APA Resource Document: Legal Sanctions for Mental Health Professional-Patient Sexual Misconduct

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I. Overview

Psychiatric sexual misconduct with patients is a serious problem, which has rightfully become of paramount concern to the profession and to legislators and other policy makers. Organized psychiatry has provided ethical sanctions and deployed educational programs in an effort to eliminate sexual misconduct. More recently, legal initiatives have been taken to address the problem. Several states have enacted legislation, generally acting to criminalize sexual misconduct and to mandate reporting of offenses; many others are actively considering doing so. This document (1) briefly reviews the scope of the problem of sexual misconduct; (2) summarizes the profession's past efforts to address misconduct; (3) reviews the major categories of legislation which have been proposed or enacted: mandatory reporting and criminalization; and (4) briefly summarizes other areas of possible legislative initiatives. The purpose of this document is to review legislative initiatives that District Branches may consider as means to effectively curb sexual misconduct. We hope that this document will serve as a resource which will assist the District Branches in making informed contributions to the legislative process.

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II. The Scope of the Problem

Psychiatrist-patient sexual misconduct is a problem of major proportions. There are three ways in which sexual misconduct is harmful.

1. Psychiatrist-Patient Sexual Misconduct Victimizes Patients The true scope of sexual misconduct may never be known. Victims are often reluctant to come forward, and perpetrators are reticent to divulge their transgressions. Even so, available studies outline a problem of disturbing proportions. Surveys of psychiatrists and other classes of mental health professionals have shown that a significant number admit to engaging in sexual conduct with their patients. The percentage of therapists who report sexual conduct with patients varies between 1 and 15 percent, perhaps due to differing response rates, definitions of sexual activity, and sampled populations.[1–4] The best studies of psychiatrists report that approximately seven percent have engaged at some time in their careers in sexual misconduct.[1] Of those reporting sexual conduct, one study found that more than one-third admitted to having been involved with more than one patient.[1] It must be noted that these studies are based on self-report; most authorities consider them to underestimate the frequency of sexual misconduct.[5] To underscore the prevalence of sexual misconduct, in one survey of psychiatrists, nearly two-thirds reported that they had treated a patient who had been sexually involved with a previous therapist, most often a psychiatrist.[6]

Authorities in the field have cataloged a wide range of emotional harms resulting from sexual misconduct. Patients may experience fear, guilt, rage, emotional lability, depression, and symptoms of posttraumatic stress disorder.[5, 7] It is a matter of dispute whether a characteristic syndrome occurs in victims of sexual misconduct.[8] It seems likely that the precise nature and degree of harm which result from sexual misconduct will vary from patient to patient, depending on preexisting mental and emotional status and vulnerability. For example, patients who have come into treatment due to problems related to previous sexual abuse may be particularly vulnerable. Authorities in the field, however, are in agreement that nearly all patients who subsequently enter treatment have been significantly harmed in some way. One authority characterizes the impact of sexual misconduct as "devastating" in about 10 percent of cases.[9]

In addition to the harms directly resulting from sexual misconduct, other harms befall victims as a result of offending psychiatrists' failure to provide appropriate treatment. Sexual misconduct is often accompanied by other forms of exploitative or abusive behavior on the part of the psychiatrist.[10, 11] Finally, it is reported that nearly all victims of sexual misconduct experience at least some difficulty in trusting subsequent therapists.[6] Thus, these patients—their original psychiatric difficulties compounded by sexual exploitation—must surmount iatrogenic obstacles in order to receive needed treatment.

2. Sexual Misconduct May Discourage People from Seeking Psychiatric Treatment Psychiatric disorders are of-

ten accompanied by feelings of vulnerability, and troubled individuals may be reticent to seek treatment under the best of circumstances. The psychiatric profession has invested considerable effort on many fronts to establish legal rules and ethical norms which foster patients' trust (e.g., the confidentiality of communications).[12] As a result of these efforts, patients who might otherwise not seek treatment are assured that psychiatric care will be provided in a safe environment. Sexual misconduct undermines this trust in psychiatrists. Although no empirical research exists which quantifies the magnitude of treatment avoidance, individuals considering psychiatric treatment would understandably be deterred by fears of sexual exploitation.

3. The Profession of Psychiatry is Damaged by Sexual Misconduct Although this damage is secondary in importance to the damage done to patients, directly and indirectly, it is significant nonetheless. Psychiatry's mission, and recognized social role, is to promote and protect the mental and emotional well-being of the members of society.[13] Sexual misconduct is particularly damaging to the reputation of psychiatry because the damages to patients which result are mental and emotional in nature. If psychiatry loses the confidence of society, its ability effectively to pursue its mission will be damaged.

III. History of Professional Actions

1. Ethics Physicians have been proscribed from sexual activity with their patients from the earliest days of medical ethics. The Hippocratic oath stated:

> In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love of women and men.[14]

Although the medical profession has disciplined physicians, including psychiatrists, for sexual misconduct with patients for many years, it was not until recently that it seemed necessary to modify the ethical code and explicitly forbid sexual activity with patients. Beginning in 1973 the American Psychiatric Association (APA) has supplemented the ethical code promulgated by the American Medical Association by publishing *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.* From the beginning, these annotations have included a section which states:

> . . . the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. Sexual activity with a patient is unethical.[12]

The American Medical Association also moved, in 1989, to make explicit this understood standard of ethical conduct.[15] Its Council on Ethical and Judicial Affairs added to the code:

> Sexual misconduct in the practice of medicine violates the trust the patient reposes in the physician and is unethical.[16]

Organized medicine, including psychiatry, has been moved to make these explicit ethical pronouncements as awareness of the magnitude of the problem of

sexual misconduct has grown. Indeed, in an effort to publicize the problem and educate psychiatrists about the ethical proscriptions, discussion of ethical proscriptions against sexual misconduct has been taken up in journal articles and editorials, and other professional publications have devoted increasing attention to the topic.[17–24]

2. Education In 1985, the American Psychiatric Association funded the development of a teaching program on sexual misconduct, suitable for use in residency training and other professional educational efforts. The committee developed a set of materials, including videotape discussion vignettes, accompanied by a teaching manual.[25] A companion tape discusses reporting obligations.[26] This training program was directed at helping psychiatrists identify: potential problems, how to seek consultation, and the ethical boundaries concerning physician-patient interactions about sex.

The American Psychiatric Association has also developed for patients a fact sheet on psychiatric sexual misconduct. The fact sheet has been designed to inform patients about ethical proscriptions of sexual misconduct, to assist patients in identifying inappropriate behavior which may herald sexual misconduct, and to provide patients who have been sexually exploited a list of legal and other options they may pursue and resources at their disposal.

Over the last several years, the APA annual meetings have included numerous workshops and symposia which have educated members about the clinical, ethical, and legal dimensions of sexual misconduct. These presentations have been extensively covered by the APA publication, *Psychiatric News*, which is disseminated to all APA members.

It is clear that ongoing educational efforts are required to convey the profession's standards of conduct to its members. The impact of education is threefold.[27] First, the members of the profession become informed about the standards of professional conduct. Second, informing the members of the profession about the serious, negative consequences of sexual misconduct will lead to greater appreciation of the need to avoid this behavior and to resist any temptations that may arise. Third, through education an atmosphere conducive to monitoring and reporting misconduct may be created.

3. Other Organized Efforts It is impossible fully to chronicle the efforts of the profession to educate psychiatrists about standards of conduct and their responsibilities. District branches of the APA, state and local professional organizations, universities, and other groups have held workshops, conducted training programs, offered outreach services, and distributed educational materials.

IV. Legal Initiatives

Sexual misconduct continues in spite of educational efforts and ethical sanctions. Growing public concern about the problem has led legislatures in nine states to pass legislation, criminalizing psychiatrists' sexual misconduct[28–36]; some states have enacted statutes obliging subsequent therapists to take action when patients report sexual misconduct.[37–39] An increasing number of states have

placed similar legislative action under consideration.[40]

Legislative approaches to sexual misconduct have attracted the attention of the APA's District Branches as well. A recent survey found that District Branches had supported statutes criminalizing psychiatric sexual misconduct in 8 of 13 states in which legislation has been proposed.[41] In some instances, district branches, although, opposed to specific bills, stated that they would favor a well crafted criminal statute.

Legislation—particularly criminalization—may be opposed by some District Branches on several grounds. Some psychiatrists may feel that the problem of sexual misconduct is best addressed through professional organizations. In some jurisdictions, psychiatrists may find that the current regulatory system is adequate. Alternatively, some psychiatrists may judge that criminalization will stigmatize the psychiatric profession or unfairly punish impaired physicians. Finally, some psychiatrists may believe that the availability of the option of criminal prosecution will divert patients from seeking other remedies they find more appropriate, such as disciplinary action. These represent realistic and understandable concerns.

On the other hand, legal initiatives such as criminalization may be seen by some District Branches as necessary means to address the problem of sexual misconduct for a number of reasons. Authorities in the field believe that some psychiatrists who engage in sexual misconduct are not amenable to educational efforts; rather, they are predatory in their actions.[42, 43] Ethical procedures alone are not likely to be effective in eliminating these psychiatrists from the profession. In addition, the overlapping schemes of legal regulation of psychiatric practice—licensure, professional societies, the tort system, the criminal justice system—vary in their precise form and in degree of coordination from state to state. In some states, the tools available to the psychiatric profession to police individual clinicians may be inadequate to the task.

The differing perspectives and actual experiences of psychiatrists outlined above may account for the diversity of views among the District Branches regarding the necessity of criminal sanctions. In light of these differences, the Work Group has chosen to outline features of legislative initiatives that District Branches should consider in light of the particular circumstances and needs in their states, rather than to prescribe a single approach for all jurisdictions.

In the opinion of the Work Group, when legislative actions are taken, nonlegislative efforts should never be regarded as completely ineffective and, therefore, should never be abandoned. Indeed, the Work Group believes educational efforts should be redoubled.

The remainder of the report discusses various legislative actions which District Branches may wish to consider.

V. Criminalization

1. Background Not every socially disapproved behavior should be subject to criminal punishment. In some instances, criminal sanctions may be disproportionate to the seriousness of the transgression

and, in others, costs of criminalization may exceed benefits in suppressing the behavior. In general, criminal punishment is most appropriate for behavior that is socially harmful and repugnant to prevailing moral standards.

Criminal sanctions for sexual misconduct by psychiatrists may be justified on several grounds. *First*, sexual misconduct qualifies as a morally repugnant act. Patients seek out psychiatrists expecting medical treatment for mental and emotional distress. Psychiatrists act in a morally repellent fashion when they use their positions of authority, their patients' confidences, and their patients' trust for the purposes of sexual exploitation. *Second*, criminalization of sexual misconduct will deter psychiatrists from future harmful behavior toward patients; criminal sanctions will send a clear and unmistakable message to psychiatrists and potential patients that sexual misconduct is unacceptable. Sexual misconduct has persisted in spite of clear ethical prohibitions, the risk of civil suit, and possible disciplinary action.[20] Professional societies' ethical procedures may be subject to delaying tactics and the ultimate penalty—loss of membership—has modest deterrent value. The threat of civil action is little better: civil suits routinely require several years to reach resolution and, in the end, it is likely that an insurer—not the offending psychiatrist—will pay the judgment.[44] The threat of criminal prosecution is the fastest and most potent available sanction likely to deter sexual misconduct. *Third*, criminal penalties are the most effective means of incapacitating offending psychiatrists. Civil suits and ethics sanctions, even when successful, will leave the offending psychiatrist in a position to continue to practice and to place new patients at risk. Even revocation of the medical license will leave psychiatrists in many states free to practice psychotherapy, unlicensed and outside the reach of regulatory supervision; alternatively, clinicians may evade disciplinary sanctions by moving to another state. *Finally*, criminal sanctions may play a role in bringing to treatment those offenders who are amenable to therapeutic interventions, but who would avoid treatment in the absence of coercion.

Some may find it puzzling, at first glance, that consensual sexual activity between a patient and a physician may be construed as a crime. But consent does not immunize any activity from status as a criminal act. Society does not allow a citizen to beat or to kill another who consents: the victim's consent is no defense to aggravated assault or to murder. Consenting adults who exchange sex for money may commit a crime in doing so. Corrupt political practices and illicit drug transactions are criminalized even though none of the participants object or complain. In the view of advocates of criminalization, the high likelihood of harm resulting from sexual misconduct in this context is sufficient to justify criminal punishment.

District Branches will need to consider the need for criminalization of sexual misconduct on a state-by-state basis, taking into consideration the effectiveness of

lesser sanctions already in place. The following section discusses the relevant dimensions of a criminalization statute for use by District Branches in considering proposed legislation.

VI. Components of a Criminal Statute

Scope of Sanctioned Behavior If criminal sanctions are to be adopted, they should be reserved for those most deserving of punishment (i.e., those psychiatrists who deviate most significantly from norms of professional conduct and who place their victims at the greatest risk of harm). Criminal sanctions, therefore, should be reserved for psychiatrists who engage in sexual misconduct while a physician-patient relationship is ongoing or, alternatively, for psychiatrists who terminate treatment in order to engage in sexual misconduct.* In addition, the rigorous procedural protections found in the criminal justice system, including the high burden of proof necessary for conviction, ensure that criminal prosecution will be reserved for the most serious and clear cases of sexual misconduct.

Definitions of Sexual Misconduct The proscribed sexual activities must be defined specifically in order to avoid legal challenge as vague or overly broad. In other words, before someone can be fairly subjected to criminal penalties it must be clear what is being outlawed.

Definitions of Mental Health Professional There are many arguments in favor of including a broad range of mental health professionals within the ambit of the criminal statute. In virtually all states, unlicensed practitioners, some of whom have lost their medical licenses for past misconduct may continue to practice psychotherapy. These practitioners trained to be psychiatrists, established themselves in practice as psychiatrists, and may still be perceived by the public and their patients as psychiatrists, even after they have lost their licenses.†

It is undesirable to characterize mental health professionals as "psychotherapists" or to confine a criminal statute to those practicing psychotherapy, as opposed to somatic treatments. It is not necessary to rely on transference and other psychological mechanisms to explain the special vulnerability of patients. While these concepts offer a valuable way of understanding and describing certain instances of sexual misconduct, the justification for criminal sanctions does not rest upon any particular theory of psychotherapy or the mode of practice of the mental health professional. The justification for

*There are other reasonable approaches to defining the scope of sanctioned behavior. For example, some jurisdictions have extended the time-frame for criminal liability beyond the termination of treatment, typically to sanction sexual misconduct with patients who are unusually dependent upon their former treating mental health professional.

†District branches may encounter proposals to criminalize physician-patient sexual misconduct as well as mental health professional-patient sexual misconduct. The context and circumstances of physician-patient sexual misconduct present different and unique problems which are beyond the scope of this document.
Alternatively, there may be jurisdictional reasons to apply criminal sanctions to a more circumscribed set of clinicians, for example only to psychiatrists. In determining the proper definitions of target professionals, district branches will need to take into consideration existing statutory definitions, the availability and effectiveness of existing disciplinary bodies, and other factors.

criminalization is found in the high frequency of patients who are harmed as a consequence, and the morally repugnant nature of the exploitative behavior.

Definitions of Patient Status Some statutes may define "patient" as well as mental health professional. In the view of the Work Group, a definition should include those who receive any kind of consultative or evaluative service and should not be constrained to patients in psychotherapy. However brief the professional relationship, patients place their trust in the psychiatrist to act in their best interests.

Punishment The types and range of punishments specified by existing statutes vary from jurisdiction to jurisdiction. In the view of the Work Group, determinations of the range of possible punishments are best left to the judgments of the individual legislatures which must reconcile existing penal codes with new criminal statutes. The appropriate punishment in individual cases, as with criminal punishment in general, will be determined by courts and reflect contextual factors and determinations rooted in specific cases. In sum, punishment in a given case will be allotted based on the moral blameworthiness of the perpetrator and the suitability of the perpetrator for rehabilitative alternatives.

Shielding of Records States which enact criminalization statutes should extend "rape shield" statutes, where they exist, to protect the confidentiality of sexual misconduct victims.

The Appendix contains a model criminal statute.

VII. Reporting Statutes

1. Background Studies have demonstrated that only a small proportion of the instances of sexual misconduct which come to the attention of subsequent treating mental health professionals are reported.[5] The reasons for this are not known, but many believe that psychiatrists are reluctant to report the misdeeds of other psychiatrists or are uncertain about their obligations. In either event, mandatory reporting statutes have been enacted by a number of state legislatures as a means of increasing the quantity of reports and improving the quality of monitoring of mental health professionals.[40] Undoubtedly, the existence of legal duties will increase professionals' awareness of their obligations to report.

Reporting statutes must take into consideration the interests of victimized patients, future patients, the profession of psychiatry, and accused psychiatrists. Finally, society has a compelling interest in identifying and punishing wrong-doers; this societal interest has elements of retribution, incapacitation, and deterrence.

Victims of sexual misconduct have a special interest in the formulation of reporting requirements. In some instances, victims are reluctant to confront perpetrators and may feel—and be—vulnerable with respect to them. As a result, statutes which require mandatory reporting of all instances of sexual misconduct which come to the attention of a subsequent psychiatrist may lead to renewed feelings of powerlessness and traumatization on the part of victims. Many victims and their advocates feel that patient control

over the process is necessary for therapeutic and safety reasons.

2. Components of a Reporting Statute. *Definitions of Sexual Misconduct* Definitions of sexual misconduct will need to be included in any reporting statute if definitions have not already been established for other purposes (criminalization). This is necessary in order to provide guidance to mental health professionals unsure if patients are describing reportable acts.

Trigger to Duty to Report The question of reporting will be raised when a mental health professional is told by a patient that a prior mental health professional, in a professional relationship with the patient, has engaged in behavior which constitutes sexual misconduct. In the view of the Work Group, a workable reporting statute must establish as a predicate to the reporting obligation a report, an allegation, or a description of sexual misconduct by a patient which gives the current treating psychiatrist reason to believe that sexual misconduct has occurred. Psychiatrists should not be placed in the position of inferring sexual misconduct from the behavior or conduct of patients, nor should they be required to rely on third party reports. While the treating psychiatrist should not judge the truth of allegations, the Work Group believes that there should be no duty to report patently false allegations which might be based, for example, on delusional beliefs.

Time-Frame for Reporting It is desirable to place a deadline on mental health professionals' responsibility to report, to avert unnecessary delay.

Responsible Agency A reporting statute should specify how psychiatrists can effectively discharge their duty. In most states, the regulatory body which oversees licensure and discipline of physicians will be the appropriate agency to receive reports of sexual misconduct. A reporting statute should also designate how the duty is discharged if the alleged misconduct occurred out of state or by unlicensed therapists.

Patient Control of Reporting In the opinion of the Work Group, it is essential that reporting statutes allow patients to determine whether a report is to be made. In other words (subject to some exceptions as noted above), the reporting is "mandatory" if the patient wishes it to be. Patient control of reporting strikes the best balance between the interests of the profession in policing itself and the interests of the victims.

Reporting statutes which are truly mandatory, that is, which require psychiatrists to report patients' reports of sexual misconduct even over the objections of the victim, are arguably better suited to the interests of policing the profession. In the opinion of the Work Group, the possible advantages to policing which such a statute would carry, are illusory. In some instances, reporting over the objections of the victim will threaten the treatment relationship, endanger the safety of the patient, or retraumatize the patient.

Victims who do not wish their current psychiatrist to report are unlikely to commit themselves to pursuing disciplinary action. Some victims, although deeply disturbed by the sexual misconduct, are unwilling to subject themselves to recounting their experiences, to enduring

the rigors of testifying, to undergoing cross-examination, and to confronting the perpetrator. Without such a commitment, any disciplinary action will be fruitless.

Treatment may be threatened by reporting over the wishes of the patient. Some victims of sexual misconduct do not perceive themselves as victims and idealize their former psychiatrist, at least early in the course of treatment. Reporting of the misconduct over the patient's wishes will risk premature termination of treatment. Alternatively, some patients, even when they do feel victimized, may feel violated anew if reports must be made against their wishes. Indeed, when others learn of allegations of sexual misconduct, there may be adverse consequences for victims at home, in the workplace, and in other social spheres. Psychiatrists treating victims point to the potential therapeutic effects of empowering victims by placing control of reporting in their hands. Finally, victims of the sexual misconduct may face threats or more severe retaliatory actions from perpetrators following a report.

Therefore, in the opinion of the Work Group, it is crucial that reporting statutes should place the option to report in the hands of the victim.

Anonymous Reporting Anonymous reporting has received attention as a method for increasing the willingness of victims to bring sexual misconduct to the attention of disciplinary bodies. The state of Wisconsin and the province of Ontario have adopted anonymous reporting. Some victims are understandably reluctant to lodge a formal complaint out of concern that, as the sole complainant, it will be their word against the mental health professional's; the likelihood of arriving at an outcome favorable to the complainant is low. But an anonymous complaint which identifies the current treating psychiatrist can be kept on file—no action is to be taken by the regulatory board—until a second complainant comes forward. The anonymous complainants would be notified via their physicians of the existence of other complaining parties and given the opportunity to come forward together.

To date, little experience has accrued regarding the effectiveness of anonymous reporting. And two concerns have been voiced regarding this method of reporting. First, disciplinary bodies may be uncomfortable or unwilling to accumulate anonymous reports which they cannot act on. Second, psychiatrists may be legitimately concerned about the possible existence of "secret files" which contain allegations which may taint their names—at least within the disciplinary body—but, because of their secrecy, cannot be answered or rebutted.

In the opinion of the Work Group, although anonymous reporting is intriguing, insufficient information is available to assess its real merits. At the present time, the Work Group suggests that the experience of Wisconsin and Ontario with anonymous reporting be carefully observed. It is hoped that empirical results of their experiment will clarify the usefulness of anonymous reporting.

Confidentiality of Reports Mandatory reporting statutes should include provisions which assure that the information in the report, including the identity of the

victim, remain confidential. Confidentiality provisions should be written broadly so that they cover all agencies, officials, and individuals who will handle reports.

Reports should also be made privileged from discovery. Parties to unrelated actions against the alleged perpetrator may seek access to files in order to bolster their claims. Victims should be immune from these invasions of their privacy.

Immunity for Reporting Mental health professionals should be accorded immunity from civil suits for complying with reporting statutes. Suits alleging that the reporting psychiatrist should have known that the allegations were unfounded will greatly reduce compliance. Psychiatrists are not in a position to investigate allegations or form judgments about the veracity of allegations based on clinical examinations. Therefore, these statutes should include a provision which precludes tort liability, as long as the reporting professional acted in good faith.

Penalties for Failure to Report Reporting statutes should carry some penalty for failure on the part of the mental health professional to comply.

The Appendix contains a model statute for a mandatory reporting statute.

VIII. Other Legislative Initiatives

A variety of legislated reforms intended to curb psychiatric sexual misconduct have been suggested. The Work Group has chosen, at this time, to briefly describe these efforts in order to familiarize District Branches with them.

Civil Statutes Some states have enacted statutes which specify that sexual misconduct may be the basis for a civil lawsuit. This is necessary, in some jurisdictions, because there is no common law (nonstatutory) precedent for sexual misconduct suits. In the absence of legislative reform, it is likely that the claims of victimized patients will be dismissed. These civil statutes establish, as a matter of law, that sexual misconduct is negligence.[45–48]

Even in jurisdictions in which sexual misconduct is established as the basis for civil suit at common law, courts may still be grappling with defining the contours of liability. As a result, it may be unclear to psychiatrists, patients, and lawyers, precisely what behavior is proscribed. Drafting a civil statute provides an opportunity for the legislature clearly to define the scope of liability. Therefore, proposed civil statutes are likely to vary considerably, particularly in how sexual misconduct is defined.

There are several aspects of civil statutes which deserve special mention.

Post-Termination Sex Civil statutes enacted to date have allowed for suits based on post-termination sex between mental health professionals and former patients.[49] Definitions of "former" varies from within six months to within two years following termination.[45–48]

Employer Liability Statutes may assign liability to employers who, in the usual language, "knew or should have known" that the mental health professional would be sexually exploitative. The intent of an employer liability provision is to provide encouragement to employers appropriately to screen and monitor mental health professional employees. Victims are also accorded an-

other avenue of recovery, in the event the mental health professional is judgment-proof (i.e., without malpractice coverage or independent means to pay victims' damages).

Silence Agreements Frequently, as one element of the settlement of a civil suit, the offending mental health professional will exact an agreement from the patient to remain silent about the sexual misconduct. These agreements prevent victims from subsequently reporting sexual misconduct to licensing boards and other disciplinary agencies. Because such agreements act against the public's interest in disciplining misconduct, some states have declared them void.[50]

Statute of Limitations States that have passed civil statutes for sexual misconduct have also considered statutes which extend the typical time period within which suits must be brought, typically two or three years. This has been considered necessary because many victims of sexual misconduct may not perceive themselves as having been exploited until long after termination.[51,52] Some victims may be too traumatized by their experiences and too fearful to confront offenders until they have received a period of treatment. Statutes may simply provide those alleging sexual misconduct a longer time period for filing a suit than is typical. Alternatively, states may enact a "discovery" rule under which the time period does not begin until the victim discovers that they have been harmed.

Victim Shield All states which have enacted civil statutes covering mental health professionals' sexual misconduct have also passed victim shield provisions. These provisions place the victims' sexual history off limits during the discovery process and at trial, unless the defendant can demonstrate its relevance to the case. Victim shield rules prevent routine use of victims' sexual history as a means of humiliation and as a device to discourage worthy suits.[53]

Anonymous Complaints Because many patients fear public exposure and identification may result from filing a suit, some states have established procedures under which plaintiff-patients may substitute real or fictitious initials for their name.[54]

Injunctive Relief Injunctive relief is a government-enforced remedy proscribing future conduct, in this case the practice of therapy.[55] In most states, it is possible to continue to practice therapy—but not to prescribe medications—after the loss of medical or other professional licensure. Unlicensed therapists, therefore, fall outside the grasp of disciplining bodies. These unlicensed therapists will fall within the ambit of criminal statutes, if "mental health professional" is appropriately defined. Injunctive relief would provide a means of removing these therapists from practice in those states which have not criminalized sexual misconduct. Alternatively, injunctive relief may be employed in those instances in which repeated sexual misconduct indicates that a particular therapist should not be allowed to return to practice.

A civil injunction statute might operate to allow access to the full array of interested parties. For example, the statute might specify that, after a licensing board has acted to revoke the license of a mental

health professional because of sexual misconduct, the district attorney, the board, or the patient/victim could petition for an order enjoining the disciplined professional from undertaking specified aspects of clinical practice without a license. To assure adequate involvement on the part of the district attorney, the statute could provide that within 60 days of the filing of such a petition by a party other than the district attorney, the district attorney's office would be required to notify the court whether it wished to support the petition.

Mandatory Provision of Information Some states may not be in a position to implement mandatory reporting due to economic or other constraints. In these jurisdictions, an alternative to mandatory reporting is to require psychiatrists to provide patients with information about the criminal, civil, ethical, and regulatory remedies available to them and the procedures for initiating a complaint. This information can be readily summarized in a pamphlet and discussed with patients.[56]

Appendix: Model Statutes

These statutes are models that reflect the discussion on the preceding pages. Particular provisions may need to be altered to accommodate local variations and alternative approaches.

Model Criminal Statute

SECTION 1. Definitions

Mental Health Professional In this Act, "mental health professional" includes psychiatrists, other physicians, and other persons who render or offer to render services for the purpose of assessing, diagnosing, or treating emotional, mental, or behavioral disorders, or who offer services to alleviate problems pertaining to interpersonal relationships, work and life adjustment, and personal effectiveness which are caused by mental or emotional disorders or distress. This Act pertains to mental health professionals who are licensed and unlicensed, and to mental health professionals in training.

Patient In this Act, "patient" is defined as a person who obtains a professional consultation, or who obtains an assessment, diagnostic, or therapeutic service from a mental health professional.

Sexual Penetration In this Act, "sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion, however slight, into the genital or anal openings of the patient's body of any part of the mental health professional's body or any object used by the mental health professional for this purpose. Emission of semen is not a required element of "sexual penetration."

Indecent Sexual Contact In this Act, "indecent sexual conduct" means intentional touching by the mental health professional, or by the patient with the cooperation or consent of the mental health professional, of the genitals, anus, or the immediately surrounding areas, including the groin, inner thighs and buttocks, or the breasts, or the clothing covering any of these areas of the other person, other than in accordance with practices generally recognized as legitimate by the mental health profession.

Sexual Misconduct In this Act, "sexual misconduct" means either sexual penetration or indecent sexual contact.

SECTION 2. Punishment for Sexual Misconduct

(a) A mental health professional who engages in sexual misconduct with a patient during the period that a professional relationship exists between the mental health professional and the patient, or who terminates a professional relationship with a patient primarily for the purpose of engaging in sexual misconduct and who thereafter engages in sexual misconduct with the patient, shall be convicted of a felony and shall be punished as provided in paragraph (c).

(b) The consent of the patient to sexual misconduct shall not be a defense in a prosecution under this section.

(c) A first offense in violation of this Section shall be punished by a term of imprisonment not exceeding xx years unless the sexual misconduct

included one or more acts of sexual penetration, in which case the term of imprisonment may not exceed yy years. A second or subsequent offense may be punished by a term of imprisonment not exceeding zz years.

SECTION 3. Shielding of Records

That portion of the records of the court or any police department of the state or any of its political subdivisions, which contains the name of the patient involved in an alleged offense prohibited by this Act in any documents relating to arrest, investigation, complaint or indictment for such an offense, shall be withheld from public inspection (as provided in the state's "rape shield" law).

Model Mandatory Reporting Statute

(a) When a mental health professional receives a credible report from one of his or her patients that the patient has been subjected to acts by another mental health professional which constitute sexual misconduct as defined in [ ], as soon thereafter as practicable, taking into account clinical circumstances, the mental health professional shall ask the patient if he or she would like a report to be filed under this section. The mental health professional shall inform the patient that any report will identify the patient by name.

(b) The mental health professional shall obtain written consent from the patient prior to filing any report.

(c) Within 30 days of receiving consent under (b), the mental health professional shall report the suspicion of sexual misconduct to the appropriate state regulatory body, if the reporter believes that the subject of the report is licensed by the state. If the appropriate state regulatory body is not known to the reporter, or if the subject of the report is not licensed, the report shall be filed with the district attorney for the county in which the alleged sexual misconduct is likely, in the opinion of the reporter, to have occurred.

(d) All reports and records made from reports under this section and maintained by regulatory bodies, district attorneys, and other persons, officials, and institutions, shall be confidential. Information regarding the identity of an alleged victim shall not be disclosed by a reporter or by other persons who have received or have access to reports unless disclosure is authorized in writing by the alleged victim.

(e) All reports and records made from reports under this section shall be immune from discovery in any civil, regulatory, or criminal action except where sought by the alleged victim or the subject of the report in defense of an action.

(f) Any person or institution acting in compliance with this section is immune from any civil or criminal liability for their actions. For the purpose of any civil or criminal action or proceeding, any person acting in compliance with this section is presumed to be acting in good faith.

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