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Inside

In This Issue

This issue of the *Residents' Journal* includes articles related to the topic of forensic psychiatry and psychiatry and the law. In her article, Katherine C. Michaelsen, M.D., focuses on the link between the mental health system and the criminal justice system, pointing out that law enforcement is often the first line of interception for many individuals with severe mental illness. Tobias D. Wasser, M.D., discusses how psychiatric trainees can learn to identify risk factors that may increase a mentally ill individual's risk for violence. Ryan W. Blum, M.D., provides important data regarding U.S. statutes pertaining to outpatient commitment. Rajiv Radhakrishnan, M.B.B.S., M.D., and Samuel T. Wilkinson, M.D., address the clinical and legal issue of suicide risk assessment. Last, Scott Alan Gershan, M.D., offers his commentary on torture, solitary confinement, and legal disparities.

The Judicial-Mental Health Partnership: Opportunities and Risks

Katherine C. Michaelsen, M.D.

Residents often encounter individuals with severe mental illness during training. Sometimes these individuals have active legal entanglements that present extra challenges for treaters, including coordination with parole officers, follow-up if re-arrested, and patient ineligibility for some programs and jobs. Compared with the general population, individuals with severe mental illness are overrepresented in the prison population, and compared with other prisoners, tend to serve longer terms (1). The prevalence of severe mental illness found in jails has been estimated to be 14.5% for the male population and 31% for the female population (for depressive, bipolar, and psychotic disorders) (2). Increasing concerns about the disproportionate prevalence of severe mental illness, the treatment of mental illness, and the overcrowding in prisons are leading to greater focus on diversion efforts, and in some cases may result in large-scale prison discharges (for example, California's effort to trim its prison population by more than 20%).

Many argue that the deinstitutionalization of individuals with severe mental illness in the 1960s and 1970s led to re-institutionalization (or transinstitutionalization) into jails and prisons. Shrinking inpatient units, inadequate treatment in communities, and insufficient daily structure contributed to more frequent interactions between individuals with severe mental illness and law enforcement (3). With little mental health training and few resources to safely divert individuals, law enforcement personnel are left with few alternatives to jail (3). In subsequent encounters, criminal records influence police and court decisions, increasing the likelihood of re-criminalization. Decreased funding for the mental health system and increased funding for jails exacerbate this trend, and now jails provide structure and services previously provided within the mental health system (3).

Efforts to reverse this trend focus on preventing individuals with severe mental illness from entering the criminal justice system or on minimizing their stay, with the goal of treating them safely in the community (4). Munetz and Griffin (5) describe a sequential intercept model of community-based alternatives to standard progression through the criminal justice system. They emphasize that without best clinical practice, diversions are futile. The first possible point of "interception" is law enforcement and emergency services, in which police officers may refer individuals to emergency services instead of making an arrest. Following arrest, mental health workers may screen individuals in jail or during initial court hearings and, with the individual's permission, suggest treatment as an alternative to prosecution or incarceration. After initial hearings, in jails, courts, and forensic commitments, individuals may be referred to specialized mental health courts or for mental health treatment in jail. During re-entry into the community, re-assimilation efforts can be coordinated between corrections and community mental health care. Finally, at the level of community corrections, mental health treatment may become a condition of parole or probation (5). However, conflicting roles and mixed incentives for care providers versus law enforcement, plus lack of support and funding for evidence-based mental health treatment, threaten each of these efforts.

From the patients' perspective, diversion programs may keep them out of jails and in their communities with family. Generally, diversion is associated with both decreased jail days (6–8) and decreased re-arrests in the following year (7, 8). The lower re-arrest rate despite greater time in the community suggests that diversion is not associated with increased public safety risk (4, 8). Diverted individuals have also been shown to attend more counseling sessions and are more medication compliant (4). A few studies have also found improvements in clinical measures, such as community functioning (9), symptom severity (10), and drug use (11).

However, once arrested, individuals are defendants first and patients second, and an opportunity for treatment of the patient may complicate and even threaten the civil rights protections of the defendant (12). Mandated treatment increases the defendant's legal exposure, and failure to follow up is no longer just a clinical issue but also a legal issue with legal consequences, including re-arrest, additional charges, and incarceration (12, 13). These tensions may threaten the therapeutic alliance. Additionally, diversion programs may not benefit all participants equally. In one study, postbooking diversion referrals were disproportionately for individuals who were female, white, and older, compared with the national arrestee population (14). Some studies have found that following diversion, a greater history of criminal behavior was associated with greater risk for re-arrest (7, 8). Study results vary regarding the importance of substance abuse in outcomes (7, 8). Conversely, diversion may only decrease subsequent jail time for individuals arrested for more serious crimes (15). Furthermore, despite voluntary entry into diversion programs, one study showed that one-third of diverted individuals perceived coercion (16). Finally, individuals with severe mental illness are also more likely to experience other risk factors associated with crime and arrests, including homelessness, unemployment, poverty, and substance abuse. Collectively, these factors may contribute to their disproportionate incarceration, while at the same time be outside the purview of mental health treatment and diversion programs (7, 17).

For the mental health system, diversion programs provide a way to connect

patients with care and a "hook" for noncompliant patients. Compared with treatment as usual, court-mandated treatment is associated with increased time spent in the community (out of prisons or hospitals), greater chance of being linked to residential and outpatient treatment, increased treatment utilization, and decreased drug use (11). Furthermore, perceived coercion does not seem to affect engagement in treatment (16). However, diversion may overburden the health system, since this patient population may require increased individual and institutional resources due to significant service needs, treatment resistance, and, among those with a history of violence, greater potential for violence. As Munetz and Griffin, as well as others point out, if the mental health system does not have the resources needed to provide the best clinical care, then the diversion efforts are unlikely to lead to improved public health or criminal justice outcomes.

Policy makers and participants in each system are appropriately wary of blending roles. Typically, the criminal justice system cannot civilly commit an individual to involuntary psychiatric hospitalization but can police a person charged with a crime (12). Conversely, in most states, the mental health system can commit an individual to involuntary hospitalization but cannot police an individual or guarantee that a defendant will comply with the law or the court's expectations (12). The patient-treater relationship needs to be maintained, with associated standards of practice and confidentiality (12) because monitoring compliance may conflict with the therapeutic role and increase provider liability for patients by virtue of a court order (18).

Currently, diversion generally means shifting the costs associated with the care of individuals from the criminal justice system to the mental health system. The cost of diversion varies by location and type of diversion program (10). Some postbooking diversion programs show significant overall financial savings, despite increased health care costs. However, some prebooking programs are associated with increased inpatient hospital time, and thus despite cost savings for the criminal justice system, the overall cost is greater, at least in the short-term (10). Unfortunately, diversion programs may divert individuals to mental health settings that do not necessarily have the resources or funding to be able to accommodate them (3, 18). For example, police have significant discretion in the disposition of individuals, but their options are limited in practice. Choices are often based less on symptom severity and more on system constraints, including limited inpatient psychiatric beds, strict admission criteria, and lack of facilities for dually diagnosed individuals, and thus arrest becomes the main option if police feel that someone needs to be off the streets (19).

Current constraints and demands within the mental health and criminal justice systems mean that cooperation may not be in each agency's self-interest (narrowly defined), and organizations may do better clinically and financially by selectively shifting individuals with severe mental illness to the other agency (20). Furthermore, organizational identity—often defined and funded for management of a single problem (e.g., severe mental illness versus substance abuse versus criminal behavior)—conflicts with the variable needs of persons with multiple problems and diagnoses. To these challenges are added poor communication, confidentiality concerns, conflicting roles, and risk of stigma from the potential increased association of mental illness with criminal and violent activities (20).

Jail diversion programs for severe mental illness, especially ones that couple mental health care with social services, show some promise in decreasing the over-representation of individuals with severe mental illness in our prison population, maintaining them as integrated members of the community and improving their care without sacrificing public safety. However, lack of resources limits the mental health system's ability to treat these individuals. Furthermore, collaboration between the criminal justice and mental health systems requires, but often lacks, clear definition of roles, preservation of treatment relationships, information sharing that still respects individual rights, and incentives that encourage cooperation. Most psychiatry residents will care for individuals with legal histories and increasingly may care for individuals diverted from the criminal justice system. Understanding some of the benefits and risks of diversion may assist residents as they attempt to fulfill their roles as treaters and advocates for these individuals.

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A Relevant Review of Violence Risk for the Psychiatric Trainee

Tobias D. Wasser, M.D.

While training programs devote a great deal of focus on teaching residents how to assess a patient's risk of suicide, often there is significantly less attention paid to training residents how to assess a patient's risk of violence. In one national survey of psychiatric residents, one-third of residents reported receiving no training in this area, and another third described their training as inadequate (1). A psychiatrist must be able to assess a patient's immediate risk of harm to both themselves and others. As trainees, we are tasked with learning how to incorporate this skill set into our armamentarium of clinical tools.

This is not to say that all psychiatric patients are likely to be violent. In fact, the data correlating mental illness and increased risk for violent behavior have been mixed, although most studies support the notion that serious mental illness does moderately increase the risk for violence (2). However, most individuals with mental illness do not have aggressive tendencies and will not act out violently (3). Furthermore, the severely mentally ill are significantly more likely to be victims of violent crime than they are to be perpetrators (4, 5).

Despite these findings, psychiatric trainees do have a high rate of being both threatened and assaulted. In a national survey of psychiatric residents, 73% reported having been threatened and 36% reported having been physically assaulted by a patient (1). Additionally, residents often work in high-risk clinical settings, such as the psychiatric emergency department, where 4%–17% of patients have been reported to be carrying weapons (6–8).

Thus, it is extremely important for the psychiatric trainee to have a basic understanding of violence risk assessment. However, the forensic literature describing violence risk assessment is extensive, and thus a comprehensive approach to the topic is beyond the scope of the present article. The purpose of this article is to provide a concise and relevant review, for the psychiatric resident, which identifies those factors associated with patients and situations that increase the potential for violence.

Recognizing the "Risky Patient" and the "Risky Situation"

The first step in identifying features of a patient's presentation that increase the risk for violence is completing a comprehensive psychiatric evaluation. The evaluation should focus on the psychiatric symptoms but should also take into account demographic, historical, and environmental factors that may be related to an increased risk of violence (9). In particular, the following 10 factors should be assessed (10): 1) appearance of the patient; 2) presence of violent ideation and degree of formulation and/or planning; 3) intent to be violent; 4) available means of harm and access to the potential victim; 5) past history of violence and other impulsive behaviors; 6) alcohol or drug use; 7) presence of psychosis; 8) presence of certain personality disorders; 9) history of noncompliance with treatment; and 10) demographic and socioeconomic characteristics.

In the psychiatric emergency department, additional attention should be paid to the patient's perception of his or her situation and choices, accompanying psychopathology, risk of suicide, and deterrents to violent behavior (11).

The next step when considering a patient's risk for violence is to assess for the presence of risk factors. There are many ways to group risk factors for violence, but a common and pragmatic approach is to distinguish between static and dynamic risk factors. Static risk factors are those that do not change over time (e.g., a history of violent behavior) (12). Dynamic risk factors are those that have the potential to change over time, for example, ongoing substance abuse and noncompliance with medication (12). An overly simplified but helpful way to think about these two categories is to consider static risk as being associated with the "risky person" (e.g., a young, single male with a low IQ and a history of violence) and dynamic risk as being associated with the "risky situation" (e.g., that same patient was just fired from his job, is now actively abusing substances, and recently purchased a gun). This illustrates how individuals with a number of static risk factors will chronically be considered at elevated risk, but the dynamic risk factors have a substantial effect on our understanding of a patient's acute risk of violence.

Key Principles in Understanding Violence Risk

What are the factors that increase a mentally ill individual's risk of acting violently? Unfortunately, there is no simple answer to this question, since research has not produced a clearly uniform picture of the most important mental health variables associated with the risk of violent behavior. However, a few key principles can be surmised. First, substance abuse has been universally associated with a significantly increased risk of violence, far surpassing the contribution of serious mental illness. Second, nonmental health variables (e.g., sociodemographic factors such as young age, male sex, and low socioeconomic status) contribute more significantly to the overall rate of violence in the population than do mental health variables. In spite of this, as noted above, serious mental illness does seem to moderately increase an individual's risk for violence. (2)

Risk Factors for Violence

In the general psychiatric setting, there are a number of factors that have been shown to increase the risk for violence (Table 1) (13). Other clinical scenarios

TABLE 1. Risk Factors for Violence in General Psychiatric Settings

Past history
Prior violence
Prior arrest
Young age at time of first arrest
Drug and/or alcohol abuse
Cruelty to animals and people
Fire setting
Risk taking
Behavior suggesting loss of control or impulsivity
Present circumstances and mental state
Male under age 40
Noncompliance with treatment
Access to weapons
Role of significant other and/or caretaker (either provacative or not protective)
Sees self as victim
Lack of compassion/empathy
Intention to harm
Lack of concern over consequences of violent acts

[a] Adapted/modified with permission from Buchanan A, et al., "Resource Document on Psychiatric Violence Risk Assessment (data supplement)" [Am J Psychiatry 2012; 169:1–10]. Copyright © 2012 American Psychiatric Association.

that raise the risk for violence during an interview with patients include intoxicated patients, agitated patients, first meetings, confrontation, and recent loss. Trainees commonly encounter these situations in the emergency department, making it a potentially high-risk clinical setting. Among patients with psychosis, two symptoms related to violence risk are persecutory delusions and command auditory hallucinations. For both, research examining their contribution to violent behavior has been mixed. However, it is clear that patients who suffer from persecutory delusions and negative affect are more likely to act on their delusions and to act violently. Additionally, patients are more likely to comply with violent command auditory hallucinations if they have a belief that the voice is powerful, a sense of personal superiority, a belief that the command auditory hallucinations are beneficial, delusions that are congruent with the action described, or hallucinations that generate negative emotions (14).

There are also certain unique factors that contribute to violence risk on the inpatient unit. Not surprisingly, a history of previous assaultive behavior is the best long-term predictor of inpatient violence (15). Interestingly, although in the community men are more violent than women, this gender disparity is not seen in the inpatient setting (16, 17). Clinical, rather than sociodemographic, risk factors have been shown to best predict aggression in the short-term in the inpatient setting (18). Such clinical factors include recent physical violence and threats of violence; poor therapeutic alliance; a hostile attitude and irritable mood; psychomotor agitation; and attacks on objects or property damage (16).

In addition to considering risk factors for violence, the psychiatric resident must recognize that behavior is a function of the person and his or her environment (19). The patient should be assessed in light of his or her personality, symptoms, and environment, in combination with an understanding of the likely causes of violence for that individual (13). A simple but often helpful rule is, "The best predictor of what will happen in the future is what happened in the past, *unless something is different*" (19).

Limitations of the Violence Risk Literature

These risk factors should be appreciated but also placed in context with some recognition of the limitations of this area of study. First, we know relatively little about the interplay between clinical factors and contextual and environmental issues (2). Second, the low base rate for violence and the weak contribution of mental health variables to violence in society combine to make all our risk assessment activities open to high rates of false-positive error(s) (2). Finally, the ability of any psychiatrist to be accurate in predicting violence is limited by our inherent role: to intervene and treat. Consider the analogy of using a metal detector in an airport to prevent plane hijackings. Metal detectors are effective at detecting metal. Because of their accuracy in detecting metal, they are considered useful in preventing hijackings. However, they are useless at "predicting" hijackings because once metal is detected, interventions take place to prevent negative outcomes. Similarly, the task of the psychiatrist is to assess who is at an increased risk for acting violently and to intervene accordingly, not to predict that violence is likely to occur and then stand by idly (20).

Conclusions

The mentally ill are more likely to be victims of violence than perpetrators. However, despite this finding, there is evidence that a significant proportion of psychiatric residents are the victims of assault by their patients. This is likely related to repeated exposure to a small percentage of this population who are at increased risk for violence and a result of frequent exposure to individuals who abuse drugs and alcohol. Having an appreciation of the individual characteristics and situations that raise the risk for violence should improve residents' ability to engage in basic violence risk assessment and should help decrease their chances of being physically harmed by their patients.

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Outpatient Commitment and Statutory Law

Ryan W. Blum, M.D.

Outpatient commitment is a civil court procedure intended to facilitate psychiatric care for patients who are 1) unable to function, 2) at high risk of recurrent hospitalization, and 3) unable to participate in treatment on their own accord. Laws authorizing the practice originated in the 1960s movement toward deinstitutionalization and the creation of community mental health centers, as well as the accompanying idea that providers and courts must select the "least restrictive alternative" among options for involuntary psychiatric care (1).

In the last 20 years, a handful of states in the United States (as well as countries such as Australia, New Zealand, Israel, and Great Britain) have implemented outpatient commitment programs that vary widely in scope, operation, and outcome (2). Studies, while numerous, are difficult to interpret because of limitations on design and accompanying bias (3). While outpatient commitment has become a target of criticism by those who consider it a violation of civil liberties, it remains a symbol of progress for those who believe that the psychiatric system is too lax about those who slip through its cracks—and, problematically, for a public who is increasingly concerned about the potential danger that our patients represent.

The purpose of the present article is to introduce these statutes and their operationalization—not as an exhaustive review of ethics, policy, or outcomes—in order to promote discussion about whether these programs support our most vulnerable patients and whether outpatient commitment is justified.

Overview of Existing Statutes

Outpatient commitment seems widely authorized, with 45 states having something resembling an outpatient commitment law (all except Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee) (4, 5). However, many laws are antiquated, and few are commonly used. A 1995 survey indicated that less than one-third of jurisdictions authorizing outpatient commitment used it "commonly" or "very commonly" (6). Even California's comprehensive 2002 law is underutilized because of lack of funding (7).

On the whole, many of the outpatient commitment statutes are missing guidance on selecting candidates and treatment settings, procedures for governance and evaluation, and how to address inevitable nonadherence to these mandatory orders. This vagueness deters use, produces regional differences in implementation, and may also, as an APA task force pointed out in a 1987 report on outpatient commitment, privilege legal negotiations akin to "plea bargaining" over clinical judgment and patient-centered treatment planning (8).

In most states, the selection criteria are indistinct from inpatient commitment laws, which are based on a patient's dangerousness. This means that patients selected for outpatient commitment in most jurisdictions must meet criteria for inpatient hospitalization yet also be appropriate for stabilization outside the hospital. Left out are those who are not dangerous but who are significantly impaired—those who may predictably decompensate without care.

A minority of states justify outpatient commitment at least in part on functional status or potential to decline, irrespective of imminent threat. This authorizes outpatient commitment for patients who would be otherwise ineligible for civil commitment, aiming to prevent hospitalization and the social and neurological deterioration that is common in exacerbations of these diseases.

States define function in different ways. Texas focuses on "the ability to carry out activities of daily living" and to "function independently [and] live safely in the community" (9), while California, Hawaii, and North Carolina authorize outpatient commitment for those judged to be at high risk of deterioration. In Wisconsin, commitment may be justified for those lacking insight needed for critical decisions about care (10).

Several statutes require a history of hospitalization and noncompliance. Georgia's criteria are solely based on risk for recidivism (11). The APA's 1987 model statute requires any hospitalization within the last 2 years and evidence of nonadherence to outpatient recommendations (8). In New York and California, evidence that noncompliance has led to either hospitalization (twice in 36 months) or an act or threat of violence (once in 48 months) is required (12, 13).

The duration of outpatient commitment orders varies from 90 days in Indiana to up to 1 year or more in several states. Many have initial lengths of commitment that then can be extended up to a year.

Enforcing Outpatient Commitment

What to do with a patient who is unable to comply with an outpatient commitment order? Enforcement of outpatient commitment has been criticized alternatively for lacking teeth and being unjustifiable. In practice, most statutes avoid the question entirely. Even worse, Arizona and Kansas stipulate that outpatient commitment should only be used for those likely to follow a court-ordered outpatient treatment plan. This ambivalence about utilizing the law to force treatment neglects how outpatient commitment is likely most beneficial for those with a history of noncompliance.

For those who violate outpatient commitment, states generally refrain from imposing any consequences other than mandating a re-evaluation. Typically, this is accomplished through police transport (or, in New York, "police officers, ambulances, or mobile crisis outreach teams"), often specifically ordered by the court or a county mental health clerk but sometimes directly triggered by clinician report.

Only in Kansas, Vermont, and Illinois can re-evaluation lead to hospitalization as a consequences of violating the outpatient commitment order. Elsewhere, evaluators must respect existing commitment laws, nearly always based on dangerousness. Therefore, many patients will have little or no direct consequences for nonadherence, other than the ordeal of the re-evaluation.

Re-evaluation, however, may present a significant burden to the patient and clinical challenge to all involved. In one published case, a homeless Army veteran in outpatient commitment continually showed up late to clinic, obstructing successful treatment (14). Should his clinicians have reported these infractions to the authorities, forcing a re-evaluation? This might necessitate the patient being placed in police custody, possibly handcuffed, and led to a treatment facility. Would the benefits of this show of force/care indeed outweigh the harms to this patient's liberty?

Discussion

There is a direct connection between the public perception of violence perpetrated by individuals with psychiatric illnesses, such as Andrew Goldstein (15), a man diagnosed with schizophrenia who pushed a woman into the path of an oncoming subway train, and the passage of outpatient commitment laws in states such as New York and California. In the public view, these laws appear to protect the general public from violence, but this is at best a dubious goal (16).

While the public may be focused on containing violence, outpatient commitment may actually be beneficial for patients such as Linda Bishop, a 51-year-old woman with schizoaffective disorder who died alone in an abandoned New Hampshire farmhouse during the coldest months of 2007 (17). Ms. Bishop had just been released from a psychiatric hospital when she stopped taking her medication and never returned to care. We have become tragically accustomed to this type of story.

What types of liberty better define human dignity—civil liberties to refuse treatment or freedom to receive treatment to minimize debilitating symptoms and promote functioning and recovery? Perhaps the most compelling justification for an outpatient commitment program is utilitarian: are patients better off under outpatient commitment orders? Are they in the hospital less often, less preoccupied by symptoms, more engaged in life? Would a 20% chance of avoiding re-admission justify supervising one's life for a year, or need this estimate be higher?

These questions have been exceedingly difficult to answer through rigorous research. Advocates tout improvements in hospitalization, arrests, victimization, medication possession, and other outcomes (2), while critics cite numerous studies that have been equivocal, including a recent trial of 336 British patients with psychotic disorders who were randomly assigned to conditional release versus outpatient commitment, which produced no difference in re-admission rates after 12 months (18).

Rowe's (19) suggestions of interventions such as peer support and citizenship initiatives may benefit many, but there may be patients who would still fall out of care. Coercion may seem like it should be a last resort, but in reality, outpatient commitment is not the only coercive intervention that occurs in the mental health system—mandated treatment is ordered by criminal courts, social services, and in conservatorship proceedings—but it is one that could be driven not by legal mandates but by clinical need.

Ultimately, outpatient commitment is an intervention that commits not only a patient to treatment but a society to providing care. For some, the patients we see most frequently in our emergency departments and inpatient units, outpatient commitment is probably beneficial. But it is far from accessible. While California's comprehensive law passed in 2001, it has been profoundly underutilized because there are no funds appropriated for its support. Appelbaum (7) points to this as evidence of the ambivalence toward treatment of severe psychiatric disorders in general. Outpatient commitment is no different than any other type of psychiatric care: its success hinges not on moral justification or legal framework but on material and human support dedicated toward improving our patients' lives.

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Suicide Risk Assessment: A Clinical and Legal Issue

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Samuel T. Wilkinson, M.D.

Suicide is one of the most challenging clinical issues that psychiatrists face. The clinical axiom states that "there are two kinds of psychiatrists, those who have had patients commit suicide, and others who will" (1).

In 2010, suicide was the 10th leading cause of death in the United States and the second most common cause of death among people aged 25–34 years (2). The prevalence of nonfatal suicidal thoughts and behaviors is much greater, estimated at 8.3 million adults or 3.7% of the adult U.S. population. This translates to one completed suicide for every 25 attempted suicides (3). Therefore, the task of identifying patients who are at foreseeable risk of suicide, relative to those who are not, by a systematic assessment of suicide risk is not an easy one. Furthermore, suicide risk assessment is a core competency requirement for psychiatrists (4) and is often required of psychiatric trainees in outpatient, inpatient, and emergency department settings.

What Does or Does Not Constitute an Adequate Suicide Risk Assessment?

Although the APA Workgroup on Suicidal Behaviors has authored a practice guideline for the assessment and treatment of patients with suicidal behaviors, the legal criteria for determining the standard of care for suicide risk assessment vary according to state statutory definitions in the United States (5). While most states previously defined the standard of care as that of an average physician, increasingly a number of states are embracing the standard of care as that of a "reasonable, prudent practitioner" (5). Suicide risk assessment is hence expected to be reasonable in aiding clinicians to make a commonsensible determination of whether a patient's suicide attempt or suicide is foreseeable. At a minimum, this would include an assessment of modifiable and treatable, acute and chronic suicide risk factors, as well as protective factors, while taking into account the context in which "this patient" has presented at "this time" and in "this manner," which then informs the patient's subsequent treatment plan (5). Documentation of the systematic suicide risk assessment is also an important aspect of the process. Isolated statements, such as "Patient denies active or passive suicidal ideation, intent, or plan" or "Patient is able to contract for safety," do not constitute adequate risk assessment. The ascertainment of risk based solely on a suicide rating scale or checklist is also insufficient.

When to Perform a Systematic Suicide Risk Assessment

Suicide risk assessment is an integral part of the psychiatric examination of every patient. While it may be the obvious task required for the evaluation of psychiatric patients who present to the emergency department reporting suicidal ideation or following a suicide attempt, it is equally relevant to the evaluation of seemingly stable psychiatric patients in other settings where suicide attempt or suicidal ideation is not the presenting complaint. Although inpatient admission is intended to reduce suicide risk, studies show that, paradoxically, the first week of an inpatient admission and the period shortly following discharge are associated with the highest risk for suicide (6). Hence, in an inpatient setting, suicide risk assessment should be performed at the times of admission and discharge, as well as regularly throughout hospitalization.

How to Perform a Systematic Suicide Risk Assessment

A number of systematic protocols have been devised for the assessment of suicide risk, such as the Collaborative Assessment and Management of Suicidality (7), and the Chronological Assessment of Suicide Events approach (8). A systematic suicide risk assessment can be conceptualized as consisting of three main components, as listed below:

1. Data gathering regarding "this patient's" presentation at "this time," including demographic information, acute stressors, psychiatric illness, comorbid medical illness, family history of suicide, suicide risk factors, protective factors, and warning signs of suicide.
2. Uncovering further information regarding "this patient's" presentation in "this manner," including presence and chronicity of suicidal ideation, details of suicide plan, intentionality and lethality of suicide attempt, efforts to conceal act or avoid detection, and nature of help-seeking behavior.
3. A synthesis of the information obtained from available sources, such as the patient or reliable collateral informants, in conjunction with corroboratory evidence and objective signs in order to arrive at a commonsensible determination of foreseeable suicide risk.

A systematic suicide risk assessment begins with establishing rapport. Establishing a connection with the patient and expressing empathy is likely to facilitate the sharing of important yet sensitive information regarding suicidality. The assessment, however, should not rely solely on the patient's denial of suicidal ideation. A study of inpatient suicides found that about 80% of patients denied suicidal ideation shortly before their death (9). Additionally, patients who are determined to commit suicide may consider the psychiatrist as an adversary and are hence more prone to self-concealment (10). In this regard, the Chronological Assessment of Suicide Events approach offers useful strategies, such as the techniques of normalization (e.g., "Sometimes when people are upset they have thoughts of killing themselves. Has this ever happened to you?"), shame attenuation (e.g., "With all your pain, have you been having thoughts of killing yourself?"), sequenc-

ing behavioral incidents leading up to the presentation, and gentle assumptions of suicidal intent (8).

The general risk factors for suicide include previous suicide attempt(s) or violence, history of depression or other psychiatric disorder, comorbid alcohol or substance abuse, family history of suicide or violence, serious physical illness, hopelessness, and loneliness and lack of social support (11, 12). In addition to risk factors, the assessment should also include an evaluation of protective factors (Table 1). Notable protective factors include having a good social support system (13), having dependent children (14), pregnancy (15), religious and moral objection to suicide (16), and resilience and coping skills (13). With respect to children being a protective factor, postpartum psychosis or mood disorder must be considered and can potentially offset any protection conferred by children in the home.

Corroboratory evidence and individual risk factors that are unique to the patient can be obtained through reliable collateral information. Approximately 25% of patients tell their family members about having suicidal thoughts, although they may deny having them when asked by their clinician (17). Family members and friends may also be aware of recent changes in behavior or warning signs, such as recent changes in an individual's will or other financial transactions. The presence of objective signs, such as hesitation cuts, ligature marks, or cuts over the arms or legs, should prompt suspicion regarding intentionality of suicide.

A previous suicide attempt (even when remote) has been consistently shown to be one of the strongest predictors of future suicide (18). Inquiry into the acuity of suicidal ideation, details of the plan, degree of impulsivity, and the intentionality and lethality of each attempt provide valuable information. In addition to asking about suicide attempts, patients should be asked about aborted attempts, which patients may not consider formal attempts and may not spontaneously disclose. For instance, in addition to thinking about shooting him- or herself, has the patient ever pointed a loaded gun at his or her head but balked at pulling the trigger? Or has the patient ever searched the Internet for ways to kill oneself?

TABLE 1. Risk and Protective Factors for Suicide

Risk Factors
General
History of previous suicide attempt or violence
Family history of suicide
Access to lethal means (i.e., firearms)
Lack of social support
History of childhood physical and/or sexual abuse
Serious physical illness
Recent loss or separation
Recent hospital discharge
Homelessness
Unemployment or other financial hardship
Knowledge of and/or exposure to another person's suicide
Psychiatric/personality disorders
Bipolar disorder, especially mixed states
Schizophrenia, especially with active psychotic episode, early phase of illness, or antipsychotic-induced akathisia
Active or history of substance abuse
Severe major depressive disorder, especially with anhedonia, psychotic features, psychomotor agitation, hopelessness, Recent antidepressant use in adolescents[a], panic attacks, global insomnia, psychic anxiety, or diminished concentration
Borderline personality disorder
Antisocial personality disorder
Demographic
Caucasian race
Native American or Native Alaskan ethnicity
Age 18–44 or >65 years
Male[b]
Rural populations
Active/retired military
Single, divorced
Protective Factors
Good social support
Adequate coping skills
Active psychiatric treatment
Good rapport with treatment team
Cultural and religious beliefs that discourage suicide
Pregnancy[c]
Dependent and/or minor children[c]

[a] In 2004, the Food and Drug Administration issued a black box warning for antidepressants and risk of suicide in children and adolescents; this warning was extended to young adults (ages 18–25) in 2006. No actual suicides occurred in these trials with placebo or antidepressants. Hence, this concern is based on increase in suicidal ideation and attempts.
[b] Rates of completed suicide are higher among males, while rates of suicide attempts are higher among females.
[c] Postpartum mood disorder or psychosis must be considered and can potentially offset any protective factors conferred by pregnancy or dependent children

It is also important to remember that there are significant regional differences in risk and protective factors, as well as

modes of suicide (19). For example, in New York City, unique modes of suicide include railway suicides, jumping from tall buildings (more common than in the rest of United States), and the phenomenon of suicide tourism (i.e., nonresidents traveling to New York City in order to commit suicide) (20). Also relevant to this discussion is the role of the media and the Internet in the phenomena of cyber-suicide pacts, copycat suicides, and access to lethal means (19).

Conclusions

Suicide risk assessment is a systematic evaluation of risk and protective factors in determining the foreseeable risk of suicide given the unique sociocultural context of the patient. The process involves establishing rapport, data gathering with regard to the context in which the patient has presented, and synthesis of the information obtained with corroboratory evidence and objective signs in order to arrive at a commonsensible determination of suicide risk. In addition to the identification of general risk and protective factors, an awareness of local suicide risk factors, including frequently used suicide spots or locations and modes of recent suicides depicted in the media and on the Internet, would enhance the assessment of risk.

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Commentary

Torture, Solitary Confinement, and the Legal Disparities

Scott Alan Gershan, M.D.

Torture is a practice born in antiquity, writ in Greek mythology, coded in Roman ritual, touted in the Middle Ages, and continues today in nations lauded as democracies. There have been bright moments in history ethically and legally challenging this human (mis)conduct. Under the banner of Humanism during 17th-century European Enlightenment, "cruel and unusual punishment" was denounced under the Bill of Rights. That was in 1689. Temporally we have aged, but have our ethos and our humanism commensurately matured?

It took over 60 million deaths after World War II for the blueprints of human rights to enter an international formula. Consequently, an unprecedented article was written in international law under the Universal Declaration of Human Rights. Article 5 within the declaration avowed, "No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment." Despite this, the notion of torture imbues inherent subjectivity, rendering it amorphous and difficult to unanimously define. Arguments for or against its legality persist on arbitrary semantics or phenomenological terms.

As the ethical discourse on torture roars onward, there is an important subject linked to this debate, namely solitary confinement. In 1890, the U.S. Supreme Court nearly declared solitary confinement in prisons to be unconstitutional (1). Over 100 years later, this method is far from outlawed, but rather extensively practiced in the United States prison system. The United States holds the largest number of prisoners in solitary confinement out of any democratic nation (2), with estimates ranging from 20,000 to 80,000 inmates at any given time (3).

The mental health ramifications have been in psychiatric discourse for nearly a century and are not surprisingly consequential. Solitary confinement has been demonstrated to induce psychosis, depression, anxiety, and paranoia and to definitively create an acute risk for suicide (4). The United Nations has understood these psychological afflictions and therefore concluded that solitary confinement in as few as 15 days could be tantamount to torture (5). Thus, it is important that efforts be made to protect the human dignity and rights of prisoners.

I see several barricades to hurdle for changes to take place. One is the stigma of "protecting" prisoners and viewing them not just as criminals but also as individuals with psychiatric symptoms subsequent to imposed conditions. Another is demonstrating that psychological torture, like solitary confinement, is as damaging as physical torture. Perhaps if there was empirical evidence to prove neuropathological parallels, there would be more traction in policy making.

Some say that our federal prisons are the largest de facto psychiatric facilities in the country. At what price will it take for lawmakers to believe that solitary confinement is torture as much as it is causal to psychiatric illness and a neglected public health issue? Sadly, history has tirelessly shown that we are most convincingly drawn to modify our practices consequent of catastrophe alone. Understanding transparent correlations probably won't be enough.

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Psychiatry and Its Importance

Barinder Singh, M.D.

Psychiatry is a medical specialty devoted to the study, diagnosis, treatment, and prevention of mental disorders. Currently, there is a debate on the future of psychiatry. As noted by Insel (1), in the United Kingdom, "the number of medical students choosing psychiatry has dropped more than 50% since 2009, and over the past decade the number of psychiatrists has dropped by 26%, while the number of physicians overall has increased more than 31%." In 2012, less than 4% of U.S. medical graduates chose psychiatry, which is a bit lower than in recent years. Despite this trend, the number of M.D.-Ph.D. students choosing psychiatry has more than doubled in the past decade in the United States. These students could have matched to any specialty, yet they picked psychiatry. The M.D.-Ph.D. students in psychiatry give several reasons for their choice. They agree that psychiatry is "the place to make a mark" (1). These young researchers are looking to make a mark by turning psychiatry into a clinical neuroscience. Although there seems to be an identity crisis for psychiatry in the United Kingdom and the United States, the mental health needs of the general population are on the rise. Psychiatry as a specialty was, is, and will remain vital. It remains increasingly important because mental health is relevant to physical health. Neuropsychiatric disorders are estimated to contribute to 13% of the global burden of disease, and these numbers are expected to increase, while the resources to treat and prevent mental illness remain insufficient.

Dr. Brock Chisholm, the first Director General of the World Health Organization (WHO) and a psychiatrist by profession, stated that "without mental health there can be no true physical health" (2). He was among the first to acknowledge the intimate link between mental and physical illness. Half a century later, we have evidence supporting his statement. There is a strong bidirectional relationship between mental illnesses and physical health outcomes. Patients with type 2 diabetes mellitus are twice as likely to experience depression as the general population (3). Compliance with medication, ability to exercise, and healthy eating habits are of secondary importance to an individual whose mind is riddled with depression. The overall health outcomes are reduced in patient populations suffering from mental illness. Patients with mental disorders are twice as likely to smoke cigarettes as the general population and therefore are at an increased risk of suffering from sequelae of smoking (4). In patients with chronic obstructive pulmonary disease, mental illness is linked to poorer outcomes clinically (4, 5). Treating symptoms of depression in cancer patients may improve survival time (6). Up to 50% of cancer patients suffer from a mental illness, especially depression and anxiety (7). Patients who are depressed have twice the risk of having a heart attack as the nondepressed population (8). Depression also increases the risk of death in patients with cardiovascular disease (9). It has been shown that treating the symptoms of depression after a heart attack lowers both mortality and rehospitalization rates (10). With this mounting evidence, it becomes more important than ever to tackle comorbid mental illnesses in the epidemic of noncommunicable diseases.

Comorbid mental illnesses are amplifiers of the burden of other noncommunicable diseases. Therefore, primary health care needs to assess and monitor mental health. The medical profession needs to prioritize the training of professionals in mental health care and critically incorporate mental health interventions within chronic disease programs (2). Addressing mental illnesses in primary care settings will delay progression, improve outcomes, and reduce health care costs of other noncommunicable diseases. The training of primary health care professionals to tackle mental illness calls on the experts in mental health (i.e., psychiatrists) to collaborate and lead their primary health colleagues. Psychiatry therefore has an important part to play in the emerging initiative that is being put forth by the leading organization on health, WHO.

Depression is ranked as the leading cause of disability worldwide (11). According to data collected by WHO, approximately 20% of the world's children and adolescents have mental disorders or problems. Similar types of disorders are being reported across cultures. Around the world, on average, about 800, 000 people commit suicide every year. More than one-half of the people who kill themselves are between the ages of 15 and 44. The highest suicide rates are found among men in eastern European countries (11). Mental illnesses, such as depression, bipolar disorder, and schizophrenia, are the most prominent and treatable causes of suicide. War and other major disasters also have a major impact on the mental and psychosocial well-being of the population. Rates of mental disorders tend to double after traumatic events (11). Trauma therefore increases the mental illness burden on overall health outcomes. Mental illness also contributes to unintentional and intentional injury. Treating mental illness can prevent such injuries and in turn can decrease the cost incurred by health care.

Mental disorders are a risk factor for communicable and noncommunicable diseases. Mental illness coexists with chronic disease conditions, such as diabetes, cardiovascular disease, and chronic obstructive pulmonary disease (3, 5, 8). Treating mental disorders can decrease the burden of disease overall. Psychiatry once again becomes important in the equation. Without experts in mental health, the disease burden of mental disorders cannot be tackled effectively. With the increasing rate of mental illness and the inadequate resource distribution, psychiatry needs to take on the headship. Psychiatrists are increasingly needed to take on a role in public

health. They are needed to collaborate with primary health care. Psychiatrists are also needed in efforts to improve the inadequate human resources currently available for mental health.

The resources to treat and prevent mental illness remain insufficient. According to a WHO mental health fact sheet, there is an immense inequality in the distribution of skilled human resources for mental health care across the world (11). There is a shortage of psychiatrists, psychiatric nurses, psychologists, and social workers. These shortages are among the major barriers preventing treatment and care in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100,000 people. With many of the world's children having mental health problems, the concerning issue is that the regions of the world with the highest percentage of populations under the age of 19 have the poorest level of mental health resources. Most low- and middle-income countries have only one child psychiatrist for every 1 to 4 million people (11). Therefore, the disparity between the burden of mental illness and available psychiatric resources appears overwhelming.

Stigma about mental health and discrimination against patients and families prevent people from seeking treatment for mental illness (11). Psychiatry has a role to play in decreasing stigma and therefore increasing access to mental health resources for this at-risk population. Many continue to believe that mental illness is related to either stress or lack of willpower, rather than to medical disorders. Experts in mental health are needed in efforts to decrease this stigma among the general population through education. There are human rights violations of psychiatric patients reported worldwide. These violations include use of physical restraints, seclusion, and denial of basic needs and privacy (11). Very few countries have legal frameworks that protect the rights of people with mental illness. In order to change policy, it falls on those taking care of the health needs of these patients to play a key role. The WHO cites inadequate human resources for mental health as one of the barriers that need to be overcome in order to increase the availability of mental health services around the world (11) Psychiatrists are needed not only to treat mental illness but also to take on a leadership role. Mental health needs to be on the public health agenda, and organization of mental health services needs to be revamped.

Psychiatry henceforth becomes increasingly important. With inadequate resources available for treatment of mental illness, increasing burden of mental disorders worldwide, and the mounting evidence supporting the intimate link between mental illness and physical health, psychiatry will be called forth to play a key role. Psychiatrists will be needed more than ever to meet the physical and mental health care needs of the world. Whether medical students pick psychiatry as their specialty or not, whether psychiatry tries to reinvent itself or not, whether it is the place to make the mark or not, one cannot be certain. What is certain is that psychiatry is important, and there is a need for psychiatrists worldwide. This need will continue to rise whether the medical profession acknowledges it or not. It is then up to us, as psychiatrists, to rise up to the challenge of the mental health care needs of our patients or to sit back and let someone else do our job.

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Perspective

Issues in Informed Consent and Serious Mental Illness From the Perspective of an Institutional Review Board Member

Simha E. Ravven, M.D.

The issue of serious mental illness and informed consent confronts psychiatrists (and other physicians) frequently. The capacity to provide consent for treatment, enter into contracts, stand trial, and participate in other legal proceedings can be impaired in subtle and overt ways by mental illness. Ability to give informed consent to participate in medical research is a particularly important topic that I carefully considered as a resident during my time as a member of the institutional review board of the Cambridge Health Alliance, an affiliate of Harvard Medical School. The job of the institutional review board is to review research protocols involving human subjects to ensure that participants' rights are protected, that they are not subject to unreasonable harm, and that their private information is kept confidential.

Persons with mental illness disproportionately suffer from comorbid medical illness yet are often excluded from clinical trials (1, 2). One possible reason for this is that to participate in a clinical trial, an individual must be able to give informed consent, a capacity that may be impaired by mental illness. People with mental illness can also be excluded by investigators because of concern that they will have poor outcomes. Failure to include people with mental illness in clinical trials and to disclose that they were excluded has also been the subject of a lawsuit (3). This litigation consisted of hundreds of cases in multiple state courts involving allegations that the smoking cessation medication varenicline caused severe medical and psychiatric side effects.

Informed consent for research is often more complicated than consenting to the medical intervention alone. There can be direct and indirect financial risks to individuals, either costs of an intervention itself or of medical care associated with complications of an experimental intervention.

Reviewing research protocols aroused in me a passionate desire to protect patients from harm. I worried that an experimental protocol of an antipsychotic medication in treatment of an anxiety disorder could expose patients to the potential side effects of the medication unnecessarily. During my time on the institutional review board, we frequently debated the potential costs of treatment to participants. As a researcher, I wanted to support and promote research that could ultimately help my patients, as well as foresee potential harm to patients and prevent it. The tension between the two often conflicting aims of patient protection and support of research met in the crafting of rigorous and detailed informed consent documents.

There is a robust literature on assessment of the capacity to give informed consent and elements of informed consent in medical research, as well as relevant case law (4). Institutional review board members are given the duty to anticipate risks and to see how these risks can be mitigated and conveyed to potential study participants. Inclusion of psychiatrists on institutional review boards can help ensure that factors that affect decision making and consent are addressed.

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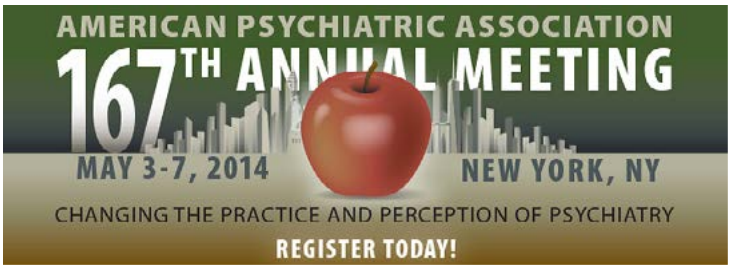
3. Varenicline products liability litigation MDL 2092, 09-cv-2039 US District Court, Northern District of Alabama (Florence)

4. Kaimowitz v Department of Mental Health for the State of Michigan, Civil No 73-19434-AW (Cir Ct of Wayne County, Mich, filed July 10, 1973)



Residents, fellows, and students are invited to attend this year's *American Journal of Psychiatry Residents' Journal* workshop, to take place at the Annual Meeting in New York. This year's workshop title is "The American Journal of Psychiatry Residents' Journal: How to Participate." Bring your thoughts and ideas about the *Residents' Journal*; hear a brief presentation about the Journal's new developments; meet with *Residents' Journal* editors and editorial staff as well as the *American Journal of Psychiatry* Editor-in-Chief Robert Freedman, M.D. The workshop is scheduled for Saturday, May 3, 2014, from 1:30 p.m. to 3:00 p.m. in the Jacob K. Javits Convention Center, Level 1, Room 1D03/04. For further information please contact ajp@psych.org.

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TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions.
(answers will appear in the next issue)

This month's questions are courtesy of Arshya Vahabzadeh, M.D., a fellow at Massachusetts General Hospital, McLean Hospital, and Harvard Medical School, Boston, and Editor-in-Chief of the Residents Journal.

Question 1

"Sam" sees his mother struggling to turn on a lamp; it seems the light bulb has burnt out. Sam asks his mother if the lamp is "afraid." What Piagetian concept does this demonstrate?

A. Reversibility
B. Animism
C. Mindfulness
D. Object permanence
E. None of the above

Question 2

Factors believed to be associated with a better prognosis in schizophrenia include all except which of the following?

A. Female gender
B. Good premorbid functioning
C. Earlier age at onset
D. Rapid symptom onset
E. Positive symptoms

ANSWERS TO DECEMBER QUESTIONS

Question 1

Answer: D. Serotonergic hallucinogen

Serotonergic or classical hallucinogens are the largest categories of hallucinogens. They share a common ability to bind at a particular population of serotonin receptors (i.e., serotonin type 2_A receptors) and act in an agonist fashion. Classical hallucinogens are made up mainly of indolealkylamines and phenylalkylamines. Mescaline is another example.

Reference

1. Weaver MF, Schnoll SH: Hallucinogens and club drugs, in The American Psychiatric Publishing Textbook of Substance Abuse Treatment, 4th ed. Edited by Galanter M, Kleber HD. Washington, DC, American Psychiatric Publishing, 2008

Question 2

Answer: D. Higher prevalence of the paranoid subtype of schizophrenia

Approximately 75% of late-onset schizophrenia is of the paranoid subtype (compared with 50% for early onset). Age at onset after 40 years is considered late-onset schizophrenia. Women make up the majority of individuals with onset of schizophrenia in middle to late life. It has been speculated that estrogen may serve as an endogenous antipsychotic, masking schizophrenia symptoms in vulnerable women until after menopause.

Reference

1. Jeste DV, Lanouette NM, Vahia IV: Schizophrenia and paranoid disorders, in The American Psychiatric Publishing Textbook of Geriatric Psychiatry, 4th ed. Edited by Blazer DG, Steffens DC. Washington, DC, American Psychiatric Publishing, 2009

We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured.
Submissions should include the following:
1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
***Please direct all inquiries and submissions to Dr. Hsu: davidhsu222@gmail.com.**

Author Information for *The Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted. To submit a manuscript, please visit http://mc.manuscriptcentral.com/appi-ajp, and select "Residents" in the manuscript type field.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
2. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
4. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
6. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
7. **Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Themes

Please note that we will consider articles outside of the theme.

Global Psychiatry

If you have a submission related to this theme, contact the Section Editor, Misty Richards, M.D., M.S. (mcrichards@mednet.ucla.edu).

Adolescent Psychiatry

If you have a submission related to this theme, contact the Section Editor, Justine Wittenauer (jwittenauer@challiance.org).

Media and Psychiatry

If you have a submission related to this theme, contact the Section Editor, Holly S. Peek, M.D., M.P.H. (hpeek85@gmail.com).

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