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In This Issue

Forensic Psychiatry: The Interface Between Psychiatry and the Law

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In this issue, we focus on the subspecialty of forensic psychiatry. Although residents may not complete a forensics rotation until late in their training, issues pertaining to this field will undoubtedly arise during any psychiatric rotation. Questions of decision making capacity, risk of violence, inpatient commitment, and forced medication are but some of the examples that lie at the interface between psychiatry and the law. The competent clinician cannot practice psychiatry with a blind eye turned to the legal and ethical complexities surrounding our patients.

The issue begins with an introduction to the field of forensic psychiatry and to the process of applying for a forensic psychiatry fellowship. Next, Drs. Todd Broder and Felipe Suplicy discuss the important effect of landmark court cases on clinical practice. In another clinically oriented article, the behavior of fire setting is described with a review of the relevant scientific data. Later, Dr. Jason Yanofski describes two issues for the child and adolescent psychiatrist: the shifting standards of child custody evaluations and the relationship between immaturity and juvenile competency to stand trial. Lastly, Dr. Maya Prabhu reflects on the potential for international law to advance global mental health goals.

Applying for a Forensic Psychiatry Fellowship

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Although medical school and residency applicants may readily find resources to provide advice, little exists for psychiatry residents who apply for subspecialty fellowships. Applying for a forensic psychiatry fellowship is no exception (1, 2). The purpose of the present article is to introduce residents to the field of forensic psychiatry and to the process of applying for and successfully completing a forensic psychiatry fellowship. Based on my personal experience with recently interviewing at many forensic psychiatry training programs across the country, this article may also serve as a starting point to guide residents through the application process.

A common question asked by friends and family is, "What is forensic psychiatry?" Some relate the profession to roles depicted in television shows, such as *C.S.I.*, *Law & Order*, and *Criminal Minds*. The similarities, however, are lacking. The American Academy of Psychiatry and the Law (AAPL) defines forensic psychiatry as a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues (3). In other words, forensic psychiatrists work at the interface between psychiatry and the law. Since 2001, the completion of a year of training in a program accredited by the Accreditation Council for Graduate Medical Education has been required for candidates wishing to take the American Board of Psychiatry and Neurology forensic psychiatry subspecialty examination.

Issues encountered in forensic psychiatry include the following: competency, criminal responsibility, disability, malpractice, fitness for duty, psychic injury, and risk assessment. Forensic examinations deal with a broad array of patient demographics and clinical conditions. Evaluations in criminal courts (e.g., competence to stand trial, criminal responsibility) may deal with psychosis, substance use, antisocial personality disorder, and mood disorders. Other evaluations are more focused (e.g., posttraumatic stress disorder in psychic injury evaluations or parental fit in child custody evaluations). By its very definition, malingering is a diagnosis that is considered in most forensic evaluations because of the potential to feign symptoms for secondary gain.

The breadth of issues addressed by forensic psychiatrists lends itself to a multitude of job opportunities. Opportunities exist in private, public, and academic settings. Referrals for forensic evaluations may come from lawyers, courts, insurance companies, employers, and general psychiatrists or hospitals. Defendants who are adjudicated not competent to stand trial and not criminally responsible often need inpatient psychiatric treatment, another setting in which forensic psychiatrists may work. Similarly, correctional settings (i.e., jails and prisons) attract forensic psychiatrists to provide treatment to inmates. Additionally, most forensic psychiatrists maintain some clinical experience. This is advisable in order to remain current with the standard of care and to reduce the appearance of bias.

The experiences during a fellowship in forensic psychiatry may be quite different than those encountered during residency in general psychiatry. Fellows learn to adapt to the role of performing evaluations of "defendants" or "clients" instead of providing treatment for "patients." Because the fellowship is usually only 1 year in length, a significant amount of reading is expected to ensure that fellows master the requisite legal knowledge. Exhaustive evaluations are typically followed by lengthy written reports; comfort with writing certainly eases the work. Fellows will also attend didactics and seminars. They may participate in mock trials and attend law school classes. Many fellowship programs offer funding to attend the annual AAPL conference. Programs may also provide opportunities for fellows to testify, teach, and conduct research.

Forensic psychiatry fellowships are often perceived as selective, which is likely a result of the number of available training positions. Almost all programs are 1 year in duration. There are currently 44 accredited programs in the United States. Most fellowships have two to four positions (although one program offers one position, and one program offers five). Because of a developing niche, some programs reserve a fellowship position for an applicant who has previously completed a fellowship in child and adolescent psychiatry.

When considering applying for forensic psychiatry, start early! Visit the AAPL website (http://www.aapl.org) for resources and a directory of fellowship programs. Also, consider becoming a member of AAPL, especially to receive a subscription to *The Journal of the American Academy of Psychiatry and the Law*. To apply for fellowships, contact individual programs directly. Forensic psychiatry fellowship programs do not participate in the match. There is significant variability in the rate at which programs fill their complement of positions, which is why it is best to submit all required documentation early. Applications should be submitted in the summer preceding the anticipated matriculation year. For instance, applications for the 2011–2012 academic year should be submitted in the summer of 2010. Application materials commonly required include a letter from one's residency program director, letters of recommendation, a medical school transcript, and a current curriculum vitae. Additionally, some fellowships require the submission of writing samples. Examples may include a personal statement, forensic evaluations, discharge summaries, or published articles.

Interviews are commonly scheduled from July through October and may last 1 or 2 days. Applicants will interview with faculty, meet the current fellows, attend didactics, and may be taken to lunch or

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dinner. Common interview questions that may be anticipated include the following: Why forensics? What forensic experiences have you had? Why our program? Where do you see yourself in 5 years? What do you think about this case? What questions do you have for me? At the end of the interview day, it is also common for applicants to have an exit interview with the fellowship director. This may be a slightly awkward encounter as the applicant and fellowship director try to assess each other's interest without the director committing to offering a position or the applicant accepting an offer.

Although the field is relatively small, there exist many fundamental differences among forensic fellowship programs. Similar to residency programs, fellowships vary regarding their emphasis on training and education, variability of work, and amount of service requirements. Some fellowships have contractual obligations to place their trainees at certain sites (e.g., providing psychiatric treatment in a prison). Applicants should get a sense of what their workload will be like and whether fellows receive training in both criminal and civil cases. Lastly, applicants should consider their own interests and ascertain whether the program will meet their needs (e.g., experience with testifying, auditing law school classes, conducting research, teaching residents or students).

After an interview, applicants may decide to either inform the program of their interest or accept an offer, if one is made, before all of their scheduled interviews are complete. Fellowship programs have been directed by AAPL not to demand that forensic psychiatry applicants accept an offer of a position before October 31 of the year preceding the fellowship start date (2). This date is typically near the AAPL Annual Meeting, an opportunity to informally "scramble" into open positions should an applicant be without an offer.

In conclusion, if you are considering applying for a forensic psychiatry fellowship, start the process early. Gauge your own interest, learn about the profession, research fellowship programs, and attend the AAPL Annual Meeting. Gather the application materials and prepare your writing samples. Put on your best suit, smile, ask questions, and have fun. A fellowship in forensic psychiatry is a fast-paced year that requires much energy and enthusiasm. The professional opportunities upon completion are worth all the effort.

Dr. Cooke is a Forensic Psychiatry Fellow at Yale University School of Medicine and the Editor for this issue.

References

1. Fisher C, Garakani A: Subspecialty training in psychiatry, in A Resident's Guide to Surviving Psychiatric Training, 2nd ed. Edited by Foreman T, Dickstein LJ, Garakani A. Washington, DC, American Psychiatric Publishing, 2007, pp 147–152
2. Association of Directors of Forensic Psychiatry Fellowships: Forensic Psychiatry Fellowship Application Guidelines, Bloomfield, Conn., Association of Directors of Forensic Psychiatry Fellowships. https://www.aapl.org/pdf/Applicant_Guidelines.5-22-05.pdf
3. American Academy of Psychiatry and the Law: http://www.aapl.org

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How Landmark Psychiatric Legal Cases Shape Our Clinical Practice

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Throughout training, psychiatry residents are exposed to an abundance of rules, regulations, and guidelines regarding the management of psychiatric patients. We often find ourselves discharging a patient who no longer meets the criteria for involuntary commitment, despite knowing that the patient would benefit from further inpatient care. Perhaps we have had to call an identified victim to warn the victim of the patient's plan to assault him or her.

Much of our daily clinical practice originates not from hospital policy or American Medical Association regulations, but from U.S. law. In fact, many of the policies we adhere to today, with regard to managing mentally ill patients, date back hundreds of years to English Common Law and fundamentals of the U.S. Constitution and Bill of Rights. Furthermore, specific legal cases, once tried, become case law (a type of common law), and the precedents set in these cases provide a standard of care.

Case law has provided the source for many laws and regulations we follow today in our clinical practice. Thousands of cases heard at both district and federal courts have shaped the practice of psychiatry over the years. In the field of forensic psychiatry, we focus on the most pertinent cases, known as landmark cases (1). Approximately 100 landmark cases are maintained and regularly updated for academic review.

Case law incorporates previous cases that have set clinical standards for patients' right to die, informed consent, and civil commitment. One interesting topic related to case law is a patients' right to treatment. Legal documents dating as far back as the 1700s in England indicated, for the first time, recognition that mentally ill individuals required treatment (2).

Historically, mentally ill patients were institutionalized for life, with limited consideration of individual freedoms or civil liberties. In the United States in the 1960s, physicians and attorneys began to focus on the constitutionally protected right to treatment of involuntarily committed individuals. Review of the right to due process, protected by the Fourteenth Amendment of the U.S. Constitution, was interpreted to include a mentally ill person who has not committed a crime and that the person should not be hospitalized indefinitely without treatment.

In 1966, a landmark case, *Rouse v. Cameron* (3), highlighted these issues. Charles Rouse was involuntarily committed to a state hospital after being found not guilty by reason of insanity for carrying a weapon. He petitioned for a habeas corpus, arguing that he had been committed for 3 years without treatment. Interestingly, his legal charge was a misdemeanor, which would have only earned him a maximum of 1 year in prison. The case was raised to the Washington, DC Circuit Court of Appeals, which proposed that the goal of involuntary hospitalization was treatment, not punishment, and hospitals needed to make an honest effort to provide such treatment. Two important additional outcomes came from this case. The court required hospitals to provide individualized treatment plans, which depicted specific treatment strategies to the individual patient. Also, failure to provide adequate treatment could not be justified by the lack of staff or facilities.

In 1970, a class-action suit was filed representing patients who were involuntarily admitted to Bryce Hospital in Tuscaloosa, Alabama (4). The U.S. District Court held that the patients (including a 15-year-old teenager, Ricky Wyatt, who was labeled a juvenile delinquent) had a constitutional right to treatment, which would give them a reasonable chance to improve. Since conditions at Bryce Hospital were deplorable, the court outlined a minimum constitutional standard for providing care to involuntarily committed mentally ill patients. Within this outline, the court required minimum standards, known as the Wyatt standards, which included humane psychological and physical environments. From this case came the list of patients' rights, which we are familiar with today, including concepts of the right to privacy and dignity, the right to least restrictive conditions, the right to visitation and telephone calls, and the right to be free of unnecessary and excessive medications.

A 1975 U.S. Supreme Court Case, *O'Connor v. Donaldson* (5), further highlighted a patient's constitutional rights. This case was an appeal of a previous case in Florida regarding civil commitment with minimal treatment. The U.S. Supreme Court determined that it was unconstitutional to maintain involuntary commitment if a patient was not dangerous and could live elsewhere safely. The Court ruled that states could not confine an individual without treatment if the individual is nondangerous and can survive safely alone or with the help of willing and reliable family or friends.

These selected cases provide specific examples of how important elements of our daily clinical practice have been established—from English Common Law to the U.S. Constitution—and shaped over time by specific case law.

Drs. Broder and Suplicy are Forensic Psychiatry Fellows at the University of Florida Division of Forensic Psychiatry.

References

1. American Academy of Psychiatry and the Law: http://www.aapl.org/landmark_list.htm
2. Jones K: A History of the Mental Health Services. London, Routledge and Kegan Paul, 1972, pp 25–28
3. Rouse v. Cameron, 125 U.S. App. D.C. 366, 373 F.2d 451 (1966)
4. Wyatt v. Stickney, 344 F.Supp. 387 (M.D. Ala. 1972)
5. O'Connor v. Donaldson, 422 U.S. 563, 95 S.Ct. 2486 (1975)

Risky Business: An Introduction to Evaluating Fire Setting Recidivism

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Many clinicians feel overwhelmed when presented with a patient who sets fires. The fire setting behavior may be noted upon admission to a hospital, during outpatient treatment, or during a forensic evaluation. Two common questions regarding fire setting are: 1) "What is the risk that the patient will light more fires?"; and 2) "What treatment is available to mitigate the risk?" The purpose of the present article is to introduce the reader to the recent and relevant scientific data to gain a better understanding of fire setting behaviors.

Some brief statistics from the U.S. Fire Association highlight the effects of intentionally set fires in the United States (1). In 2008, there was an estimated 1.5 million fires. There were 3,320 reported civilian deaths and 16,705 reported civilian injuries that occurred as the result of fire. Direct property loss due to fires was estimated at $15.5 billion.

One must be careful when distinguishing the terms arson, pyromania, and fire setting. *Arson* is a legal term referring to the malicious setting of a fire to cause damage. *Pyromania* refers to the deliberate setting of fire as a means to reduce emotional tension or to create a sense of release. Clinicians should be aware that not all arsonists are pyromaniacs. *Fire setting* is a broad term used to denote a specific behavior and may fall under the category of arson or pyromania.

There have been many attempts to classify fire setting, which is best summarized and critiqued by Doley (2) and Sakheim (3). One conceptualization includes classifying fire setting as accidental or unintentional, a result of delusional ideation, erotically motivated, revenge motivated, or conducted by children. Other classification systems have categorized fire setters as those who are provoked by the following triggers: excitement, an attempt to benefit from an insurance claim, vandalism, an attempt to cover up a crime, an institutionalized motive, a cry for help, the desire to be a would-be hero, attention seeking, a professional motive, a mixed motive, an acquisitive motive (arson for profit), vindictiveness, an instrumental motive, a cathartic motive, or no obvious motive. Yet another system of classification categorizes fire setters as organized (using elaborate incendiary devices and leaving little physical evidence) versus disorganized (using materials found at the scene and common ignition devices and often leaving physical evidence). The importance of an individual's history is noted by the categories of serial (involved in three or more separate fire setting episodes with an emotional cooling-off period between fires), spree (no cooling-off period), and mass arson. A criminal history may be relevant, given that one system classifies arsonists as pure (only arson in the criminal history) or nonpure (other types of offenses in the criminal history). These classification systems provide a reminder of the heterogeneity and complexity of the behavior.

There is a strong association in clinical samples between antisocial or aggressive behavior, a diagnosis of conduct disorder, and fire setting (4). Arsonists are 12 times more likely to have antisocial personality disorder than people who do not set fires (5). They tend to engage not only in fire setting but also in a wide variety of other antisocial behaviors, such as assault, robbery, rape, weapon use, and cruelty to animals. The absence of antisocial personality disorder or antisocial behaviors is clearly a protective factor for future risk.

Pyromania is associated with high rates of psychiatric comorbidity. This may include mood disorders (especially major depressive disorder), anxiety disorders, substance use disorders, and impulse-control disorders. Fire setting may represent as a behavioral manifestation of schizophrenia, bipolar disorder, substance abuse, personality disorders, or mental retardation (4). Patients will need follow-up assessment with an outpatient psychiatrist to monitor and treat these other mental disorders (if present).

There are high rates of recidivism in persons with pyromania. Fire setting recidivism rates vary widely in the literature, from 4% to 60% (6). Juvenile recidivism rates are as high as 72% (7). Although arson recidivists have rarely been thoroughly characterized, fire setting in pyromania is often episodic and may wax and wane in frequency. The prognosis for adults is typically guarded because they frequently deny their actions, refuse to take responsibility, are dependent on alcohol, or lack insight (6). It is also known that psychosocial stressors within the family, school, peer group, or community may precipitate setting fires. Outpatient therapy will need to examine these stressors to help patients understand what may trigger their behavior.

There are few clinical studies documenting well-established treatments for pyromania. Medications that have resulted in partial or complete remission among some subjects in a few scientific studies have included topiramate, escitalopram, sertraline, fluoxetine, and lithium (8). Additionally, if one takes into account the addictive properties of fire setting, it would be feasible to consider a medication such as naltrexone. For nonpharmacological treatment, an appropriate approach is to use a number of modalities. Fire setters have been described as passive and socially withdrawn (i.e., more likely to be alone and engage in fewer social activities) (9). Patients will need treatment that will engage and confront them.

Other ideas for treatment that have been

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suggested include fire safety education by fire fighters, cognitive behavioral techniques, supervision to prevent repeated episodes of fire setting, and a family-centered group intervention program (since family difficulties are common among people with pyromania) (10). Outpatient treatment may also develop problem solving skills. Exposure to burn units and disastrous fire scenes may be therapeutic and enable the fire setter to talk openly about physical and emotional reactions. The latter intervention should be carefully considered. On one hand, it may facilitate the goal of allowing a patient to express his or her emotions; on the other hand, it may promote further fascination with fire setting.

There are a limited number of multidisciplinary programs described in the literature that have demonstrated success in treating pyromania (4, 11, 12). One example is the Trauma Burn Outreach Prevention Program, involving the University of Michigan Trauma Burn Center, which collaborated with local law enforcement, fire departments, and the juvenile court system (12). It was developed to target juveniles and their families after an incident of fire setting or arson. Participants received instruction from nurse educators, trauma surgeons, social workers, and counselors. Opportunities were available in the hospital and with burn victims. In one study that examined this program, there was essentially no recidivism (0.8%) among the participants who received intervention (12). Outpatient providers may consider using this program as a model on which to base treatment.

Another important risk factor for a patient to commit further acts of fire setting is his or her urge to continue to set fires despite knowledge of adverse consequences. It is particularly concerning if a patient continues to set fires despite being on probation, facing current legal charges, or being in psychiatric treatment. It is hoped that this scrutiny would deter a patient from setting fires.

To conduct a risk assessment, one must also address the protective risk factors for future fire setting. As noted previously, the absence of certain risk factors may be protective. Additionally, protective factors may include family or social support, engagement in outpatient treatment, and insight. For some, feelings of shame, embarrassment, or guilt may deter a patient from discussing their behaviors in treatment.

Outpatient treatment providers should adapt strategies used to treat other challenging behavior-related disorders (e.g., eating disorders), namely, to treat comorbid psychiatric symptoms. It should be emphasized to patients, however, that the behavior of fire setting is not a symptom of the comorbid illness. There may indeed exist similar difficulties of impulse dyscontrol or affective instability, but the patient should not be misled to attribute his or her behavior to another disorder.

In conclusion, when attempting to assess the risk of fire setting recidivism, a psychiatrist must be prepared to conduct a comprehensive evaluation. Thorough diagnostic investigation, collateral interviews, and record review will begin to illuminate this complex behavior. Psychological testing may assist in understanding the patient. Be cognizant of any Tarasoff statutes that may exist in your state, mandating your obligation to report certain threats. Lastly, as with any risk assessment, be careful to avoid making conclusory or definitive predictions on whether the fire setter will strike again.

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References

1. U.S. Fire Administration: The Overall Fire Picture, 2008. Emmitsburg, Md, U.S. Fire Administration. http://www.usfa.dhs.gov/statistics/quickstats/index.shtm
2. Doley R: Making sense of arson through classification. Psychiatr Psychol Law 2003; 10:346–352
3. Sakheim GA, Osborn E, Abrams D: Toward a clearer differentiation of high-risk from low-risk fire-setters. Child Welfare 1991; 70:489 http://www.usfa.dhs.gov/statistics/quickstats/index.shtm 503
4. Adler R, Nunn R, Northam E, Lebnan V, Ross R: Secondary prevention of childhood firesetting. J Am Acad Child Adolesc Psychiatry 1994; 33:1194–1202
5. Vaughn MG, Fu Q, DeLisi M, Wright JP, Beaver KM, Perron BE, Howard MO: Prevalence and correlates of fire-setting in the United States: results from the National Epidemiological Survey on Alcohol and Related Conditions. Compr Psychiatry 2010; 51:217–223
6. Lindberg N, Holi MH, Tani P, Virkkunen M: Looking for pyromania: characteristics of a consecutive sample of Finnish male criminals with histories of recidivist firesetting between 1973 and 1993. BMC Psychiatry 2005; 5:47
7. Kolko DJ, Kazdin AE: The emergence and recurrence of child firesetting: a one-year prospective study. J Abnorm Child Psychol 1992; 20:17–37
8. Grant JE, Kim SW: Clinical characteristics and psychiatric comorbidity of pyromania. J Clin Psychiatry 2007; 68:1717–1722
9. Cox-Jones C, Lubetsky MJ, Fultz SA, Kolko DJ: Inpatient psychiatric treatment of a young recidivist firesetter. J Am Acad Child Adolesc Psychiatry 1990; 29:936–941
10. Barreto SJ, Boekamp JR, Armstrong LM, Gillen P: Community-based interventions for juvenile firestarters: a brief family-centered model. Psychol Serv 2004; 1:158–168
11. Webb NB, Sakheim GA, Towns-Miranda L, Wagner CR: Collaborative treatment of juvenile firesetters: assessment and outreach. Am J Orthopsychiatry 1990; 60:305–310
12. Franklin GA, Pucci PS, Arbadi S, Brandt MM, Wahl WL, Taheri PA: Decreased juvenile arson and firesetting recidivism after implementation of a multidisciplinary prevention program. J Trauma 2002; 53:260–266

Joint Child Custody: Conflicts of Interest and an Interest in Conflict

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During the last century, child custody evaluations have gone through several basic paradigm shifts. These include the "tender years" doctrine, the "best interest of the child" standard, and a more recent trend toward joint custody. Research suggesting that family conflict is a predictor of poor outcomes may result in a new shift toward a "minimal conflict standard."

Courts have to settle various issues regarding the custody of children after a divorce. Where will the child live? Will the noncustodial parent have visitation rights? Will there be child support? What rights will grandparents have? Should the child's opinions on these matters have legal weight?

Tender Years

During the first half of the 20th century, custody disputes were generally resolved according to the tender years standard, which presumed that the mother should retain custody of the children after a divorce. Literature supported the idea that a mother's nurturing was more important for a child than a father's nurturing (1).

The practice of awarding custody to mothers was also reinforced by the common situation of holding fathers financially liable for child support. Ironically, as women's rights advanced, this particular advantage on their behalf was lost (2). Eventually, the standard of favoring the mother in custody disputes was challenged as being a violation of equal protection rights under the Fourteenth Amendment in the legal cases of *Watts v. Watts* (1973) (3) *and Devine v. Devine* (1981) (4).

Best Interest of the Child

A new standard was exemplified by the legal case of *Painter v. Bannister* (1966) (5). In this case, a child's grandparents were awarded custody instead of the father because it was thought to be in the "best interests of the child." According to this standard, neither parent is presumed to automatically retain his or her custody rights. However, because many people continued to believe that living with the mother was in the best interest of the child, this standard did not make much of an effective difference in outcomes (1).

Joint Custody Standard

Certain interest groups have recently challenged the best interest of the child standard (6). New research has found that children raised by both parents generally fare better than children raised by only one parent. More specifically, children in joint custody arrangements, compared with those in single custody arrangements, tend to have a higher sense of psychological well-being (7), a decreased risk for psychiatric disorders and suicide (8), and a decreased likelihood of drug and alcohol use (9, 10).

The American Psychological Association has taken the stance that joint custody is generally in the best interest of the child (11). Many states have since mandated by statute the presumption that both parents have presumed rights to retain custody. This trend toward joint custody has been considered a relative victory for fathers.

Current Controversy

Critics of the joint custody standard have argued that a potential problem with research supporting the standard is that children may have falsely appeared to have done better under joint custody arrangements because children whose parents were agreeable to joint custody were from families that were probably more stable to begin with. In reality, forcing parents who are hostile toward each other to share custody may increase conflict even further (9).

Contemporary research supports the idea that the stability of the home environment may be a critical factor in a child's development (12). Children fare worse when there are multiple changes in their arrangements, which is more likely to be the case if the court imposes a joint custody arrangement on two feuding parents (13). While having access to two parents is better than having access to only one, the negative consequences of having disruptions in parenting are worse than the consequences of having one parent missing entirely (14).

If research continues to highlight family conflict as a predictor of poor outcomes, the future of child custody disputes may be a shift toward a minimal conflict standard. By creating an incentive for parents to be cooperative and civil toward each other, the courts would not just be basing decisions on the best interest of the child but would actually be promoting those interests.

Whether or not a minimal conflict standard could be practical is something that only time will tell. The only thing we can predict with confidence is that whatever the next standard is, it will have parties of supporters and parties of opponents. Each group will seek out and rely upon research that supports its view and will criticize the validity of research that opposes its view.

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References

1. Warsh R: Custody Revolution: Father Custody and the Motherhood Mystique. New York, Simon and Schuster, 1992

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2. Derdeyn A: A reflection of cultural change. J Clin Child Adolesc Psychology 1978; 7:169–173
3. Watts v Watts, 77 Misc 2d 178, 350 NYS 2d 285 (1973)
4. Devine v Devine, 398 So 2d 686 (Ala, 1981)
5. Painter v Bannister, 258 Iowa 1390, 140 NW 152 (1966)
6. Crowley JE: Defiant Dads: Fathers' Rights Activists in America. Ithaca, NY, Cornell University Press, 2008, pp 43–46
7. Clarke-Stewart K, Hayward C: Advantages of father custody and contact for the psychological well-being of school-age children. J Appl Develop Psychology 1996; 17:239
8. Brent D, Perper JA, Moritz G, Liotus L, Richardson D, Canobbio R, Schweers J, Roth C: Post-traumatic stress disorder in peers of adolescent suicide victims: predisposing factors and phenomenology. J Am Acad Child Adolesc Psychiatry 1995; 34:209–215
9. Duncan T, Duncan S, Hops H: The effects of family cohesiveness and peer encouragement on the development of adolescent alcohol use: a cohort-sequential approach to the analysis of longitudinal data. J Studies Alcohol 1994; 55:588–589
10. Berman D: Risk factors leading to adolescent substance abuse. Adolescence 1995; 30
11. American Psychological Association: Guidelines for child custody evaluations in divorce proceedings. Am Psychologist 1994; 49:677–680
12. Poehlmann J: Representations of attachment relationships in children of incarcerated mothers. Child Develop 2005; 76:679–696
13. Demo D, Cox M: Families with young children: a review of research in the 1990s. J Marriage Family 2000; 62:876–895
14. Heard H: Fathers, mothers, and family structure: family trajectories, parent gender, and adolescent schooling. J Marriage Family 2007; 69:435–450

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Recognizing Immaturity as a Cause of Juvenile Incompetency to Stand Trial

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The right to be both physically and mentally present when defending one's self in criminal court is an old precedent. In the landmark case *Dusky v. United States* (1960) (1), the Supreme Court ruled that adult defendants had the right to be competent when being tried for legal charges. In this case, competency was defined as having the "present ability to rationally consult with an attorney" and to "factually understand the proceedings" (1). A competency to stand trial evaluation may also determine whether a defendant has the capacity to appreciate the adversarial nature of the legal process, understand the possible penalties, testify relevantly, and behave appropriately in the courtroom.

While adult legal proceedings do not automatically apply to the juvenile court, a 1967 juvenile case, *In re Gault* (2), found that various due process rights given to adults, by way of the Fourteenth Amendment, were also required in juvenile court. This ruling was made in the setting of a trend toward more adversarial, adult-like proceedings for juveniles. Several specific procedural rights were stated, but whether juveniles had a strict right to be competent was left open to interpretation.

A Spectrum of Juvenile Competence Recognition

Most states today generally recognize the right of juveniles to be competent to stand trial, but the question remains of what competency means in this population. One important issue that is rarely addressed by statute is the fact that a child's capacity for legal competency develops over time, and therefore children's lack of competency may sometimes be better explained by developmental immaturity than by mental illness or deficiency (3).

On one end of the spectrum is the state of Oklahoma, which is unique in outright rejecting a juvenile's right to competency. The reasoning is that juvenile proceedings are rehabilitative rather than punitive, and thus the court should be able to provide the appropriate placement for juveniles in all situations (4).

Illinois and Georgia laws recognize juvenile competency but do not define it (5, 6). Indiana recognizes juvenile competency and has held that the adult statute specifically does not apply in juvenile court, but there is no juvenile competency statute (7). Arizona and Connecticut, on the other hand, have held that their adult competency statutes do apply to juveniles (8, 9). Louisiana and Ohio similarly apply their adult statutes to juveniles, but they make the qualification that the adult statute should be adapted as necessary to make it more relevant and appropriate to juveniles (10, 11). It is a positive first step for a statute to suggest that adult criteria should be adapted before being applied to juveniles, but specific guidance is needed.

Juvenile Competency Statutes and Immaturity

When determining that a juvenile is incompetent, it is important to assess whether he or she has primary legal incompetence (i.e., never been competent) or secondary legal incompetence (i.e., previously been competent, such as prior to development of a mental illness, etc.). The brains of juveniles are not completely developed, particularly the areas involved in higher level thinking, such as the prefrontal cortex (12). Not surprisingly, an adolescent's level of legal competency correlates with his or her age (13). One study showed that 9- to 12-year-olds had a 20% rate of being restored to competency, and 14- to 16-year-olds had a 50% restoration rate (14).

States vary in their specific statute-mandated methods used to assess juvenile competency. For example, Wisconsin requires that the evaluator describe his or her methods of assessment but does not mandate what the methods should include (15). On the other hand, Virginia, Florida, and Arkansas statutes define specific mental capacities to be assessed (16, 17). Arkansas goes as far as to include assessing a juvenile's ability to extend his or her thinking into the future and to consider the impact on others (18).

While mandating the methods of competency assessments allows for examinations that are more standardized, it may be more salient to understand the factors on which different states base juvenile incompetency (such as whether or not age or developmental immaturity is acknowledged). For example, the states of Texas and Arizona require juvenile incompetency to be based on mental illness or mental retardation only (8, 19). On the other hand, Florida's progressive statute acknowledges developmental immaturity as a basis for juvenile incompetency, but it does not define incompetency or qualify it by an age range (17). Arkansas also recognizes developmental immaturity and addresses specific circumstances in which the juvenile is to be automatically considered incompetent, such as being less than 12-years-old with a murder charge (18).

Immaturity and Restoration

Recognizing developmental immaturity as a basis of incompetency is important in order to avoid the false positives that would result from prosecuting all children who did not have a mental health diagnosis, regardless of their actual mental capacities to understand the proceedings and work with their attorney. One hurdle in recognizing developmental immaturity may be the new question that this category of incompetent juveniles would create: Should juveniles who are incompetent due to developmental immaturity be treated differently, and if so, in what way?

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Florida statute has distinct pathways for juveniles with primary versus secondary legal incompetence. By the state's statute, while juveniles deemed incompetent due to mental illness or mental retardation receive restoration services, those incompetent due to age or immaturity do not (17).

Virginia has a large program focused on the restoration of juvenile incompetency, and the state provides multidisciplinary assessments of juveniles' needs and individualized treatment programs. The state statute does not specifically recognize immaturity as a cause of incompetence that should be treated differently. However, it found that juveniles in the individualized programs who were categorized as being incompetent due to reasons other than mental illness or mental retardation had the highest rate of being restored to competency (91%) (20).

Conclusions

Assessing the competency of juveniles to stand trial is made difficult by the fact that a juvenile's incompetency may be appropriate for his or her developmental level. If this is the case, should and can they be restored to competency? If the word "restoration" suggests returning something to its previous state, is this term relevant when describing those who have not yet ever reached the capacity for competency? Does creating a structured setting for a child to develop appropriately serve as restoration?

If you perform juvenile forensic evaluations, learn your local law. Does your state specifically recognize a juvenile's right to be competent? If so, does it apply the adult statute to them? Is there a juvenile statute? If so, does it recognize juveniles who are incompetent due to immaturity, and are they sent for restoration or are they exempt? While each state has different laws on this matter, most have significant gray areas. During testimony, take advantage of the opportunity to explain to the court whether the juvenile defendant's developmental level played a role in your finding of his or her incompetency.

While juvenile courts have become increasingly adversarial, a judge may struggle to simply make a decision that reflects a reasonably sensible solution. Despite the narrow scope of the original question, you may find a judge looking for your opinion about what is appropriate for a particularly complex child. You may or may not feel comfortable advising in that role, but do not underestimate how much your expertise is valued.

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References

1. Dusky v United States, 362 US 402, 402 (1960)
2. In re Gault, 387 US 1 (1967)
3. Bonnie R, Grisso T: Adjudicative competence and youthful offenders, in Youth on Trial. Edited by Grisso T, Schwartz R. Chicago, University of Chicago Press, 2000, pp 73–104
4. GJI v State, 778 P 2d 485, 487 (Okla, Crim, 1989)
5. 808 NE 2d 631 (Ind, 2004)
6. Georgia Code re Competency of Juveniles, OCGA § 15-11-150–155
7. In re KG, 808 NE 2d 631 (Ind, 2004)
8. Ariz Rev Stat § 8–291 (2005)
9. State v Juan L, SC 18295, Juvenile Matters at Waterbury (Ct, 2009)
10. In re Causey, 363 So 2d 472, 476 (La, 1978)
11. Office of the Ohio Public Defender: http://www.opd.ohio.gov/Juvenile/Jv_Competency.htm
12. Gogtay N, Giedd JN, Lusk L, Hayashi KM, Greenstein D, Vaituzis AC, Nugent TF 3rd, Herman DH, Clasen LS, Toga AW, Rapoport JL, Thompson PM: Dynamic mapping of human cortical development during childhood through early adulthood. Proc Natl Acad Sci U S A 2004; 101:8174–8179
13. Scott E, Grisso T: The evolution of adolescence: a developmental perspective on juvenile justice reform. J Crim Law Criminology 1997; 88:137–189
14. Cowden V, McKee G: Competency to stand trial in juvenile delinquency proceedings: cognitive maturity and the attorney-client relationship. Univ Louisville J Fam Law 1995; 33:629–660
15. Wisc Stat § 938 295(2)(b)
16. Va Code Ann § 16 1-356 (2005)
17. Fla Stat Ann § 985 223(1)
18. Ark Code Ann § 9-27-502(b)(7)(C)(ix)(b) (2002)
19. Tex (Fam) Code Ann § 55 31(b)
20. Warren JI, DuVal J, Komarovskayaa I, Chauhanc P, Buffington-Vollumd J, Ryan E: Developing a forensic service delivery system for juveniles adjudicated incompetent to stand trial. Int J Foren Mental Health 2009; 8:1–18

The Uses and Limits of International Law on Behalf of Global Mental Health

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Twenty years after Jonathan Mann spearheaded the health and human rights approach to international public health (1), it may seem heretical to debate the value of international human rights law to global mental health. Yet this is what a group of psychiatrists and residents did recently, after a presentation on international law I gave, as part of my residency program's lively new global mental health curriculum. The presentation was inspired in part by the *Lancet* series on global mental health (2), which called for scaled-up mental health services and national legislation that was in accordance with international human rights instruments (3). While it seems indisputable that strong legal protections informed by international human rights principles are crucial to advancing the situation of persons with mental illness, it also seems important to consider the limits of those same international legal agreements and the ways in which physicians could make better use of them.

As our group as well as other legal commentators have observed, international human rights law is a most imperfect tool for social change (4). The most serious charge against international instruments is their limited capacity to enforce compliance: while human rights law legitimizes the scrutiny of practices within countries, it cannot compel countries to behave in a nondiscriminatory or nonabusive manner toward any of its citizens (5). As a result, despite comprehensive international human rights obligations, which prohibit every potential form of mistreatment against all individuals, egregious human rights violations persist around the world (6). Second, the process by which international documents are crafted is painstakingly slow. Years will pass between the initial drafting of nonbinding declarations and principles and final treaties. Moreover, the resulting documents, by virtue of needing to be consensus statements, are often criticized as vague or aspirational. Lastly, international documents crystallize the perspectives of a given historical period and cannot reflect the most up-to-date language or approaches, which might be of particular concern when the issue area is science- or health-related.

Notwithstanding these limitations, I would still argue that there is tremendous potential in areas of international law, even beyond human rights law, to advance global mental health goals. Although the global health agenda has traditionally been separate from the international legal agenda, the two have drawn together in several ways over the last decade (7). In 2005, the Framework Convention on Tobacco Control entered into force the first international treaty ever negotiated under the auspices of the World Health Organization (WHO). Scientific evidence played a foundational role in this international treaty, and it is being watched as a potential model for other health treaties. In 2006, the United Nation's General Assembly adopted the Convention on the Rights of Persons with Disabilities to address the rights of individuals with disabilities, including mental health problems. The Convention on the Rights of Persons with Disabilities is sure to be invoked in human rights jurisprudence, particularly at the national and regional levels, where the right to health is being defined and applied. Finally, in 2007, WHO adopted the revised International Health Regulations, which focuses on public health emergencies of international concern. The International Health Regulations incorporates an expansive view of public health risks. It will be important to see how this is applied.

If mental health physicians are to make constructive use of these and other international instruments, they will need to find ways to educate themselves about the international process and international legal regimes. Although psychiatrists are familiar with the basic tenets of domestic civil laws that protect the mentally ill, the international equivalents of these

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Table 1. International Instruments of Relevance to Global Mental Health

- United Nations Charter
- Universal Declaration of Human Rights
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Cultural and Social Rights
- Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care
- Convention on the Rights of Persons with Disabilities
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention on the Elimination of All Forms of Discrimination against Women
- Convention on the Rights of the Child
- Declaration on the Rights of Mentally Retarded Persons
- Declaration on the Rights of Disabled Persons
- World Programme of Action Concerning Disabled Persons
- Standard Rules on the Equalization of Opportunities for Persons with Disabilities

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protections are rarely discussed in training. The language of conventions versus norms was as arcane to most of the doctors in our lecture room as Piaget's stages of development would be to most legal theorists. No doubt, there is nothing straightforward about the patchwork of international instruments that have relevance to mental health (Table 1) (8); nor is it always clear how core human rights obligations interact with specialized conventions, interpretive guidelines, national laws, and domestic and international monitoring agencies (8, 9). Regardless, as the campaign for essential medicines has shown, physicians can be very effective legal advocates. In this global effort, medical campaigners have been able to use international intellectual property agreements to reaffirm governments' rights to address public health emergencies at the national level (10). Similarly, international human rights instruments can be used by mental health advocates to identify gaps in domestic legislation and to ensure minimum standards for treatment. There may well be other important models, precedents, and references on health to be found in other international legal areas, such as international humanitarian law and environmental law.

If the *Lancet* series was a call to action on behalf of global health, then we concluded our evening with a call to action to psychiatrists: international law is too important to be left to the lawyers. Even if international human rights obligations and other bodies of international law cannot be a panacea for urgent global mental health problems, they are, nonetheless, valuable tools for the global mental health agenda. If psychiatrists interested in global mental health are to be the best possible advocates for their patients, it behooves them to gain access to the world of international legal regimes.

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References

1. Tarantola D, Gruskin S, Brown TM, Fee E: Jonathan Mann: founder of the health and human rights movement. Am J Public Health 2006; 96:1942–1943
2. Patel V, Garrison P, de Jesus Mari J, Minas H, Prince M, Saxena S: Series on global mental health: 1 year on. Lancet 2009; 374:1354–1357
3. Lancet Global Mental Health Group: Scale up services for mental disorders: a call for action. Lancet 2007; 370:1241–1252
4. Jones M: Can international law improve mental health? Some thoughts on the proposed convention on the rights of people with disabilities. Int J Law Psychiatry 2005; 28:183–205
5. Gostin LO: Human rights of persons with mental disabilities: the European convention of human rights. Int J Law Psychiatry 2000; 23:125–159
6. World Health Organization: World Health Report: Mental Health: New Understanding, New Hope. Geneva, Switzerland, World Health Organization, 2001
7. Fidler DP, Gostin LO: The new International Health Regulations: an historic development for international law and public health. J Law Med Ethics 2006; 34:85–94
8. World Health Organization: WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva, Switzerland, World Health Organization, 2005
9. Gostin LO, Gable L: The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health (May 19, 2009).Geneva, Switzerland, World Health Organization, 2005. http://ssrn.com/abstract=1435443
10. Medecins Sans Frontieres: Campaign for Access to Essential Medicines. http://www.msfaccess.org/