage for the duty to warn cases found within the field of mental health. A man with a package wrapped in a newspaper was trying to board a moving train. It seemed as though he was going to fall. A railroad guard pushed the man onto the train, preventing him from falling off and injuring himself. The man dropped his package. It was a package of fireworks that, when they struck the railroad tracks, exploded. As a result of the explosion, some scales fell down and struck Palsgraf. He was standing on the other side of the station. The majority of the judges found that Mr. Palsgraf was not in the zone of danger and not entitled to damages. Their rationale was that it was not foreseeable that the passenger was carrying explosives wrapped in a newspaper, and that, at some distance, some scales would fall and injure someone.

Justice Andrews, in his dissenting opinion, in that case, stated that once negligence is established, the defendant is liable for unforeseeable harm to unforeseeable victims. More than 75 years later, we continue to struggle with this concept of foreseeability of harm and foreseeability of victims when determining whether someone or some community is at risk for harm from individuals with diagnosed mental disorders. In the post-9-11 era, where consideration of uses of chemical, biological, or nuclear material to harm large numbers of individuals must be considered, the burden of determining dangerousness will only grow. False positive

identifications will be deemed acceptable; false negative identifications will not be acceptable. Mental health professionals will be found in the middle of this imbroglio.

Failure to accurately predict dangerous behavior, that is, failing to prevent a future harm by a dangerous person to a known or even unknown individual, may be the claim for negligence, for medical malpractice, against the physician⁶⁻⁸. Federal and state laws and regulations, and their respective case law, define socially acceptable and unacceptable behavior. A physician, who notifies authorities about the potential dangerousness of a patient, when none is later thought to exist, may be sued for malpractice and damages. A physician who does not notify authorities about the potential dangerousness of a patient, and someone is subsequently injured or killed, or property damaged or destroyed, may be sued for malpractice and damages.

Generally, there is no duty to control the conduct of a person, in this instance a patient, to prevent him or her from causing harm to another unless, "a special relation exists between the actor [in this instance, the physician] and the person [in this instance, the patient] which imposes a duty upon the actor [physician]"⁷ to protect the intended victim(s). While the legal language may sound stiff and awkward, the implications are straightforward.

Accepted public health policy, in the 19th Century, was that a physician would notify health authorities when certain communicable diseases were diagnosed so that appropriate interventions could be made to protect others. The list of communicable diseases now includes sexually transmitted diseases and leprosy, as well as rodent, insect, water, air and blood borne diseases, such as plague, malaria, typhoid, tuberculosis, or HIV/AIDS. Public health medicine, for several centuries, had an explicit concept of dangerousness and an implemented pragmatic policy of a duty to warn that was operational long before the issue of extending these concepts to mental illness and mental health related conditions was contemplated by the United States judicial system.

Public policy is implemented by laws

promulgated by legislative bodies; public policy is also implemented by litigation (case law). The criteria for extending responsibility for damages, by a physician, to a third person not involved in the therapeutic relationship between doctor and patient was established by the California Supreme Court in Biakanja vs. Irving (1958)⁹. The California court, in that decision, acknowledged that there could be a duty to a person who was not a patient. The court said that it was a matter of public policy to determine whether such a duty should exist. To balance the various factors in determining whether a duty to a third party should exist, the court stated the following criteria:

- (1) The extent to which the transaction, the action by the patient, was intended to affect (harm) the victim
- (2) The foreseeability of harm to the victim
- (3) The degree of certainty that the victim suffered (or was going to suffer) injury
- (4) The closeness of the connection between the defendant's (proposed) conduct and the injury to the victim
- (5) The policy of preventing future harm

The extension of this little known case to national public policy considerations began at the University of California, Berkeley, California. In August 1969, an Indian student, Prosenjit Poddar, informed his therapist, psychologist Lawrence Moore, of his intention to kill Tatiana Tarasoff. Tatiana, also a student, had rebuffed his romantic advances. Prosenjit became withdrawn, depressed, disorganized, and enraged. Dr. Moore, took Prosenjit's threat quite seriously. After consulting with his supervisors, Moore made arrangements with the campus police to pick up Prosenjit and commit him. Prosenjit was interviewed by the campus police and promised not to have any further contact with Ms. Tarasoff. In his follow-up note to the police, Moore wrote that Prosenjit was having a severe paranoid schizophrenic episode. He advised the police, that at times, Prosenjit could seem completely lucid; at other times, he was psychotic. Dr. Moore's supervisor ordered him to make no further attempts to commit

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THE TRANSINSTITUTIONALIZATION OF THE MENTALLY ILL

RALPH SLOVENKO, J.D., PH.D.

PROFESSOR OF LAW AND PSYCHIATRY AT WAYNE STATE UNIVERSITY, DETROIT, MI

PART ONE IN A TWO-PART SERIES

This article draws on writings by the author on the hospitalization of the mentally ill and was presented on March 21, 2003 at Ohio Northern University Law School.

In a process called transinstitutionalization, the mentally ill are alternately and repeatedly routed between the mental health and criminal justice systems. Is it an advance over earlier times? The more things change, we often find, the more they stay the same.

In colonial America, families were expected to take care of their own members who were mentally ill (those without family became social outcasts or drifters). Confinement at home was often the only recourse available to families, and that was allowed under the common law. Ironically, when Patrick Henry in 1775 said, "Give me liberty or give me death," he had his wife, a mother of six, confined in a basement room. She was disturbed and he was left with no other recourse. The family physician wrote, "His beloved companion had lost her reason, and could only be restrained from self-destruction by a strait-dress."¹

It was not until around the 1850s that special laws on commitment were enacted in various states of the United States. Shortly before, in the late eighteenth and early nineteenth centuries, insanity was regarded as a disease rather than as divine retribution or demonic possession that was cured by exorcism or "beating the devil out of the person."² In the early nineteenth century, in a period called the era of moral treatment, a convergence of popular indignation, growing medical interest, and several actual cases seemed to prove that, with humane treatment, insanity could be cured by humane methods.³

In 1841 Boston schoolteacher Dorothea Dix visited a jail where she was appalled to see insane persons locked up. It turned her into a crusader, an important figure among reformers of the mid-nineteenth century. The best-remembered reform movements of the period centered on the abolition of slavery, women's rights, public education, and the eradication of poverty and child labor. Dorothea Dix campaigned for the dignity of the mentally ill who had been penned away in horrific conditions. She advocated having the mentally ill transferred from jails to hospitals. She travelled across the country to investigate conditions. She persuaded some eleven

states to build asylums to treat insanity as an illness.

As the number of seriously mentally ill persons on the streets and in the jails grew, there was considerable social pressure to take care of the mentally ill on a larger scale than was done in the beginning of the nineteenth century. Expensive palatial manors were built in rustic, attractive (though remote) parts of the states. These facilities were designed with the premise that madness might be soothed in a setting of architectural and environmental beauty.

Charles Dickens in his writings noted approvingly that mental hospitals in the United States were supported by the state making the government a merciful and benevolent protector of people in distress. In fact, the constitutions of various states in the United States mandated state-sponsored care of the mentally ill. In England, on the other hand, public charity was minimal. The government offered the mentally ill, Dickens said, "very little shelter or relief beyond that which is to be found in the workhouse and the jail."⁴

The era of moral treatment came to an end by the middle of the century, shortly before the civil war. It was a time of mass influx of immigrants, unemployment, resistance to military service, and violence in the streets.⁵ Soon asylums as well as penal facilities were used to warehouse debtors and delinquents.

In early times, at their inception, most state hospitals had a farm, dairy, or some form of self-supporting program which provided meaningful work and activity. However, beginning in the latter half of the nineteenth century, business interests seeking to sell supplies to these big institutions effectively pressured to have the farms and dairies closed. As a result, once meaningful work experiences in the hospital were replaced with a state of idleness. The thousands of people in these institutions had no power of vote or other influence on government. The hospital degenerated into the "snake pit." It became a large place of custodial detention. The term "asylum" lost its meaning as a place of refuge — for patients but not for beleaguered families.

One victim of this change was Mrs. E.P.W. Packard, the most famous crusader for the enactment of commitment laws. She had been committed

In a process called transinstitutionalization, the mentally ill are alternately and repeatedly routed between the mental health and criminal justice systems. Is it an advance over earlier times? The more things change, we often find, the more they stay the same.

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TRANSINSTITUTIONALIZATION

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at the request of her husband. An 1851 Illinois statute allowed married women and infants to be committed at the request of the husband or guardian without a judicial hearing but with the approval of the asylum.⁶ Upon her release in 1863, following three years of confinement, she was again confined at home by her husband. She was released as a result of a writ of habeas corpus brought by her son. Thereupon, she began a campaign to stir up public concern against what she charged was the “railroading” of people into mental hospitals. (She was brought to the hospital by railroad.) In 1864 she published a book titled, “Trial and Self-Defense from the Charge of Insanity; or Three Years’ Imprisonment for Religious Belief, by the Arbitrary Will of a Husband with an Appeal to the Government to so Change the Laws as to Protect the Rights of Married Women.” In subsequent years she wrote a number of other books including the two-volume “Modern Persecution, or Insane Asylums Unveiled” published in 1873. As a result of her campaign, many of the present-day safeguards in this field were introduced (such as notice and trial by jury). She did not seek closure of mental hospitals but rather safeguards.⁷

At the turn of the twentieth century, on the basis of new learning, laws were enacted on sexual psychopathology, alcoholism, and drug addiction that would divert individuals out of the criminal law process and into the hospital system. These behaviors came to be regarded as mental illness rather than as a crime. However, these laws proved ineffective and therefore short-lived. At that time psychiatry was considered a treatment for personality as well as neurotic or psychotic disorders. Today it is only in the fictional “Sopranos” or “Analyze That” where a psychiatrist attempts to treat a mobster.⁸

Following World War II, in the 1950s, the development of anti-psychotic medication resulted in a decrease in the use of physical restraints, psychosurgery, electroshock, hydrotherapy, insulin coma, and other physical means of treatment. For the first time, as a result of these chemical agents, the number of persons admitted to or confined in hospitals declined. Why have the hospitals? The

range of chemical agents developed in the years just after World War II along with other considerations brought about a move to abandon state mental hospitals altogether. For the first time an armamentarium of specific treatments for specific disorders became available, an arsenal of magic bullets as they were called. A mood prevailed among professionals approaching euphoria that a window had opened up on the treatment of mental illness. The pharmaceutical industry quickly exploited the implications of the new compounds. Medication would become the mainstay of treatment. Psychiatrists no less than other physicians began to be called “hydraulic doctors” whose task was to raise or lower dosage.⁹

Then too, it was argued that hospitalization produces “institutional dependency,” which offers not mental health, but mental death, and robs the individual of incentive and autonomy. Sociologist Erving Goffman wrote that the syndrome known as “chronic schizophrenia” is merely an adaptation to the social system of the hospital. In his 1961 book *Asylums*, Goffman presented a scathing critique not only of the conditions prevailing in mental hospitals but also of the basic philosophical premises on which such institutions were founded.¹⁰ The word “asylum” became evermore a derogatory term.

In his novel *One Flew Over the Cuckoo’s Nest* Ken Kesey described the hospital staff as a tyrannical, sadistic group which forced patients into total submission.¹¹ Coming at a time when more and more of America’s youth were engaged in a struggle to defy authority, *Cuckoo’s Nest* was a fresh-sounding anti-authoritarian fable. In still another dramatic view, Thomas Szasz in his book *The Manufacture of Madness* (as well as in other books) drew a parallel between the persecution of witches in the thirteenth through the seventeenth centuries and what he termed the persecution in the twentieth century of people labeled mentally ill. In his view, modern psychiatry has led not to more enlightenment but only to different victims for persecution.¹² The anti-psychiatry Church of Scientology’s Citizens Commission on Human Rights, which sometimes claims Szasz as a founder,

depicted hospitalized psychiatric patients as normal individuals being persecuted by evil psychiatrists.¹³

It was during the tumultuous 1960s and 1970s that these anti-psychiatry writings appeared and found resonance. At this time, Bruce Ennis, an attorney for the American Civil Liberties Union, led the Mental Health Bar litigation to close all mental hospitals. These efforts were unlike those of Mrs. Packard who, a century earlier, sought hospital safeguards and regulations instead of outright closings. In 1972, Ennis and three other young attorneys, Charles Halpern, Paul Friedman, and Margaret Ewing, formed the Mental Health Law Project, which rapidly became — and has remained — the ideological and logistical center of the mental patient liberation bar. They were abolitionists, not reformers, who challenged every assumption of the mental health system.

In 1972 Ennis also published *Prisoners of Psychiatry*, a polemic against mental hospitalization.¹⁴ In a preface, Szasz praised Ennis for recognizing “that individuals incriminated as mentally ill do not need guarantees of ‘treatment’ but protection against their enemies — the legislators, judges, and psychiatrists who persecute them in the name of mental health.” In this book, Ennis portrayed psychiatry as a means to control or dispose of people who annoy others. As Ennis wrote: “How would we tame our rebellious youth or rid ourselves of doddering parents, or clear the streets of the offensive poor, without it?” Ennis believed hospitals were places “where sick people get sicker and sane people go mad.” In 1974, in an interview published in *Madness Network News*, Ennis stated, “My personal goal is either to abolish involuntary commitment or to set up so many procedural roadblocks and hurdles that it will be difficult, if not impossible, for the state to commit people against their will.”¹⁵

Ironically, in the 1960s and 1970s, with some notorious exceptions, mental hospitals were at their best since the era of moral treatment of the early 1900s. Staffing and facilities were greatly improved. In the 1960s,

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CALL FOR AN END TO JUVENILE DEATH PENALTY

The nation's leading American medical institutions, including the American Psychiatric Association, American Medical Association, American Society for Adolescent Psychiatry, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law and the National Mental Health Association, filed an amicus curiae brief calling for an end to the juvenile death penalty. In their friend-of-the-court brief, the groups state that the juvenile death penalty is unacceptable because adolescents are less developed than adults and therefore should not be held to the same standard of culpability.

According to the brief, "To execute 16- and 17-year-old offenders is to presume full adult responsibility and to hold them accountable not just for their acts, but also for the immaturity of their neural anatomy and psychological development." Adolescents behave differently than adults because their minds operate differently, their emotions are more volatile and their brains are anatomically immature.

The brief also states that scientists have documented differences between teens and adults in several critical areas. For example, adolescents underestimate risks and overestimate short-term benefits, are more emotionally volatile, and more susceptible to stressful situations.

The brief cites recent scientific imaging technology which reveals that the adolescent brain continues to mature into early adulthood, and that the regions associated with impulse control, regulation of emotions, risk assessment and moral reasoning are the last to develop.

Moreover, most, if not all, juveniles on death row have suffered from severe abuse, neglect, trauma and other mental problems that exacerbate the already existing vulnerabilities of youth, according to the brief. Adolescents also undergo significant emotional and hormonal changes that affect behavior.

The U.S. Supreme Court will hear oral arguments in *Roper v. Simmons* during the October 2004 session when the Justices will weigh whether it is constitutional to sentence juvenile offenders to death. In August 2003, the Missouri Supreme Court overturned the death sentence of Christopher Simmons on the ground that it violated the Eighth

Amendment's ban on cruel and unusual punishment. Today, lawyers for Simmons filed a brief asking the Supreme Court to uphold the lower court's decision.

Medical experts have said that Christopher Simmons, who was sentenced to death row for a crime he committed at age 17, should be spared the death penalty because he was a minor at the time of the criminal act.

Robert Weinstock, M.D., APA Committee on Judicial Action member and APA distinguished life fellow said, "Our society understands the differences between adolescents and adults when it comes to driving, drinking alcohol and smoking, voting and marriage. We are contradicting ourselves to deny these privileges to adolescents, yet still enforce the ultimate punishment on them — death."

"Research has clearly demonstrated that the brains of adolescents are still actively changing and developing," said David Fassler, M.D., APA trustee-at-large and board certified child and adolescent psychiatrist. "As a result, they think and reason in fundamentally different ways than adults. They are also much more likely to act on impulse, without considering the consequences of their actions."

Briefs on behalf of Christopher Simmons were also filed by Nobel Peace Prize Laureates including former President Jimmy Carter, former Soviet President Mikhail Gorbachev, former South African President F. W. de Klerk and the Dalai Lama, nine former U.S. Diplomats, legal and religious institutions, child advocacy groups, and nearly 50 countries including the European Union and Members of the International Community.

Additionally, a cross section of more than 420 prominent pediatricians, child and adolescent psychiatrists and neurologists, including such notable physicians as former Surgeon Generals C. Everett Koop and Julius Richmond, and Drs. T. Berry Brazelton and Alvin Poussaint, submitted the Health Professionals' Call to Abolish the Juvenile Death Penalty to the Court.

The Simmons briefs are available at www.abanet.org/crimjust/juvjus/simmons/simmonsamicus or www.cjedfund.org. □



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Christopher Meyers, M.D.

The APA's Council on Medical Education and Lifelong Learning announced the Irma Bland Award for Excellence in Teaching Residents. **Irma Bland** was a Distinguished Fellow of LPMA and APA who died in 2003. The award will give certificates annually to APA members who have made outstanding and sustaining contributions to resident education in psychiatry. For more information and to download a nomination form, visit <http://www.psych.org/edu/blandaward.cfm>.

Announcement received from the former editor of the Newsletter. "Craig & Priscilla are pleased to announce the recent adoption of their baby Bayfield boat Paolina born in Clinton, Ontario in 1982. Weight – 3500 lbs., Length – 25 feet, white hull with teak trim. She has a prominent bowsprit nose, is sloop rigged and has a cute clipper profile. Her waist is a respectable 8 feet.

Christopher Meyers was presented the "Chairman's Award, 2003-04" on June 25th in recognition of his outstanding contributions to resident training and medical student education by a member of the clinical faculty" of the Department of Psychiatry, LSUHSC, New Orleans.

Carmen Ramos, a former LPMA member, is now Sister Pia Therese of the Intercessors of the Lamb, a community of contemplative nuns based in Omaha, NB.

Paul Rodenhauer presented on creative expression and mental illness using Walter Anderson as an example at the Dixon Gallery in Memphis, TN and at the Huntsville, AL Museum of Art. An article of his, co-authored by third year Tulane Medical student Mathew Strickland and former Tulane Medical student Cecilia Gambala, was published in "Teaching and Learning in Medicine." This was a follow-up study to an initial survey the results of which were published in the same journal two years ago, senior-authored by Mathew Strickland.

Cheryll Bowers-Stephens, the Assistant Secretary of Louisiana's Office of Mental Health, was a featured speaker at NAMI Ruston pediatric-geriatric mental health symposium at the Washington Complex on the campus of Grambling State University. The conference was entitled "Trends, Trials and Treatments of the Mentally Ill Across the Lifespan." **Paul Ware**, chairman of the Department of Psychiatry at LSUHSC, Shreveport also spoke at the symposium.

Cheryl Wills, assistant professor of psychiatry at Tulane, was featured in an article in *Daily Bulletin* at the APA Annual Meeting in New York. It was entitled "Remarkable Member" and described her work with juvenile offenders in Louisiana.

The August 2004 edition of the "New Orleans" magazine published a list of the New Orleans psychiatrists who are in the Best Doctors in America database. The LPMA psychiatrists listed are **Milton Anderson, James Barbee, J. Robert Barnes, Ted Bloch, III, Gordon Lane Blundell, Jr., George Daul, Debra DePrato, Martin Drell, Robert G. Ellis, Edward Foulks, Remigio Gonzalez, Douglas Greve, Dean Hickman, Janet Johnson, Craig Maumus, Christopher Meyers, Patrick O'Neill, Howard Osofsky, Gunther Perdigao, Ted Reveley, Judy Roheim, Joseph J. Roniger, Jr., Richard Roniger, Alvin Rouchell, Samuel Rubin, Kenneth Sakauye, Sylvia Schneller, Dudley Stewart, Jr., Mark Townsend, L. Lee Tynes, Jr., Daniel Winstead and Charles Zeanah.**

Doctors do not pay to be included on this list. Doctors are not permitted to vote for doctors within their own hospitals and medical practices. They are not required to pay a fee or make a purchase to be included. More than 30,000 doctors were interviewed from December 2002 through October 2003. □

RESIDENT NEWS

Sofya Rubinchik completed her psychiatric residency at LSUHSC in Shreveport and will be a Geriatric Fellow at the University of New Mexico. **Beth Valiulis** will graduate September 30 and will go to Overton Brooks VAMC in Shreveport.

LPMA Members-in-training who completed residencies at Tulane Medical School are **Jose Artecona, Christopher Borrillo, Degan Dansereau** and **Deidre Richards**. Dr. Artecona was appointed to the faculty in Forensic Neuropsychiatry at Tulane. Dr. Borrillo was appointed to the faculty in Child & Adolescent Psychiatry at Tulane.

Dr. Dansereau was appointed to the clinical faculty at Tulane and will join Dr. Gregory Ciaccio in private practice on the Northshore. Dr. Richards completed Child training and took a position with Region III Mental Health Center in Louisiana.

LSUHSC members-in-training in New Orleans who completed residencies in general psychiatry are **Dorota Gawlas** who is on staff at the VA in New Orleans, **Adelwisa Lizada** who is private practice in Las Vegas, NM, **Meri Nisimova** who is a Geriatric Fellow at LSUHSC and **Ravindra Reddy** who is on staff at the Baton Rouge Mental Health Center. □

LPMA STANDING COMMITTEES, 2004-05

Committee meetings (except for ethics committee) may be attended by any member at the meeting time as noted.

Executive: David Post, Chair
Jodie Holloway, Patricia Toups

Constitution & Bylaws: Daniel Winstead, Chair, (not meeting at Fall Meeting)
David Dawes, Jeanne Estes, Charles Murphy, Marilyn Skinner

Continuing Education: Donna Mancuso, Patrick O'Neill, Co-Chairs, (8-9 AM)
Robert Fisher, Juliana Fort, Brian Isaacson, Catherine McDonald, Patrick O'Neill, Joni Orazio, Navin Patel, Marilyn Skinner, John Straumanis, Kashinath Yadalam, Mark Zielinski

Ethics: Mary Jo Fitz-Gerald, Chair (11-12 noon)
J. Robert Barnes, Debra DePrato, Douglas Greve, Robert Lancaster, Donna Mancuso, Christopher Meyers, Aretta Rathmell, David Rees, Wallace Tomlinson, Charlene Smith (staff)

Governmental Affairs: Dudley Stewart, Anita Snow, Co-Chairs, (10-noon)
James Anderson, Dale Archer, J. Robert Barnes, Carol Bayer, Adrian Blotner, Elodie Braud, Gregory Ciaccio, Edward Foulks, Daphne Glindmeyer, Victor Gonzalez, Lyn Goodin, Donna Mancuso, Catherine McDonald, Dennis Nave, Drew Pate, James Phillips, Ken Roy, Frank Silva, John Smith, Ron Taravella, Wallace Tomlinson, Patricia Toups, Jay Weiss, Howard Wetsman, Mark Zielinski

Membership: Mary Jo Fitz-Gerald, Chair, (not meeting at Fall Meeting)
Dennis Nave, Navin Patel, Aretta Rathmell, David Rees, David Regan, Ted Reveley, John Smith, Kashinath Yadalam, and Charlene Smith (staff)

Nominating: Patrick O'Neill, Chair, (9-10 AM)
Paul Pelts, David Rees, Aretta Rathmell, Lee Stevens, Patricia Toups, and Charlene Smith (staff)

OTHER LPMA COMMITTEES, 2004-05

Budget: Patricia Toups, Chair, (8-9 AM)
Paul Pelts, David Post, Aretta Rathmell, David Rees, Lee Stevens, and Charlene Smith (staff)

Child & Adolescent: Donald Schexnayder, Daphne Glindmeyer, Co-Chairs, (9-10 AM)
Milton Anderson, William Bergeron, Gregory Brown, Edgardo Concepcion, David Buttross, Robert Dahmes, Juliana Fort, Ellen Gandle, Nancy Haslett, Jodie Holloway, Brian Isaacson, Lillian Lesser, James Lowe, Ellen Mackenzie, Raga Malaty, Charles Murphy, Joni Orazio, Drew Pate, Paul Pelts, Robert Scott Smith, Carmen Sugai, Patricia Toups, Michael Wilson

Disaster Response: Harold Ginzburg, Chair, (11-12 noon)
Drs. Ann Arretteig, Guy Brannon, Erich Conrad, Christa Eckert, Vivienne Hayne, Ross Judice, Robert Maresh, Omayra Nieves, David Regan

Geriatrics: Kenneth Sakauye, Chair, (10-11 AM)
Ghada Al-Asadi, Kaleem Arshad, Sandra Baltz, John Bick, Guy Brannon, Jason Coe,

Maria Cruse, David Dawes, Andrew Dentino, Lyn Goodin, Erle Harris, Paul Matthews, Bill McBride, Dennis Nave, Gerald Robertson, Alvin Rouchell, Samir Salama, Karen Stone, Aniedi Udofa, Edwin Urbi

Insurance & Managed Care: Ken Roy, Chair, (8-9 AM)
Robert Ancira, James Anderson, Kaleem Arshad, J. Robert Barnes, Adrian Blotner, Guy Brannon, Gregory Brown, Robert Davis, Jeanne Estes, Craig Maumus, Catherine McDonald, Dean Robinson, Sylvia Schneller, Carmen Sugai, Wallace Tomlinson, Michael Wilson

Psychiatry & Law: Marc Colon, Beatrix Urvat, Co-Chairs, (8-9 AM)
Kaleem Arshad, Herman Colomb, Rennie Culver, Debra DePrato, Patrick Dowling, Ellen Gandle, Nancy Forrest, Harold Ginzburg, Dean Hickman, Jodie Holloway, Harminder Mallik, David Post, David Regan, Shawn Richard, Chester Scignar, George Seiden, Herman Soong, John Thompson, Craig Troxclair, Jay Weiss

Psychiatry & Religion: Bill McBride, Janet Johnson, Co-Chairs, (8-9 AM)
Herman Colomb, David Dawes, Dabney Ewin, Nancy Forrest, Susan Glade, Frances Hagaman, Erle Harris, Vivienne Hayne, James Lowe, Elizabeth Schwarz, Michelle Simon, Carmen Sugai

Public Affairs: Edward Foulks, Juliana Fort, Co-Chairs, (11-12 noon)
Gregory Brown, Frances Hagaman, Craig Maumus, Charles Murphy, Nguyen Nguyen, Cathie Olmsted, Dean Robinson, Charles Smith, Leslie Snider, Wallace Tomlinson, Jay Weiss

Public Psychiatry: Patricia Toups, Degan Dansereau, Co-Chairs, (10-11 AM)
Ann Arretteig, J. Robert Barnes, Charles Bramlet, Edgardo Concepcion, David Dawes, Daphne Glindmeyer, Robert Fisher, Douglas Greve, Frances Hagaman, Ellen Mackenzie, Robert Maresh, Robert McCormick, Howard Osofsky, Michael Prejean, David Rees, John Smith, Robert Scott Smith, John Straumanis, Karen Stone, Ron Taravella, John Thompson, Mark Townsend, Krishna Yalamanchili □

DUTY TO WARN IN THE POST 9-11 ENVIRONMENT

Continued from page 10

Prosenjit. Prosenjit withdrew from treatment. Two months later, in October, 1969, he sought out Tatiana and fired a pellet gun at her. She fled; he pursued her and murdered her with a knife. He then calmly called the police. Ms. Tarasoff's family filed a medical malpractice / wrongful death claim. The case was heard, on appeal, by the California Supreme Court in 1974¹⁰, and then, again in 1976¹¹.

In the 1974, the California Supreme Court held, in its review of Tarasoff (Tarasoff, I) that because a psychotherapist has a special relationship with a person whose conduct may need to be controlled, the therapist has a duty to exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances" in predicting whether the patient poses a serious danger to others. Two years later, the same court, (Tarasoff II) the California Supreme Court, in its re-examination of the issues raised in Tarasoff [the original California Supreme Court decision required that the lower court take a second look at a number of unresolved issues, and then the lower court decisions were again appealed to the California Supreme Court], held that a second duty existed, and that it was the duty "to exercise reasonable care to protect the foreseeable victim of that danger." The Tarasoff II decision recognized a societal right to expect that a licensed psychotherapist shall realize when a patient poses a serious danger to another, and, if that potential victim is identifiable, will act reasonably to protect the victim. The diagnosis and appropriate steps necessary to protect the victim are not separate or severable, but together constitute the duty to warn and protect.

The California Supreme Court in Tarasoff, and its progeny, stated that the duties to warn and protect emanate from the fiduciary duty established when treatment commences. These duties are derived from the fundamental public policy consideration that health care providers have a very real responsibility to protect the welfare of the community. This latter statement may be in-

terpreted to mean that physicians may, in some instances, have delegated, or implicit, police powers. Physicians are inherently linked to the legal system. They are licensed by the state to practice medicine and to dispense controlled substances; they have a duty to warn about communicable diseases; they are required, often by statute law to identify victims of child abuse, sexual abuse, spousal abuse, and elder abuse. Physicians, by the nature of their role in the community, have become an integral component of the legal process which balances individual's rights and freedoms against the need to protect the entire community.

Since Tarasoff II, psychotherapists have an affirmative duty toward third parties who may be in imminent danger from the clients. This duty may involve warning the third party, and/or taking reasonable protective measures on behalf of the third party.

Direct threats by the client are not necessarily the only trigger for this duty. Any set of symptoms or observations which reasonably lead to a conclusion of imminent danger may trigger the Tarasoff responsibility. The duty may extend not only to the person directly threatened, but also toward other individuals, if they can be identified as reasonably foreseeable victims.

The elements of the public policy that determine when damages are to be assessed in a failure to warn and protect situation were stated in Tarasoff II. These elements include:

- (1) The foreseeability of harm to the victim flowing from the patient's act
- (2) The degree of certainty that the victim suffered [or will suffer] injury
- (3) The "closeness" of the connection between the patient's conduct and the injury suffered
- (4) The moral blame attached to the patient's conduct
- (5) The policy of preventing future harm
- (6) The burden on the patient and to the community of imposing a duty to exercise due care
- (7) The availability, cost, and prevalence of insurance to cover the risk.

Tarasoff II was decided by a 4-to-3 majority. The majority spoke in terms of what

the doctor "knew or should have known." Judge Mosk, writing the dissenting minority opinion, stated that there are no professional standards for forecasting violence and that any rule should:

Eliminate all reference to conformity to stands of the profession in predicting violence. If a psychiatrist does in fact predict violence, then a duty to warn arises. The four judges in the majority opinion expand that rule [and] will take us from the work of reality into the wonderland of clairvoyance.

The Tarasoff decisions never reached a final resolution of their dilemma. The question of liability was left to the lower court to decide; it merely found that the therapist was potentially liable under the law. The case settled out of court. The Tarasoff family was paid a settlement by the University of California. Prosenjit returned to India and married.

The New Jersey Supreme Court, in 1979, in McIntosh v. Milano¹², extended the possibility for liability under the Tarasoff decisions. That court held that a duty to warn may exist and be based on a broad moral obligation to the welfare of the community. The court used the analogy of the existing obligation of a physician to warn a third person of infectious and contagious diseases. That court held that:

The relationship giving rise to that duty may be found either in that existing between the therapist and the patient as was alluded to in Tarasoff II [1976 decision] or in the more broadly based obligation a practitioner may have to protect the welfare of the community.

Direct threats by the patient are not necessarily the only trigger for this duty. Any set of symptoms or observations which reasonably lead to a conclusion of imminent danger may trigger the Tarasoff responsibility. The duty may extend not only to the person directly threatened, but also toward other individuals if they can be identified as reasonably foreseeable victims.

Some courts, rather than broadening the

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MEMBERSHIP COMMITTEE

Changes since the last Newsletter Membership report are as follows.

Members-in-training: Andrew Williams and Vida B. Robertson (LSU/Ochsner)

Upgrade to General Member: David Tucker

Transfers-in: Gregory Seal (GM) of Shreveport from Texas

Transfers-out: Arthur Freeman (DF) to Memphis, TN, Okon Enyenehi (MT) to Knoxville, TN, Brooke Parish (MT) to New Mexico, Denese Shervington (GM) to Nashville, TN.

Resignation: Clifford Crafton (GM)

Dropped for failure to pay 2003 APA dues: Brian Babiak, (GM), Leslie Lawrence (MT), Michelle Liokis (MT), Betty Ann Muller (GM), Rachel Ross (MT), Lynn Simon (GM), Christine

Smith (GM), Kenneth Sumner (GM), Khoa Tran (MT), Craig Troxclair (MT), Marchant Van Gerpen (GM)

Member Updates

Dr. Gregory Seal is on staff at Brentwood Hospital in Shreveport. He graduated from LSUHSC in Shreveport and completed a residency in psychiatry at the United States Air Force Medical Center in San Antonio. He is a diplomate of the American Board of Psychiatry and Neurology.

Dr. David Tucker is on staff at DePaul/Tulane Hospital. He graduated from Tulane Medical School and completed both general and child psychiatry residencies at Tulane. □

TRANSINSTITUTIONALIZATION OF THE MENTALLY ILL

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when the allegations of abuse at mental health facilities began to mount, Senator Sam Ervin (later of Watergate fame) held hearings and uncovered no cases of “railroading.”¹⁶ The American Bar Association also commissioned field investigations of mental hospitals in six states, and it concluded that railroading was a myth. In general, a patient in a mental hospital who wanted to leave simply had to put one foot in front of the other and walk out.¹⁷ Professor Gerald N. Grob, the prize-winning historian of mental hospitals, has written that the hospitals provided an asylum nowhere else available.¹⁸ In one of his many writings on the history of mental institutions, Grob wrote:¹⁹

In mid-nineteenth century America, the asylum was widely regarded as the symbol of an enlightened and progressive nation that no longer ignored or mistreated its insane citizens. The justification for asylums appeared self-evident: They benefitted the community by offering effective medical treatment for acute cases and humane custodial care of chronic cases. In providing for the mentally ill, the state met its ethical and moral responsibilities and, at the same time, contributed to the general welfare by limiting, if not eliminating, the spread of disease and dependency. After World War II, by way of contrast, the mental hospital began to be perceived as the vestigial remnant of a bygone age.

With liberty said to be at stake, the Mental Health Law Project urged that the civil commitment process apply the due process requirements of crimi-

nal justice procedures. The political abuse of psychiatry in the Soviet Union also contributed to the introduction of criminal justice procedures in the civil commitment process (the substantive concept of “dangerousness” as well as criminal justice procedural law).²⁰ The concept of the least restrictive alternative (LRA), also known as the least restrictive environment, was also utilized to restrict the use of hospital commitment. Under this doctrine, state intervention resulting from commitment is to take place in the least restrictive manner. The basis for the doctrine is the constitutional requirement that the state may restrict the exercise of fundamental liberties only to the extent necessary to effectuate the state’s interest. Under this scheme, the state hospital was posited as the most restrictive environment with community-based services and outpatient care seen as less restrictive. Under the theory of LRA, the court could mandate outpatient commitment without first an inpatient hospital commitment but that has been questioned, so special legislation authorizing outpatient commitment directly has been adopted in a number of states.²¹ Outpatient commitment is sometimes referred to somewhat euphemistically as assisted outpatient treatment.

Thinking in terms of liberty, proponents of LRA did not use the phrase “most beneficial alternative.” Under the LRA concept, any feasible alternative must be implemented in lieu of involuntary hospitaliza-



INTERNET RESOURCES

LPMA
www.lpma.net

National Mental Health Association
www.nmha.org

American Academy of Psychoanalysis and Dynamic Psychiatry
www.aapsa.org

National Alliance for the Mentally Ill
www.nami.org

American Psychiatric Association
www.psych.org

American Psychoanalytic Association
www.apsa.org

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duty, have extended the period of time between the patient's recognized potential for violence and the violent act. The Supreme Court of Delaware, in 1988, in Naidu v. Laird¹³, found a psychiatrist was liable for failing to foresee a patient's potential to act violently even though the act of violence occurred five and one-half months after discharge from the hospital. In the Michigan case of Davis v. Lhim¹⁴, the court considered a threat made by the patient two years prior to the violent act to be material to deciding that a duty had been breached and malpractice occurred when the patient ultimately killed his mother. Both the Naidu and Davis courts found the foreseeability of harm due to the patient's potential violence, rather than passage of time, to be the important issue in the reviewed cases.

In 1980, the Nebraska Supreme Court, in Lipari v. Sears, Roebuck & Company⁸ ruled that the Veteran's Administration could be held liable, as "any citizen" to "any foreseeable victim or to that class of victims" after Ulysses L. Cribbs, Jr., a chronic paranoid schizophrenic patient at the Veteran's Administration Hospital, with a history of being involuntarily hospitalized at the Veteran's Administration Hospital, killed Mr. Lipari. Mr. Cribbs had purchased a shotgun from Sears Roebuck, in Belview, Nebraska, in September 1977. Mr. Cribbs continued in treatment, at the Veteran's Administration Hospital until October 1977 when he terminated therapy. In November 1977, he entered an Omaha nightclub, fired his weapon and killed Dennis Lipari. Mr. Cribbs had never met Mr. Lipari; Mr. Lipari was merely at the wrong place at the wrong time. The duty imposed by the Nebraska Court required the taking of an affirmative action for the protection of a third party.

The Iowa court, in 1992, in the case of Leonard v. Iowa¹⁵, stepped away from the Lipari broadly foreseeable standard in stating that the duty extended only to "reasonably foreseeable victims," and not to the general public. Given the post-9-11 environment, one has to wonder if the case were retried today whether the decision and the analyses would change with the change in public

policy toward dangerousness and the degree of certainty, probability, possibility now attached to risk assessment analyses. Certainly, the Arizona Supreme Court decision, in 1989, in Hamman v. County of Maricopa¹⁶, in which it ruled that a psychiatrist has a duty to protect the public where at least the victim is identifiable or in a zone of danger, even in the absence of threats, is more consistent with current trends in public policy.

The Kansas Supreme Court in Durflinger v. Artiles¹⁷, in 1983, acknowledged that a "special relationship" existed between in the patient and therapist in both Tarasoff and Lipari. That said, they disagreed with the American Psychiatric Association's position on dangerousness. The Kansas Supreme Court countered arguments about the difficulty of predicting dangerousness stating:

The Court recognizes that it may be difficult for medical professionals to predict whether a particular mental patient may pose a danger to himself or others. This factor alone, however, does not justify barring recovery in all situations. The standard of care for health professionals adequately takes into account the difficult nature of the problem faced by psychotherapists. . . . The Court is of the opinion that the difficulty in predicting dangerousness does not justify denying recovery in all cases.

The Kansas court quoted from Lipari v. Sears, writing:

To summarize, this [Nebraska] Court is of the opinion that under Nebraska law the relationship between a psychotherapist and his patient gives rise to an affirmative duty for the benefit of third persons. This duty requires that the therapist initiate whatever precautions are reasonably necessary to protect potential victims of his patient. This duty arises only when, in accordance with the standards of his profession, the therapist knows or should know that his patient's dangerous propensities present an unreasonable risk of harm to others.

There are courts, over the past two decades, that have attempted to restrict liabil-

ity of health care providers, related to the prediction of dangerousness, and its consequences based, in essence, on the American Psychiatric Association's position on dangerousness. The APA states that recent research has shown that the vast majority of people who are violent do not suffer from mental illnesses. The APA recognizes that there is a small subgroup of people with severe and persistent mental illnesses who are at risk of becoming violent. Violence is defined as threatening, hitting, fighting, or otherwise hurting another person. The APA does not address identifying those who may become violent, but do not have a mental illness.

The APA *Statement on Prediction of Dangerousness* states:

Psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, predictions of future violence will be wrong for two out of every three patients." There are just too many variables in the *biopsychosocial* nature of mental illnesses. Mental illnesses are *biological*, arising in part from disturbances in brain or other body-system chemistry; they are *psychological*, manifesting in disturbances in thought and/or emotion; and they are *social*, arising in part from patients' social and cultural environment—how they are raised, the norms of their community, what sorts of stress they face in their everyday lives. Psychiatrists always take into account these three intertwined areas of an ill person's life in diagnosis and in designing an effective treatment plan. However, these factors are not always sufficient to predict behavior.

Lidz¹⁸ and colleagues studied the accuracy of predictions of violence to others. They note that clinical judgment adds to predictive accuracy but, overall accuracy was considered modest and especially low for female patients. The overwhelming majority of instances of patient violence were initiated by

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men. Lidz and colleagues¹⁹ also found that actuarial predictions based only on patients' histories of violence were more accurate than clinical predictions. Mathematical models developed for understanding the spread of infectious diseases are being applied to the study of group violence²⁰.

Binder²¹, more recently states, that her research group can show that short-term predictions of violence can be relatively accurate. She notes that the most likely victims of decompensating psychiatric patients are caretakers, rather than strangers. She concludes that a history of violence, co-morbid substance abuse, and noncompliance are related to a higher risk of violence in psychiatric patients. Mossman²² had found similar results, that is, past behavior alone appears to be a better long-term predictor of future behavior than clinical judgments. Buchanan²³ has examined the issue of detaining people with severe personality disorders to prevent their engaging in violent acts. He notes that the greater the amount of data available on a given individual the better the predictive ability, however accurate that might be.

Elbogen²⁴, in his 2003 article in the *Journal of the American Academy of Psychiatry and the Law*, opines the opinion that research studies have identified risk factors that show a strong association with violent behavior in psychiatric populations. His own research also indicates that documentation of risk factors for violent behaviors varies widely with the type of mental health facility. It should be axiomatic that good record keeping is required when dealing with a potentially dangerous patient. Without good record keeping, retrospective analyses cannot be accomplished and clinical epidemiological research will continue to be hampered.

Fear of a loss of confidentiality of the content of medical records from HIPAA², the Patriot Act³, and other state and federal laws should not limit one's documentation of violent behavior.

Mental health providers, and specifically, psychiatrists, have been held accountable and liable, and will continue to be held accountable and liable, for failing to consistently and accurately identify patients who become vio-

lent. The ultimate question that arises in failure to warn and protect cases is whether the failure to warn, after actual knowledge of an imminent harm to an identifiable or unidentifiable third party or third parties, is malpractice or simple negligence. Was there a breach of duty? If that question can be answered in the affirmative, and damages have occurred as a direct result of the breach of duty, then a successful malpractice claim may be asserted. Simple negligence may occur in any circumstance. Reducing a failure to warn malpractice claim to a simple negligence claim implies that the critical objective criterion would be, What would a reasonable man or woman do in a similar circumstance? Rather than, What is the professional standard in a similar circumstance?

Conclusion

Mental health providers.

The clinician, based upon his or her clinical experience, will be faced with patients similar to those described in the opening paragraph of this paper.

Most might agree that a Tarasoff notice would not be necessary for the patients described in examples one and two, depending in large measure on the clinician's knowledge of the patient's past history, including military history and whether the patient has a previous history of violence or has made threats of violence and then acted on them. The third example is much more problematic. The more specific the threat, that is, the identification of potential victims, and the more detailed the plan, the greater the likelihood that a warning should be given. The last two examples are contingency circumstances. The question then would appear to be, not if the warning should be given, but when and to whom. Once a warning is given, it then becomes the responsibility of those warned to assess the seriousness of the warning and to take whatever actions they deem necessary to protect themselves and give themselves and others a sense of security.

As the war on terrorism continues, and as the community becomes more concerned about dangerous behaviors of those with and without mental illness, mental health provid-

ers, and especially physician-mental health providers, will be called upon to help law enforcement and other government agencies identify those at potential risk for engaging in dangerous activities that affect not only individuals but also communities. The evolution from Palsgraf to Tarasoff is merely anticipatory to the challenges, within psychiatry, over the next decades.

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NOTES

1. Diagnostic and Statistical Manual, 4th Edition, Text Revision, American Psychiatric Association, Washington, D.C. 2000.
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA).
3. Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT ACT) Act of 2001.
4. Ginzburg HM. The evolution of psychiatric-legal diagnostic dilemmas, In: Simon RI. (Ed.) *Annual Review of Clinical Psychiatry and the Law, Volume 1*, American Psychiatric Press, Washington, D.C., 1989, pp. 241-294.
5. Palsgraf v. Long Island Railroad Company, 248 N.Y. 339, 162 N.E. 99 (1928).
6. Tarasoff v Regents of University of California et al, 108 Cal Rptr 878 [Cal App 1973], superseded by Tarasoff v. Regents of University of California et al, 13 Cal3d 177, 118 Cal Rptr 129, 529 P2d 553 (1974), subsequent op on reh Tarasoff v Regents of University of California et al, 17Cal3d 425, 131 Cal Rptr 14, 551 P2d 334 (1976).
7. Restatement [Second] Torts § 315 (1965).
8. Lipari v Sears, Roebuck and Co., 497 F. Supp. 185 (D. Neb. 1980).
9. Biakanja v. Irving 49 Cal.2d 647 (1958).

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tion. The first enunciation of LRA in the law on hospitalization was in 1966 in the case of *Lake v. Cameron*.²² The case involved Mrs. Catherine Lake, a sixty-year-old “bag lady.” Mrs. Lake carried her worldly possessions around with her in a shopping bag, appearing disoriented, wandering about in the downtown crime-ridden district of the nation’s capital. In assessing her habeas corpus petition, the District of Columbia Circuit Court of Appeals ruled that any course of treatment should not exceed the minimum necessary to ensure the patient’s protection.

In a case decided in 1979 by the United States Supreme Court, *Addington v. Texas*,²³ the Mental Health Law Project sought to invoke the “proof beyond a reasonable doubt” standard of criminal justice into the civil commitment process. The case involved a man whose mother filed a petition to have him committed to a state mental hospital. The Court held that to require proof beyond a reasonable doubt of the criteria for civil commitment — “mental illness” and “dangerousness” or “gravely disabled” — would be well-nigh impossible, and thereby would do away with involuntary commitment, as Chief Justice Warren Burger recognized. Writing the opinion of the Court, he said that the criminal law “beyond a reasonable doubt” standard was inappropriate because, “given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous.”²⁴ Nevertheless, the Chief Justice called for a “clear and convincing evidence” standard in commitment hearings as opposed to the “preponderance of the evidence” standard of the ordinary civil case and less than “proof beyond a reasonable doubt” of criminal cases.²⁵

The establishment of community mental health centers (CMHC) in the 1960s were designed to maintain patients in the community thereby sparing them the allegedly dreadful consequences of institutionalization. Based on a community services approach to mental health care, the Landerman-Petris-Short (LPS) Act was regarded as the “outstanding accomplishment of the California

Legislature in its 1967 session.” It was designed to “protect the civil liberties of persons alleged to be mentally ill” and to accelerate the trend toward “community” treatment of the mentally ill as an alternative to hospitalization in remote state institutions. Presumably the mentally disturbed would come to the center with small problems before they became big ones, thus shifting the government’s role from custodial to preventive.

President Kennedy was impressed with the Report of the Joint Commission on Mental Illness and Health, *Action for Mental Health*. He endorsed it, and made funds available for its implementation. The Report echoed Goffman’s critique of institutionalization.²⁶ The CMHC program had the support of both the political right and left. The right wanted to close the mental hospitals to save money and the left thought it was freeing prisoners of snake-pit psychiatric bureaucracy. At the time, there was little or no support among policy makers for mental hospitals.

Both the legal and psychiatric professions persuaded legislators that mental hospitalization was both outdated and expensive. The community mental health program was sold to legislators on the basis of saving money — an argument very appealing to a legislator’s heart. For example, the legislators after whom the 1967 California commitment law was named (Lantermann-Petris-Short) were members of the Ways and Means Committee — a finance committee — and were, therefore, probably most concerned about the state getting its moneys’ worth.

NOTES

1. R.D. Meade, *Patrick Henry: Patriot in the Making* (Philadelphia: Lippincott, 1957), p. 281.

2. Jewish tradition as stated in the Talmud portrayed the insane as victims of a disease, not of possession. G. Mora, “History of Psychiatry,” in A.M. Freedman & H.I. Kaplan (eds.), *Comprehensive Textbook of Psychiatry* (Baltimore: Williams & Wilkins, 1967), p. 12.

3. J.S. Bockhoven, “Moral Treatment in American Psychiatry,” 124 *J. Nervous & Mental Disease* 167 (1956).

4. C. Dickens, *American Notes and Pictures from Italy* (1942; New York: Oxford University Press, 1957), p. 28. In England, asylums were not built until the 19th century, and their establishment there “is better seen not as an act of state but as a side effect of commercial and professional society.” R. Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002).

5. Violence among gangs in antebellum New York is depicted in the book turned into a film, *Gangs of New York*. Kevin Baker, author of historical novels, vouches for its accuracy in “A Nation’s Wild Start,” *New York Times*, Dec. 26, 2002, p. 35.

6. According to the historian Albert Deutsch, Mrs. Packard had claimed to be the Mother of Christ and the Third Person of the Blessed Trinity. Her husband, the Rev. Theophilus Packard, Jr., found that the bonds of matrimony had become a bond of acrimony, and he had her committed. In accordance with Illinois law, the superintendent at the asylum had to be willing to accept her, and the physician on duty was willing. Dr. Andrew McFarland, her physician at the asylum, found her incurable, and threw up his hands, swearing that he would not again ever attempt to treat a woman. A. Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times* (New York: Doubleday, 1973), pp. 424-25. Discussions of the commitment of Mrs. Packard invariably omit the requirement of hospital approval and simply state that a husband at the time had an uncontrolled power to institutionalize his wife.

7. B. Sapinsky, *The Private War of Mrs. Packard* (New York: Paragon House, 1991).

8. In recent years, with the demise of indeterminate sentencing generally, a number of states enacted laws for the commitment of “sexually violent predators” (SVP). The new laws are different from the early sexual psychopath statutes and from ordinary civil commitment laws in several important respects: first, they do not require a medically recognized serious mental disorder; sec-

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ond, they do not require any allegation or proof of recent criminal wrongdoing; third, they require sex offenders to serve their full prison term prior to commitment; and fourth, no bona fide treatment program need be in place. The new legislation has no great hopes for treatment, as earlier legislation did, and much more emphasizes incapacitation. Sooner or later, it will be realized that the SVP laws, like the earlier sexual psychopath laws, are so exorbitant in costs and their efficacy so doubtful that they will be abandoned or repealed. See R. Slovenko, Psychiatry in Law (New York: Brunner-Routledge, 2002), pp. 391-405. In the fictional "Sopranos" the mobster Tony Soprano walked out on his psychiatrist, Dr. Jennifer Melfi. A year earlier the American Psychoanalytic Association gave a special award to the actress who played her. C. Haberman, "Analyzing the Imagery Off the Couch," New York Times, Jan. 24, 2003, p. 22.

9. See S. Gelman, Medicating Schizophrenia: A History (New Brunswick: Rutgers University Press, 1999); D. Healy, The Creation of Psychopharmacology (Cambridge: Harvard University Press, 2002); R. Whitaker, Mad in America (Cambridge: Perseus, 2002).

10. E. Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (New York: Doubleday, 1961).

11. K. Kesey, One Flew Over the Cuckoo's Nest (New York: Viking, 1962). See also L. McMurtry, "On the Road," New York Review of Books, Dec. 5, 2002, p. 46.

12. T. Szasz, The Manufacture of Madness (New York: Harper & Row, 1970).

13. It also may be noted that Fred Cohen's casebook on civil commitment published in 1980 by West, the leading law school publisher, was titled The Law of Deprivation of Liberty: A Study in Social Control/Cases and Materials.

14. B. Ennis, Prisoners of Psychiatry (New York: Harcourt, Brace & Jovanovich, 1972).

15. L.R. Frank, "An Interview with Bruce Ennis," in Madness Network News Reader (1974), p. 162. Madness Network

News was published by ex-mental patients in Oakland beginning in 1972 and continued until 1986. A collection appears in S. Hirsch et al., Madness Network News Reader (1974). See also R.J. Isaac & V.C. Armat, Madness in the Streets (New York: Free Press, 1990).

16. Constitutional Rights of Mentally Ill, Hearings before the Subcomm. on Constitutional Rights of the Comm. on the Judiciary, 87th Cong., 1st Sess. (1961).

17. R. Rock et al., Hospitalization and Discharge of Mentally Ill (Chicago: University of Chicago Press, 1968).

18. G.N. Grob, Mental Institutions in America/Social Policy to 1875 (New York: Free Press, 1973).

19. G.N. Grob, "Mental Health Policy in America: Myths and Realities," 11 Health Affairs 7(1992).

20. For example, the North Dakota Supreme Court observed in a civil commitment case, "Of particular concern is the situation in the Soviet Union, where commitment proceedings are utilized to confine political dissidents, religious activists, ethnic nationalists and persons who have requested permission to emigrate." In Interest of Goodwin, 366 N.W. 2d 809 at 812 (N.D. 1985).

21. See K. Kress, "An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa," 85 Iowa L. Rev. 1269(2000). See also M.R. Munetz et al., "The Effectiveness of Outpatient Civil Commitment," 47 Psychiatric Services 1251(1996); C. Slobogin, "Involuntary Community Treatment of People Who are violent and Mentally Ill: A Legal Analysis," 45 Hosp. & Community Psychiatry 685 (1994).

22. 364 F.2d 657 (D.C. Cir. 1996).

23. 441 U.S. 418 (1979).

24. 441 U.S. at 429.

25. 441 U.S. at 433.

26. See E.F. Torrey, Nowhere to Go (New York: Harper & Row, 1988).

Look for Part Two published in our next issue. □

DUTY TO WARN

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10. Tarasoff v. Regents of University of California et al, 13 Cal3d 177, 118 Cal Rptr 129, 529 P2d 553 (1974),

11. Tarasoff v Regents of University of California et al, 17Cal3d 425, 131 Cal Rptr 14, 551 P2d 334 (1976).

12. McIntosh v Milano, 168 NJ Super 466, 403 A2d 500 (1979).

13. Naidu v Laird, 539 A2d 1064 (Del 1988).

14. Davis v Lhim, Estate of Davis v. Yong-Oh Lhim, 422 N.W.2d 688 (1987).

15. Leonard v. Iowa 491 N.W.2d 508 (Iowa 1992).

16. Hamman v. Co. of Maricopa, 775 P.2d 1122 (Ariz.Sup.Ct. 1989)

17. Durlfänger v Artiles, 673 P.2d 86 (Kan 1983).

18. Lidz CW, Mulvey EP, Gardner W. The accuracy of predictions of violence to others, JAMA 269:1007-11, 1993.

19. Gardner W, Lidz CW, Mulvey EP, Shaw EC. Clinical versus actuarial predictions of violence of patients with mental illnesses, J Consult Clin Psychol 64:602-9, 1996.

20. Patten SB. Epidemics of violence, Med Hypotheses, 53:217-20, 1999.

21. Binder RL. Are the mentally ill dangerous? J Am Acad Psychiatry Law 27:189-201, 1999.

22. Mossman D. Assessing predictions of violence: being accurate about accuracy. J Consult Clin Psychol 62:783-92, 1994.

23. Buchanan A, Leese M. Detention of people with dangerous severe personality disorders: a systematic review, Lancet 358:1955-9, 2001.

24. Elbogen EB, Tomkins AJ, Pothuloori AP, Scalora MJ. Documentation of violence risk information in psychiatric hospital patient charts: an empirical examination. J Am Acad Psychiatry Law 31:58-67, 2003 □

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COMMITTEE TO CONSIDER NOMINEES FOR 2005-06

The LPMA Nominating Committee will meet on Friday, September 17 at 11 AM at the Sandestin Hilton Hotel in Destin, FL to consider nominations for LPMA President-Elect, Treasurer, and Secretary, for 2005-06. They will also nominate members for the LPMA Representative and Deputy Representative to the APA Assembly for 2005-08. Members of the committee are Drs. Patrick O'Neill (Chair), Paul Pelts, Aretta Rathmell, David Rees, Lee Stevens, Patricia Toups, and Mark Zielinski.

The date for the first meeting of the Nominating Committee is at the Fall Meeting when most of the Nominating Committee members are together. The membership will have greater access to the committee at this time.

If you want to bring someone to the attention of the committee, please contact any member of the committee or submit his/her name to the LPMA office by fax, email or regular mail. Guidelines for selecting officers are as follows.

1. Past LPMA involvement
2. Past chapter involvement

3. Past community involvement
4. LSMS membership
4. Leadership ability
5. Knowledge and ability to relate to other community organizations
6. Contraindications

The duties of the Assembly Representatives are many. They should be present at Assembly, Area and District Branch (DB) meetings and report Assembly activities to the DB membership verbally or utilizing the DB listserv and newsletter. They should seek opportunities to talk and meet with members to solicit their views and objectives and bring their concerns and requests for action to the Assembly by crafting Action Papers that propose effective and feasible actions. The DB should review such papers prior to submission to the Area Council and Assembly.

The Representatives should serve as mentors to interested new Representatives, Members-in-training and Early Career Psychiatrists. □

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