Learning to Collaborate: The Teaching Legacy of Howard Zonana in Forensic Psychiatry

Stephen Wizner, JD

The teaching legacy of Howard Zonana in forensic psychiatry has been in educating psychiatric fellows and law students to collaborate in advocacy on behalf of individuals whose problems exist at the intersection of the law and mental health. The author describes more than three decades of collaborative teaching with Dr. Zonana in Yale Law School legal clinics serving mental hospital patients, prisoners, children, and immigrants. In those clinics, law students and forensic psychiatry fellows have worked collaboratively in representing clinic clients and advocating for their legal and medical rights. The article reports three examples of this interdisciplinary collaboration: a project conducted at a state hospital shortly after the Supreme Court's decision in *O'Connor v. Donaldson*; a class action on behalf of individuals with developmental disabilities inappropriately subjected to long-term confinement in a state hospital; and an asylum case on behalf of a severely traumatized African woman fleeing persecution in her home country. The author concludes that Dr. Zonana's legacy reflects not only his contributions to medical and legal education, but also his profound commitment to effective and humane medical practice and to justice.

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For more than three decades, I have had the privilege and good fortune of collaborating with Howard Zonana in advocating for the medical and legal rights of individuals with mental disorders and in the teaching and supervision of law students, forensic fellows, and psychiatry residents in Yale Law School's clinical program.

For those of you who may not be familiar with the widespread adoption by law schools during the past four decades of the clinical method of teaching law, let me describe briefly how legal educators have adopted and adapted medicine's clinical approach to professional education in preparing law students for the practice of their profession.

Beginning in the spring semester of their first year of law school, Yale law students may elect to enroll in one of the Law School's clinical courses. In those courses, clinical faculty members serve as instructors and supervising attorneys for students providing direct legal services to low-income and other underrepresented individuals. The two original clinics, Prison Legal Services and Mental Hospital Legal Services, were established in the early 1970s.

In the prison clinic, law students visited inmates at the Federal Correctional Institution at Danbury, Connecticut, and provided legal representation to prisoners regarding parole, sentence modification, conditions of confinement, and other legal matters in both administrative and judicial proceedings.

In the mental hospital clinic, students visited individuals confined at Connecticut Valley Hospital in Middletown, Connecticut, then one of the state's three large public mental hospitals, where they provided legal representation to patients regarding civil commitment, discharge, conditions of confinement, treatment, and other medicolegal matters.

Beginning in the fall semester of 1976, Howard Zonana began attending the Mental Hospital Legal Services clinical seminar. At first, he taught individual classes about the classification, diagnosis, and treatment of mental illness. He showed videotaped interviews of individuals exhibiting symptoms of mental illness and discussed the diagnosis and treatment of their symptoms. He described the various types of medication and other treatments given to

Mr. Wizner is William O. Douglas Clinical Professor of Law Emeritus and Professorial Lecturer, Yale University Law School, New Haven, CT. Address correspondence to: Stephen Wizner, JD, Yale Law School, PO Box 208215, New Haven, CT 06520. E-mail: stephen.wizner@yale.edu.

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psychiatric patients and the challenges of assessing dangerousness.

As time went by, Howard's role changed from that of a consultant to a full collaborator in the law school's clinical program. He continued to offer expert instruction and consultation to students in the mental hospital, prison, and later, the child advocacy and immigration clinics. He and the forensic fellows and residents also participated as expert witnesses in the Law School's Trial Practice course. Howard began to have psychiatric residents perform evaluations of individual clients and provide expert testimony in court proceedings.

In 1979, Roy O'Shaughnessy arrived at Yale as the first fellow in the new Forensic Psychiatry Program developed and directed by Howard Zonana. Howard and Roy regularly attended law school clinical seminar meetings, and Roy provided expert evaluations and testimony in several clinic cases. Howard and I collaborated in teaching and supervising both the law students and the psychiatric residents and fellows.

Howard and the forensic fellows not only offered psychiatric consultation, evaluation, and testimony, but they also became directly involved in the planning and teaching of the classroom component of the clinics. I have a vivid recollection of one class session of the Mental Hospital Legal Services clinic in which we simulated a civil commitment hearing for the law students to help prepare them for representing real clients in those hearings. An experienced law student acted the role of the patient's legal representative, and Richard Belitsky, who was then a forensic fellow, portrayed the hospital staff psychiatrist. Those of you who know Richard will appreciate how realistic—and darkly humorous—his portrayal of the state hospital psychiatrist was.

At the conclusion of the mock hearing, Howard, Richard, and I led an animated discussion of the role of each player in the hearing and how law students could be most effective in representing clients in civil commitment cases. Howard raised the question of the ethics involved in the professional role of lawyers representing mentally ill clients who actually needed psychiatric treatment and would not receive it in the community if they were released. The law students pointed out that, other than receiving large doses of psychotropic medication and confinement on locked wards, their clients were not receiving any treatment at the state hospital. The law students also argued that their clients felt like prisoners in the hospital and wanted to be released from their involuntary confinement. The interdisciplinary discussion of the ethics related to the responsibility of lawyers representing persons with mental disorders in civil commitment cases that took place in seminar meetings of the Mental Hospital Legal Services Clinic motivated one clinic student to write and publish a scholarly article on the subject.[1]

Howard pointed out the complexities of providing community-based treatment for many of our clients. He and I then described an effective way of advocating for the release of patients by performing the "social work" necessary to prevail at civil commitment hearings. This involved preparing a discharge plan to present to the probate court judge stating where the patients would live and how they would receive the necessary support and psychiatric treatment if released to the community.

The collaboration between the law students and law faculty, and Howard and the psychiatric fellows, taught the law students a more effective method of advocacy than simply cross-examining hospital staff psychiatrists, and it taught the forensic fellows a more effective way to collaborate with legal advocates than simply providing advice on how to read patients' charts and providing critiques of the quality of treatment that was being provided to the clinic's clients.

Howard Zonana, together with his colleagues Madelon Baranoski and Bandy Lee and the forensic fellows, are now an integral part of the Yale Law School's clinical legal education program. Since this session has been titled "Grand Rounds," I would like to describe three specific examples of Howard's collaboration with the law school clinics in the teaching of forensic psychiatry.

The *Donaldson* Project

On June 26, 1975, the United States Supreme Court announced its decision in *O'Connor v. Donaldson*.[2] Kenneth Donaldson had spent nearly 15 years confined involuntarily in a Florida state mental hospital. He challenged his confinement in a federal court civil rights action in which he claimed that his confinement was an unconstitutional deprivation of his liberty. He alleged, and the evidence established, that his repeated requests for release during his 15 years of confinement had all been rejected, notwithstanding offers by responsible persons, including a halfway house for persons with mental ill-

ness, to care for him if necessary. He also claimed that he was not dangerous to himself or others and had not received any treatment other than confinement in the hospital.

The Court found that Donaldson's confinement was, in the Court's words, "a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness." The Court also found that "[f]or substantial periods, Donaldson was simply kept in a large room that housed 60 patients. . .," and that "Donaldson's requests for grounds privileges, occupational training, and an opportunity to discuss his case with [the hospital superintendent] or other staff members were repeatedly denied."[2]

In its decision upholding Donaldson's constitutional claim, the Supreme Court concluded that his constitutional right to liberty had been violated by his involuntary confinement. The Court held that "A state cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Donaldson* was not a right-to-treatment decision, but rather a decision about a state's authority to confine individuals against their will. Although the *Donaldson* decision received widespread public attention in the news media and in the professional literature, few releases of involuntary patients were precipitated by the decision.

The superintendent of the state mental hospital where Yale Law School's Mental Hospital Legal Services clinic operated suggested to me and Howard that the Yale Law School and the Yale Department of Psychiatry collaborate with him and hospital staff in developing a project to review the cases of long-term involuntary patients at the hospital to identify those entitled to release under the *Donaldson* criteria; to develop a model review procedure for identifying such patients; and to determine the need for and availability of less restrictive alternatives for long-term patients. The Edna McConnell Clarke Foundation agreed to support the project.

Howard took the lead in designing the review project, in collaboration with me and the hospital superintendent. We decided that there would be three review panels, each consisting of a Yale law student, a Yale psychiatric resident, and a hospital social worker, to review the cases of 107 patients who had been civilly committed by a probate court before March 1, 1976. Those reviews took place during a 20-week period beginning in July 1976. The three panels completed their work by December of that year.

The criteria we adopted for the patient review expanded on the Supreme Court's relatively narrow ruling in *Donaldson*. We and the superintendent wanted to identify not only those patients who legally could no longer be involuntarily confined under the *Donaldson* decision, but also those who could appropriately be released from involuntary hospitalization to less restrictive alternative placements. In other words, we wanted to know not only who could not legally be required to remain in the hospital, but also those who ought not to remain.

The law students' role on the panels was to ensure that the legal criteria for confinement were properly considered by the panels. The psychiatric residents' role was to provide the medical expertise necessary for determining patients' need for treatment. The hospital social workers' role was to provide information about hospital practices and the appropriateness and availability of alternative, less-restrictive placements.

The average age of the 107 patients reviewed was 47. Their average length of stay in the hospital was an astounding 17 years, although that number was exaggerated by the fact that a few patients had been confined for more than 40 years. Still, 70 percent of the patients had been continuously confined for more than five years.

The most common diagnosis (73% of the patients) was schizophrenia. The remaining 27% had diagnoses of organic brain syndrome, developmental disabilities, and other mental disorders. A significant number of the long-term patients had undergone lobotomies or repeated electroconvulsive treatments.

I will refrain from going into detail about how the panels actually carried out their work. (Those who are interested can read our report in the November 1977 issue of *Hospital and Community Psychiatry*.[3]) Suffice it to say that this review project was yet another example of Howard Zonana's collaborative approach to forensic psychiatry. Indeed, one of our principal recommendations was that the hospital develop a system of ongoing periodic review of involuntary patients by external, interdisciplinary panels.

The review project concluded that, of the 107 long-term involuntary patients, few if any resembled Kenneth Donaldson in their desire for release or in

their ability to function on their own in the community. However, the panels did conclude that more than half of these patients were inappropriately confined to locked wards in the hospital, and should be placed in nursing homes, group homes, or other less restrictive, community-based, residential settings.

Many of the long-term patients reviewed by the panels had become institutionalized from living for years in confinement on locked wards. Had they had the benefit of periodic external reviews early during their hospitalization, most of them would not have spent a significant part of their lives on locked wards in a state mental hospital.

The *Donaldson* decision came at a time when the goal of deinstitutionalization of mental patients had gained substantial acceptance within the legal, psychiatric, and social work professions. Large reductions in hospital populations had already occurred before the *Donaldson* decision. Nevertheless, the decision did serve to focus attention on the need for periodic review of committed patients to determine who among them should no longer be confined under current legal and psychiatric standards.

The *Donaldson* review project focused interest among law school clinic students on the issue of periodic review, resulting in a successful law suit on behalf of a long-term committed patient, establishing a constitutional right to periodic review[4] and a student note in the *Yale Law Journal*.[5] The law students, psychiatric residents, and hospital social workers who participated in the *Donaldson* review project all gained a great deal in knowledge, practical judgment, and professional skill through their work together, and I attribute much of that to Howard's collaborative approach to the design and implementation of the project.

A Class Action

As I have described, during the 1970s and 1980s, the Yale Law School clinic operated a legal services program at one of the large Connecticut state mental hospitals. Howard was one of the instructors in what was then called the Mental Hospital Legal Services Clinic. He attended every weekly seminar meeting and taught classes on the classification, diagnosis, and treatment of mental illness. He also participated in case rounds in the law clinic. During one end-of-the semester party, students in the clinic presented a parody called "The Wizner of Odds" in which Howard was caricatured affectionately as "Dr. Bananas."

Students in the clinic visited the state hospital on a weekly basis to speak with patients on the wards and in an office provided by the hospital. The local probate court appointed the clinic to represent patients in civil commitment hearings. The superintendent of the hospital cooperated with the Law School by allowing the students and their clinical faculty supervisors onto the wards to speak with patients and staff, even when the clinic brought lawsuits on behalf of the patients, some against the hospital.

One such lawsuit was a class action on behalf of 40 individuals with developmental disabilities who had been warehoused in locked wards at the hospital, some for as long as 20 years. None of these individuals had a diagnosis of mental illness. All of them had been transferred from a state training school operated by the Department of Mental Retardation (DMR) because of what was referred to as "unmanageable behavior." The only "treatment" they received was the administration of megadoses of psychotropic medications, including PRNs; mechanical restraints; and seclusion.

Hospital staff would not provide habilitative services appropriate for persons with developmental disabilities because, as they asserted, they were not trained to do so. The Department of Mental Retardation refused to provide appropriate habilitative services because, as we were told, the 40 individuals were in the custody of the Department of Mental Health and therefore that department was responsible for providing the services.

Faced with this Catch-22, the Law School clinic filed a federal court class action against the Commissioner of Mental Health and the Commissioner of Mental Retardation on behalf of the 40 individuals to vindicate their rights to live in a safe environment, to be free from unnecessary chemical and physical restraints, and to receive habilitative services and training to prevent the deterioration of basic self-care skills.

The Named Plaintiffs

A class action is brought by named plaintiffs on behalf of themselves and all other individuals similarly situated. The two named plaintiffs in this case, whom I shall refer to as Mary and Bill, were representative of the class.

Mary had been confined at the DMR state training school as a 10-year-old child and 20 years later, at the age of 30, was transferred to the state mental hospital, allegedly because of unmanageable behavior. Her diagnosis was "autism with mental retardation."

During her subsequent two decades of psychiatric hospitalization Mary was never diagnosed as having a mental illness. Her only diagnoses were autism and mental retardation. She was treated with psychotropic medication, mechanical restraints, and seclusion. Her hospital record contained repeated entries from staff stating that, in their clinical judgment, Mary did not belong in a psychiatric hospital, was receiving only custodial care, was deteriorating as a result of her inappropriate confinement and lack of behavioral programming, and should be discharged from the hospital to a small, specialized group home in the community.

For two decades Mary resided on a locked ward of the hospital with 30 other female patients. During a three-month period immediately preceding the filing of the lawsuit, Mary received 298 PRNs (in addition to her regular dosage of medications) and was placed in four-point restraints on 72 occasions.

A few years after Mary's arrival at the hospital, Bill, a 30-year-old man with a diagnosis of mild mental retardation, was admitted to the hospital from the same training school from which Mary had come. Unlike Mary, Bill had been at the training school for only a few months before his transfer. Bill's family did not learn of his transfer until they went to visit him at the training school after the transfer had already occurred. The only reason given for Bill's hospitalization was unmanageable behavior.

More than a decade later, Bill remained confined at the hospital. He was never diagnosed as mentally ill. His only treatment consisted of confinement on a locked ward, psychotropic medication, mechanical restraints, and seclusion.

Bill's hospital record contained numerous entries from staff stating that his hospitalization was inappropriate and that there was no training, education, or recreational program available that would enable him to maintain the very good level of functioning he had exhibited at the time of his arrival at the hospital. Virtually from the moment of his arrival, hospital staff members recorded that Bill was showing deterioration of his condition and abilities because of his inappropriate hospitalization and that he needed to be placed in a group home and day program in the community.

When Bill was admitted to the hospital, he was described as being clean, continent, and able to communicate his needs and to follow instructions. He could feed, dress, and bathe himself and care for his other needs independently.

At the time of the filing of the lawsuit, Bill was no longer feeding himself. He needed several showers and changes of clothing each day because of incontinence, "behaving," according to an entry in his chart, "as though not toilet-trained at all." Bill had regressed to the point that he was smearing his feces.

Hospital staff responded to Bill's "challenging behaviors" with the administration of psychotropic medications and mechanical restraints. During a three-month period preceding the filing of the lawsuit Bill received 86 PRNs (in addition to his regular dosage of medication) and was placed in four-point restraints on 10 occasions.

The Law

In its landmark 1982 decision regarding the constitutional rights of persons with mental retardation, *Youngberg v. Romeo*,[6] the United States Supreme Court ruled that individuals with mental retardation in state-operated institutions have a constitutional right to safe conditions of confinement, freedom from unreasonable physical restraint, and training that is required to ensure their safety and to facilitate their ability to function free from bodily restraints. Subsequent court decisions interpreted the *Youngberg* case to include a right to training sufficient to prevent basic self-care skills from deteriorating, and, for those institutionalized at too young an age to have learned basic self-care skills, the right to such training as would enable them to attain the level of self-help skills they would have achieved had they not been confined without that training.

The *Youngberg* Court also held that the constitutional rights of institutionalized persons with mental retardation are violated either when treatment plans and the care provided fail to conform to accepted professional standards or when treatment recommendations that do meet accepted professional standards are not implemented.

If professional evaluators determine that habilitation in a community setting is necessary to provide appropriate care in accordance with professional standards, then institutionalized persons with mental

retardation have a constitutional right to residential placement and programming in the community.

It was clear to the law students and clinical faculty that the conditions on the hospital's locked wards and the treatment of the individuals with developmental disabilities who were confined in them fell woefully short of even minimally adequate professional standards. But we were seeking more than minimum standards for our clients. We wanted no less than that they be discharged from the state hospital to small group homes, with trained staff, and to appropriate day programs, where they might have more normal, satisfying lives and receive habilitation and training that would enable them to realize their potential for productive activity and the enjoyment of life. We were committed to the goal of normalization, a goal that could not be achieved so long as the clients remained institutionalized.

The Settlement

Some time after the lawsuit was filed, I received a telephone call from my friend, Al Solnit, who had recently been appointed Commissioner of Mental Health. I told him that the rules of legal ethics prohibited me from speaking with him about the case unless his lawyer from the Attorney General's office was present, but he was determined to make a proposal for settling the case, so I listened.

Not surprisingly, his proposal was both interesting and creative. He proposed a series of individually focused interdepartmental case conferences for the class members, to be co-chaired by the commissioners of the two agencies—Mental Health and Mental Retardation. The purposes of the conferences would be to generate information regarding the care and treatment of each class member; establish a means by which the service needs of each class member could be reviewed and strategies developed to meet those needs; and provide a forum in which a candid exchange of ideas and perspectives could take place among professional staff from both departments to assure that the class members would receive appropriate care, treatment programs, and services.

The information and strategies generated at the case conferences would serve as the basis for an interagency consolidated treatment and service plan for each class member. The Department of Mental Retardation would assume responsibility for community placement of all hospitalized class members and assure that no future admissions of individuals with developmental disabilities to state mental hospitals would occur unless justified by a psychiatric emergency and then only so long as might be necessary to stabilize the individual.

Finally, the commissioners would agree to place one-third of the class members in community residences and programs within the current fiscal year and the rest within a reasonable time thereafter. The plaintiffs' legal advocates would be active participants in the interdisciplinary case conferences.

After considerable deliberation and negotiations with both commissioners and their lawyers from the Attorney General's office, the law students and their clinical faculty supervisors (Carroll Lucht, Jean Koh Peters, and I) agreed to Dr. Solnit's settlement proposal.

Implementation of the Settlement

What followed was a series of weekly interdisciplinary meetings, co-chaired by the two commissioners and attended by professional staff from the hospital and DMR, law students from the clinic, two law school clinical professors, Howard Zonana, and one or more forensic fellows or psychiatry residents.

The discussions were open and frank. Psychiatrists who headed the treatment team for each class member presented the case. Dr. Solnit pushed them to provide full histories, criticized their written case summaries, and asked pointed questions about the use of medications and mechanical restraints. He visited the class members on the locked wards, usually accompanied by law school clinic students and faculty. He was clearly dismayed by what he heard and saw. He insisted that hospital staff be more professional and caring.

The Commissioner of Mental Retardation was equally dismayed by what she heard and saw and insisted that her staff collaborate with the hospital's staff in improving conditions on the wards, provide programing for class members in the hospital, and move forward on identifying (or creating) community-based residences and programs for the class members.

Howard attended many of the weekly meetings and played an important role in teaching the law students how to be effective advocates at interdisciplinary meetings without "playing lawyer."

By the end of the first six months of meetings, every member of the plaintiff class was participating in a day program. The majority were leaving the

hospital grounds to participate in sheltered workshops, supported employment, or social and recreational programs. Bill was one of them. A few class members were being served in an on-grounds program at the hospital where they were learning (or relearning) daily living and self-help skills and engaging in recreational activities in the community. Mary was one of them. (Carroll Lucht and I further discussed this stage of the implementation of the settlement agreement in a published report.[7])

During the same initial six-month period, 15 of the 40 class members had either moved or been accepted into community residences. Mary had moved to an interim placement at a DMR Regional Center pending development of an appropriate community residence (to which she eventually moved). Bill moved to a group home near the home of his parents.

On the hospital wards, treatment improved dramatically. All class members had their medications reduced and in some cases, terminated. The incidences of the use of PRNs and mechanical restraints plummeted. Hospital staff became energized and professionalized by the attention that was paid to their work by the commissioners at the weekly meetings and by the advocates from the Law School coming onto the wards to meet with them and learn about the services they were now providing.

In little more than two years of the interdisciplinary case conferences, which eventually became biweekly, every member of the plaintiff class had been discharged from the hospital to small community-based residences and day programs.

Howard's collaboration with Law School clinic students and faculty in the class action went far beyond case consultation. He played a vital role in guiding the legal advocates in understanding how to be effective in a nonadversary setting through collaboration with professionals from other disciplines in addressing complex human services challenges. He helped the law students read and understand hospital records and made them aware of the institutional and bureaucratic complexities involved in service delivery and systemic change. Howard was not merely a professional consultant; he was a member of the advocacy team.

The Case of the African Woman Refugee

The third case I will discuss concerns a young woman, whom I shall call Celeste, still in her teens, who was living with her parents in an African country wracked by a violent and brutal civil war. Her village was attacked by rebels. Rebel soldiers forced their way into her family's home. Celeste was forced to watch as the rebels bound her parents and shot them to death. After murdering her parents, the rebels abducted her (along with other girls from the village) for use as sex slaves.

Soon after her abduction, Celeste was dragged into the forest by a group of rebels who blindfolded her and tied her hands. They tore off her clothes, beat her, and raped her, one man after the other. The attack left her, until then a virgin, covered in blood and in excruciating pain for many days. Despite her injuries, she was forced to march barefoot with the rebel soldiers. She was threatened with death or amputation of limbs if she did not submit to daily, repeated, public sexual assaults and gang rapes.

Celeste's bondage in the rebel camp lasted for three months. She suffered a serious injury to her foot, and it became increasingly difficult for her to walk, but she was threatened with death if she failed to keep marching. She watched the rebel soldiers beat, rape, mutilate, and kill local villagers, often cutting off their arms or legs.

Finally, one night, after the rebel soldiers left to attack another village and the guards became drunk and fell asleep, she managed to escape into the forest. She traveled alone for days, surviving on wild berries and stream water until she reached the border of another country, where she sought refuge.

Through a series of fortuitous events and with the assistance of sympathetic acquaintances, she managed to make her way to the United States, was admitted on a temporary basis to enable her to apply for asylum, and joined a small community of African refugees in the New Haven area. They referred her to the Yale Law School's Immigration Clinic.

The Law

To qualify for asylum, an applicant must establish that she has fled her own country because of past persecution and/or a well-founded fear of future persecution that was or would be inflicted on account of her race, nationality, religion, political opinion, or membership in a "particular social group."[8] The asylum application filed by the clinic on her behalf claimed refugee status based on the client's social group—young women living in rebel-held territory during the civil war.

Difficulties With the Case

The Law School clinical faculty and students encountered significant challenges in their representation of Celeste. She missed appointments. When asked about her experience, she often shut down and said very little. She complained of nightmares and flashbacks in which she was back in the rebel camp. She sometimes said that she wanted to die. She was not able to provide details of her experience and was inconsistent in descriptions that she was able to provide.

The law students and their supervisors were frustrated by their inability to conduct productive interviews with Celeste and worried that they would not be able to present a convincing case for asylum. They were puzzled by her lack of emotion when she did describe some of the horrific experiences she had endured, and they worried about her occasional mention of suicide.

The Role of Howard Zonana and the Forensic Fellows

Howard and the forensic fellows are participants in the Yale Law School Immigration Clinic. Along with Howard's colleagues, Madelon Baranoski and Bandy Lee, the fellows attend the weekly seminar meeting of the clinic and play an active role in class discussions. They also provide expert consultation to the law students, and suggest interviewing techniques. In many of the clinic's cases, fellows, under Howard's guidance, perform psychiatric evaluations and write reports that are submitted to the Asylum Office and to the Immigration Court.

In seminar meetings, when the law students assigned to represent Celeste spoke of the difficulties they were having with her case, Howard described techniques that psychiatrists use in interviewing and treating individuals who have experienced severe trauma. He also addressed the students' concerns about the need for assessment of the client's apparent depression and her possible suicidality. Not limiting his advice to preparation of the client's legal case, he also addressed her apparent need for psychiatric evaluation and treatment.

At the request of the legal team, Howard agreed to appoint a forensic fellow to perform a psychiatric assessment. He asked the law students to prepare a letter to him requesting the evaluation and instructed them on what that letter should contain—a description of Celeste and her experiences, the reasons for requesting the evaluation, and the specific questions that they wanted answered. He then helped them formulate what those questions should be.

Obviously, Howard knew very well what was needed, but he wanted to teach the law students and the forensic fellows how to collaborate effectively. The psychiatric evaluator needs as much information as possible about the person to be evaluated and to focus the evaluation on the specific questions that the lawyer wants answered. The lawyer needs to know what important questions the psychiatrist might be able to answer, and the lawyer should inform the evaluator what legal standards apply to the client's case.

The forensic fellow whom Howard assigned to Celeste's case read the background material provided by the law students and met with Celeste several times for a total of more than five hours. The fellow also requested a psychological evaluation from Madelon Baranoski. The fellow then wrote a lengthy report that ruled out malingering; diagnosed post-traumatic stress disorder and severe depression; concluded that, as a result of her psychiatric disorders, Celeste would experience difficulty recalling and reporting what had happened to her consistently and in detail (essential to a finding of credibility by the Asylum Officer and Immigration judge); and recommended treatment for her depression and suicidality.

Howard provided supportive supervision to the fellow in conducting her evaluation and preparing her report. The report was submitted to the Immigration Court in support of the client's claim for asylum, and the judge found Celeste credible despite her inconsistent testimony and lack of emotional expressiveness. The fellow, with the cooperation and support of the law students, was able to persuade her to accept treatment, notwithstanding the stigma attached to mental illness in her culture. With the treating therapist's approval, the law students, whom she had grown to trust, accompanied her to her weekly therapy and waited for her outside the therapist's office, until she was able to attend therapy on her own.

This case exemplifies the contributions of Howard Zonana and the Forensic Psychiatry Program as full collaborators in the legal advocacy work of the Yale Law School clinics.

Conclusion: Learning to Collaborate

In a story about Howard Zonana published in the *Yale Daily News* a few years ago, the reporter described Howard's "relaxed, courteous manner." She quoted him as asserting that "doctors don't like talking to lawyers." However, he went on to say that, while medical students and law students enter their professional studies with differing perspectives, they should learn that "both doctors and lawyers can work together to fulfill a common need."

The teaching legacy of Howard Zonana in forensic psychiatry epitomizes the belief that doctors and lawyers can learn to collaborate to achieve professional goals and to meet the needs of individuals who are simultaneously patients and clients.

Through his teaching role in the Law School's clinical program Howard has provided a model for both law students and forensic fellows, showing that lawyers and doctors can collaborate in a cooperative, open-minded, mutually respectful, professional relationship. Howard and his colleagues and the forensic fellows are an integral part of the Law School's advocacy efforts—partners, not merely advisors, collaborators, not merely consultants.

Together, we have introduced law students to psychiatry, psychiatric methodology, and medical ethics. Together, we have introduced forensic fellows to law, legal methodology, and legal ethics.

The personal friendship that Howard and I have enjoyed for many years has generated a level of mutual trust and respect that has enabled me to be receptive to his approach to interdisciplinary collaboration. I have learned from working with him over the years that, while professional boundaries should be recognized and respected, those boundaries should nevertheless be sufficiently porous to allow true collaboration to occur.

In such a collaboration, professionals from each discipline must learn the basics of each other's field of expertise, in theory and in practice. They must respect each other's professional role and expertise. And each must incorporate the other's professional role and expertise in the collaborative work. Thus, to form a successful collaborative relationship, psychiatrists should learn and apply legal standards, and lawyers should learn basic psychiatric methodology in interviewing and counseling.

It is inevitable that this level of collaboration will, at times, reveal our differing professional ethics and obligations with respect to clients' behavior, needs, and wishes. But just as Howard has been willing to talk these differences through with me and my clinical faculty colleagues in an informed, professional, cooperative, mutually respectful manner, so have we been able to establish a model of that form of interdisciplinary, collaborative problem-solving for the law students and the forensic fellows in the Law School clinic.

Learning to collaborate—psychiatrists with lawyers, lawyers with psychiatrists—is the teaching legacy of Howard Zonana in forensic psychiatry. This is a legacy that reflects not only his important contribution to medical and legal education, but even more significant, his profound commitment to effective and humane medical practice and to justice.

References

1. Goode S: Note, the role of counsel in the civil commitment process: a theoretical framework. Yale L J 84:1540–63, 1975
2. O'Connor v. Donaldson, 422. U.S. 563 (1975)
3. Crane L, Zonana H, Wizner S: Implications of the Donaldson decision: a model for periodic review of committed patients. Hosp Community Psychiatry 28:827–33, 1977
4. Fasulo v. Arafeh, 378 A.2d 553 (Conn. 1977)
5. Tepper G: Note, procedural safeguards for periodic review: a new commitment to mental patients' rights. Yale L J 88:850, 1979
6. Youngberg v. Romeo, 457 U.S. 307 (1982)
7. Lucht C, Wizner S: Of scarce resources and gilded cages: a case study. McGill J Educ 27:377–88, 1992
8. Immigration Nationality Act, 8 U. S. C. § 1158(b) (1996)