

# AAPL Newsletter

American Academy of Psychiatry and the Law

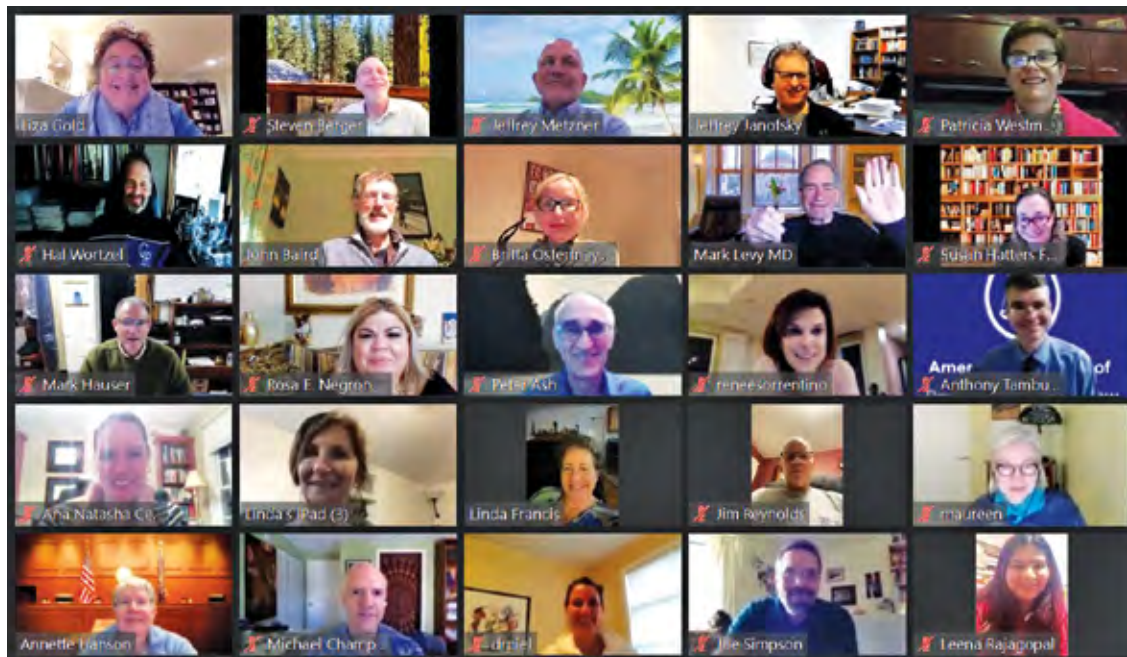


Spring 2021 • Vol. 46, No. 2

## 52nd Annual Meeting: Forensic Psychiatry and AAPL Post-COVID

Renée Sorrentino, MD

Program Chair



Wrapping up the 2020 Virtual Meeting.

The 52<sup>nd</sup> Annual Meeting and second virtual meeting will be held on October 21<sup>st</sup>-23<sup>rd</sup>, 2021. President Liza Gold's theme for the Annual Meeting is "Forensic Psychiatry and AAPL Post-COVID." The impact of the pandemic on the practice of forensic psychiatry has resulted in obvious changes but the full extent has not been studied. This year's meeting will focus on a better understanding of the pandemic effects as well as the implications for AAPL moving forward.

The conference will be held Thursday through Saturday, 10-6pm EST, with a Thursday evening panel, 7pm-9pm EST, and a Friday evening happy hour, 6pm-7pm EST. The conference will not offer courses (including the review course), as these courses will be offered throughout the year as part of the new Virtual AAPL platform.

The reallocation of courses provides an opportunity to accept a higher number of presentations during the annual conference. Last year's first virtual AAPL conference was highly attended and we expect an even larger audience this year. Although we will not gather in Vancouver as planned, mark your calendar for Vancouver in 2024. As we look to this year, we are excited to announce our keynote speaker series for 2021. The speakers are Sue Klebold and the Honorable Mary Grace Rook.

Sue Klebold is the mother of Dylan Klebold, one of the school shooters in the Columbine High School massacre which occurred on April 20, 1999. She is the author of a memoir, *A Mother's Reckoning*, which details the signs she "missed" in her son. When the shootings occurred, Dylan and

his co-perpetrator, Eric Harris, were seniors at Columbine High School. They arrived at school on the morning of April 20 dressed in black trench coats. The shooting that erupted resulted in 13 fatalities and 24 injuries. The rampage ended when Dylan and Eric killed themselves. Ms. Klebold described her initial reaction to her son's involvement as disbelief, attributing his role as secondary to Eric Harris, who coerced and brainwashed Dylan. Her perspective changed when she was confronted with the "Basement Tapes," a series of videotapes filmed in her basement. The videos depict both Harris and Klebold bragging about their plan of destruction. Ms. Klebold will share her reflection on her son's role in one of the largest school massacres, as well as the signs

(continued on page 2)



## American Academy of Psychiatry and the Law

### Editor

Joseph R. Simpson, MD, PhD

### Associate Editors

Philip J. Candilis, MD  
Ryan C. W. Hall, MD  
Stephen P. Herman, MD  
Neil S. Kaye, MD  
Britta K. Ostermeyer, MD, MBA  
Karen B. Rosenbaum, MD  
Renée M. Sorrentino, MD  
Joel Watts, MD

### AAPL Photographer

Eugene Lee, MD

### Former Editors

Susan Hatters Friedman, MD (2016-2018)  
Charles Dike, MD, MPH (2008-2016)  
Victoria Harris, MD, MPH (2003-2008)  
Michael A. Norko, MD (1996-2003)  
Robert Miller, MD PhD (1994-1996)  
Alan R. Felthous, MD (1988-1993)  
Robert M. Wettstein, MD (1983-1988)  
Phillip J. Resnick, MD (1979-1983)  
Loren H. Roth, MD, MPH (1976-1979)

### Officers

#### President

Liza H. Gold, MD

#### President-elect

Susan Hatters Friedman, MD

#### Vice President

Hal S. Wortzel, MD

#### Vice President

Britta K. Ostermeyer, MD

#### Secretary

Karen Rosenbaum, MD

#### Treasurer

Stuart A. Anfang, MD

#### Immediate Past President

William J. Newman, MD

The AAPL Newsletter is published by AAPL, One Regency Drive, PO Box 30, Bloomfield, CT 06002. Opinions expressed in bylined articles and columns in the Newsletter are solely those of the authors and do not necessarily represent the official position of AAPL or Newsletter editors.

Manuscripts are invited for publication in the Newsletter. They should be submitted to the editor via email to NewsletterEditor@aapl.org

The Newsletter is published in Winter (deadline for submission is November 15), Spring (deadline March 1), and Fall (deadline July 1).

[www.aapl.org](http://www.aapl.org)

© 2021 AAPL. ALL RIGHTS RESERVED.

## COVER STORY

### Annual Meeting

*continued from page 1*

she missed that might prevent future acts of violence.

The Honorable Mary Grace Rook, Magistrate Judge of the Superior Court of the District of Columbia, will discuss her work with HOPE Court, a novel approach to child survivors of sex trafficking. HOPE Court was piloted in 2017 to address the rehabilitation of victims of child sexual exploitation. Following the 2014 Sex Trafficking of Minors Prevention Act, which mandated law enforcement be trained to identify victims of human trafficking and to report any such suspicions to Child Protective Services, many identified minors either remained involved in the judicial system or were runaways. HOPE

Court's mission was to address the needs of the individual minor with a goal of rehabilitation. HOPE Court employs a trauma informed approach and is described as a unique approach to empowering rather than shaming individuals. Rather than an adversarial approach, HOPE Court provides an array of services to the minor including mental health treatment, educational advocacy, support through victim organizations, mentoring, medical care and vocational training. Judge Rook will share her instrumental role in combating human trafficking through rehabilitation.

We look forward to our virtual gathering in October. Please reserve your calendar for the second virtual AAPL conference in the convenience of your home. ☪

### CALL FOR AWARD NOMINATIONS

Learn more about how to make a nomination at: [psychiatry.org/awards](http://psychiatry.org/awards)

#### MANFRED S. GUTTMACHER AWARD

**Description:** The Manfred S. Guttmacher Award, established in 1975, recognizes an outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or other work.

**Eligibility:** Original works in the field of forensic psychiatry presented and/or published between May 1 and April 30 of the award review year.

**Nomination Requirements:** Six copies of the work; a statement of the nature and importance of its contribution to the literature may also be provided

**Deadline:** June 1, 2021

<https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/guttmacher-award>

#### ISAAC RAY AWARD

**Description:** The Isaac Ray Award, established in 1951, recognizes a person who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. It is a joint award of the APA and the American Academy of Psychiatry and the Law that honors Isaac Ray, M.D., one of the original founders and the fourth president of the American Psychiatric Association.

**Eligibility:** Outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence.

**Nomination Requirements:** Letter of nomination (sent with consent of candidate); nominee's CV; supplemental letter from a second nominator

**Deadline:** June 1, 2021

<https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/isaac-ray-award>

# Virtual AAPL Completes Phase 1; Phase 2 Underway!

Liza H. Gold, MD



At the time I wrote the last newsletter column, we were heading into a long dark winter. Now, as I look out my window, I see the crocuses

starting to bloom. Spring has always been my favorite season (allergies notwithstanding) and this year, more than ever, it seems spring brings more renewal and hope than we could have hoped. We are only at the beginning of the end, I know, but what better time for us to position AAPL to meet the challenges of the post-Covid “new normal?”

After the 2020 live-streamed Annual Meeting, we had to address the question of where does AAPL go from here? We re-organized the Virtual AAPL Task Force (VAAPL), now under the leadership of tech-savvy co-Chairs Dave Burrows and Anne Hanson, to plot our path forward. In addition, former AAPL President Charles Scott has agreed to serve as our first Virtual AAPL Program Chair, a position that I suspect will become permanent even after we are able to resume in person Annual Meetings.

I am delighted to report that we have developed a road map that consists of two “phases.” The first was making sure that AAPL could advance its educational mission through online education since in person meetings are still on hold through this year. Thanks to the hard work of Executive Director Jackie Coleman and her staff, we began our VAAPL “Phase 1” program of year round, online CME courses in January 2021, with Dr. Scott’s course, Substance Use Disorders and the Law: From High to Homicidal. In February, former president Phillip Resnick and his faculty provided an adapted version of the Forensic Review Course. Attendance at both exceeded our expectations.

Although the formal post-event evaluations have not yet been received, informal feedback has been extremely positive. Upcoming offerings will include an inaugural Town Hall meeting presented by the Diversity Committee, a monthly expert lecture series, a course on correctional psychiatry and a course on forensic evaluations in terrorism cases.

---

*“We are prioritizing the ability to record, store, and provide on-demand access to live-streamed or pre-recorded courses.”*

---

In addition, we can now accept proposals from members who wish to provide online educational events for CME credit. The Education Committee, co-chaired by myself and Anne Hanson, MD, has approved criteria for four hour courses (click [HERE](#) for instructions and forms) and 2 hour panels (Click [HERE](#) for instructions and forms). We also welcome proposals for our new AAPL town hall meetings (Click [HERE](#) for instructions and forms). Town hall meetings will be limited to members only and will not provide CME credits. Unlike the Annual Meeting, VAAPL is not limited in the number of presentations we can live stream. We will be happy to work with members to design informative, interactive, and enjoyable educational events.

After our first two online courses, many members asked whether recordings would be available on demand. Welcome to “VAAPL Phase 2,” which is well underway. The VAAPL Task Force is in the process of assessing AAPL’s resources and requirements for a comprehensive online educational platform that can support many innovative forms of online learning.

We are prioritizing the ability to record, store, and provide on-demand access to live-streamed or pre-recorded courses.

The VAAPL Task Force is also addressing the AAPL website as an integral part of VAAPL Phase 2. Since VAAPL educational offerings will be provided on a rolling basis year round, the website needs to be synced with the VAAPL programming to keep members informed of and able to register for newly scheduled events. The website’s ability to provide other important information for and about members is also a clear priority.

Perhaps the most exciting development of all is the return of the AAPL “tsochke,” swag usually given out to Annual Meeting attendees upon registration. This year, those who register for VAAPL CME events, including the Annual Meeting in October, will receive, via snail mail, the custom designed and fashionable AAPL face mask! The attached photo models the sleek look of this limited edition (we hope!) “must have” for our times.

This alone should be motivation to attend at least one VAAPL offering!

More seriously, I think I am safe in predicting that although we may not need to wear face masks indefinitely, VAAPL will become an integral and exciting part of AAPL’s educational mission. Member participation, through submitted proposals, suggestions for innovation, and evaluations of our online endeavors will be critical in helping AAPL thrive through and after these difficult times.

The circumstances that have necessitated an abrupt (for many of us) pivot towards the digital world have been far from ideal or desirable. Nevertheless, I am reminded of Gandalf’s response to Frodo’s lament about the peril in which he found himself. “I wish it need not have happened in my time” said Frodo. “So do I,” said Gandalf, “and so do all who live to see such times. But that is not for them to decide. All we have to decide is what to do with the time that is given us.” For AAPL, that means making a commitment to VAAPL that will create possibilities for growth we have not yet even imagined. ☯



## The 21st Century CURES Act and Information Blocking: A new regulatory framework

Jeffrey S. Janofsky, MD



Under HIPAA (1), covered entities have always been required to provide their patients access to their medical records, whether they were in electronic or paper form. Several exceptions to this requirement existed under HIPAA which are unreviewable, including psychotherapy notes; “information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding”; and, if the covered entity is a health care provider acting under the direction of a correctional institution, an inmate’s request to obtain a copy of health information can be refused if it would harm the health or safety of other inmates or correctional personnel. Covered entities can also deny a patient access to their records under several reviewable conditions, including if a licensed health care provider determines that the access is “likely to endanger the life or *physical safety*” of the patient or another or if the information released makes reference to another person and the health care provider determines the access requested is “reasonably likely to cause substantial harm to such other person.” (2) (Emphasis added.) The decision to deny access can be made within the 30-day time period (with one additional possible 30-day extension) allowed under the original HIPAA regulations. (2)

Congress passed the 21<sup>st</sup> Century CURES Act in December 2016. The Act, among many other things, contained language intended to promote electronic medical record interoperability and to prevent “information blocking.” The CURES Act defines information blocking as practices that interfere with the use of electronic health information (EHI) when a

health care provider knows that such a practice is unreasonable and is likely to interfere with use of EHI.

On May 1<sup>st</sup>, 2020 the Office of the National Coordinator for Health Information Technology (ONC) published the Final Rule implementing the Act in the Federal Register. (3) The APA and the AMA have been heavily involved with ONC in writing and seeking clarification of the rules. Because of the COVID-19 pandemic, ONC pushed back the compliance date for the new rules to April 5<sup>th</sup>, 2021. The new rules only apply to electronic medical records systems and not paper notes. Like HIPAA, they do not apply to psychotherapy notes, or to “information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.” It is also unlikely the new rules will apply to records a private practitioner keeps on their own computer in a word-processing document.

Those of us who work in health care systems with electronic records should be aware that the new rules require electronic record systems to make their office notes, lab results, and other diagnostic reports available to patients *as soon as the physician’s office receives an electronic copy.* This is significantly different from the prior HIPAA rules, which gave providers 30 days or more to respond to a patient’s request for medical records. This means that a patient’s progress notes from an inpatient or outpatient visit could be available to the patient as soon as a finalized version is placed in the record in real time. Proponents of this so-called “open notes” movement see this as an advantage, but discussions around this issue are generally limited in the literature to outpatient progress notes and not inpatient psychiatry notes. The open notes movement also advocates for writing progress notes in language

more accessible to patients, which may over time change the standard of care for how physician documentation occurs. For example, proponents of the open notes movement advise against using the term “SOB” in progress notes because of the concern that this common medical acronym may be misinterpreted by patients. (4) Whether open notes will have positive or unintended negative consequences for patient care remains to be seen.

Failure to facilitate this real-time access to patient notes is termed “information blocking” under the new regulations. ONC identified eight specific categories of information blocking exceptions to implement the reasonable and necessary exception language that were valid reasons to restrict patient information access created by Congress under the CURES Act. The category most relevant for physician practitioners is the “preventing harm” exception. To satisfy this exception physicians must hold a reasonable belief that the disclosure would endanger life or physical safety of a patient or another person. Notice that like the prior HIPAA exception, this applies only to potential physical, not psychological, harm. Unlike the prior HIPAA rules however, the determination of whether a particular progress note might meet this requirement must be done at the same time the note is written, not retrospectively. Therefore, the electronic health record needs to be set up to allow a particular note or a particular part of a note to be identified as something that could harm physical safety, and should also provide a means for the physician to contemporaneously identify why the note meets the criteria for the exception. While failure to document why a particular note meets the preventing harm exception could lead to administrative fines under the new rules, I can imagine that in the future, malpractice litigation could arise around a physician’s failure to identify a note that should have been identified as falling under a preventing harm exception.

The CURES Act and its subsequent regulations, like HIPAA and its regulations, are complex. The AMA (5,6)

(continued on page 18)

## Changing with the Times

Joseph R. Simpson, MD, PhD



With the development and approval of multiple vaccines against the COVID-19 virus, control of the global pandemic the virus unleashed appears imminent.

This is a phenomenal welcome development, but it goes without saying that the pandemic changed the (human) world in numerous ways, and it won't be going back to the *status quo ante*. Most businesses and other organizations have had to adapt to new realities, and AAPL is no exception. The first major test for AAPL was the 2020 Annual Meeting, which took place online over two consecutive weekends in October. Thanks to the Herculean efforts of several stalwart AAPL members and staff, including Virtual Task Force Head Annette Hanson, Program Co-Chairs Trent Holmberg and Ryan Wagoner, and Executive Director Jackie Coleman, among others, the meeting accomplished its goal of effectively delivering quality educational content to the AAPL membership with a minimum of technology-related headaches.

Nevertheless, many AAPL members were disappointed when they found out that the 52<sup>nd</sup> Annual Meeting later this year will also be virtual. No matter how effective a virtual meeting might be, there are many elements of an in-person conference which are necessarily impossible to replicate remotely, at least using the virtual formats common today. Online, there is no way to recreate the experience of randomly bumping into an old colleague in a hotel corridor, in front of a poster, or when you both reach for some much-needed coffee at a coffee break; nor of organizing a mini-reunion dinner with graduates and faculty of a forensic fellowship that continues late into the night, possibly spilling over to a nearby wine or cigar bar for those so inclined. Also missing is the site visit, traditionally put on by the International Relations Com-

mittee, which escorts a small group to tour a local mental health program or other interesting forensically-related destination. I still have the FBI baseball hat I bought in the tiny "gift shop" (it was more of a large closet, really) at the FBI's Boston Field Office at the end of the site visit during the 2011 Annual Meeting.

So, we can guess that many AAPL members are looking forward to the resumption of traditional in-person meetings starting in October 2022. In the meantime, AAPL, being a dynamic and responsive organization, won't simply convene another virtual meeting this year and call it good. The pandemic has accelerated the drive towards what was already ahead for AAPL: a robust digital presence. In order to thrive, as well as to attract and retain younger members, AAPL needs to become a serious player in the digital arena; this is now beginning. Dr. Gold's President's Column in this issue lays out the strategic plan. AAPL has already begun to offer online educational content with CME credit outside of the Annual Meeting. Throughout the year, there will be a variety of such programs available. Another new feature will be virtual town hall meetings, where interested parties can interact with the members of AAPL Committees and learn more about them. Most Committees have already scheduled these, and many will have already occurred by the time you read this.

In addition to the great new educational content and opportunities for interaction, AAPL is committed to bringing its website into the 21<sup>st</sup> Century. These days, many people never touch cash, and don't have a checkbook. In fact, I'd bet that some people reading this have never even *seen* a checkbook! "Digital natives" now get all information, both for their profession and otherwise, from their laptop or smartphone. The days of having to use a fax machine, for anything, are long gone. Services such as DocuSign<sup>®</sup> have made the need for the exchange of physical paper (so-

called "hard copy") unnecessary most of the time. Websites are expected to be updated regularly, and to provide full functionality for all or nearly all transactions.

In this brave new world, AAPL is going to build a website that can hold its own. This will of course require additional expenditures, which is one of the major reasons that AAPL, with its relatively small budget, is a little late to this particular party. Websites don't build themselves (not good ones anyway), and proper design and maintenance are tasks too big for amateur volunteers.

As for the Newsletter, hyperlinks will now be preserved in the PDF version that appears on the website. This is new, so please bear with us if there are some glitches, and let us know if you find links that don't work. I'm sorry to say that we are unable to activate the hyperlinks in the mailed copy. However, if you're still early in your career, I wouldn't be surprised if, in a couple of decades, you'll be reading the Newsletter on some kind of "smart" paper that is both connected to the Internet and also disposable. Of course, that's if you don't just download it from the cloud directly into your cerebral cortex – but that's a topic for another article. ☪

### AAPL Awards Committee Seeks 2021 Nominations

The AAPL Awards Committee would like your help. We would be interested in receiving nominations by June 1 for the following awards:

**Red AAPL** – For AAPL members who have provided outstanding service to AAPL, e.g., through committee membership.

**Golden AAPL** – For AAPL members over the age of 60 who have made significant contributions to the field of forensic psychiatry.

**Seymour Pollack Award** – For APA members (who may not be AAPL members), who have made distinguished contributions to the teaching and educational functions of forensic psychiatry.

**Amicus Award** – For non-AAPL members who have contributed to AAPL.

**Howard V. Zonana, MD Best Teacher in Forensic Fellowship Award** – For outstanding faculty member in fellowship program.

**Please send your nominations to Charles Scott, MD, Chair of the Awards committee at [clscott@ucdavis.edu](mailto:clscott@ucdavis.edu).**

## Ask the Experts

Neil S. Kaye, MD, DLFAPA

Graham Glancy, MB, ChB, FRC Psych, FRCP (C)

Neil S. Kaye and Graham Glancy will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to [nskaye@aol.com](mailto:nskaye@aol.com).

This information is advisory only, for educational purposes. The authors claim no legal expertise and should not be held responsible for any action taken in response to this educational advice. Readers should always consult their attorneys for legal advice.

**Q:** Can you provide some advice on the forensic aspects/applications of telemedicine?



**A. Kaye:**

Telemedicine typically refers to the use of telecommunications technology to assist in the practice of medicine. It is a broad

term and encompasses telephone, teleconferencing, video-chatting, e-mail, text messaging, and instant messaging. The benefits of telemedicine are obvious, including: convenience for patients, greater availability of services (especially rarer specialty consultation to rural areas and underserved populations including forensic settings) and potential cost/time savings for doctors, patients, insurers, and institutions.

Most states, and the federal government through Medicare, regulate the practice of telemedicine. Most of these laws are similar and include at least three key provisions of which all physicians must be mindful. These include: (1) defining the practice of medicine to be occurring where the patient is located; (2) noting that reimbursement is to be the same as for in-person services; and (3) noting that treatment and consultation recommendations, including issuing of a prescription, will be held to the same standard of care (SOC) as those

in a traditional in-person encounter (including the same degree of medical recordkeeping). Because of these requirements, it is imperative that the doctor know the patient's location during the interaction and that the doctor have a license to practice medicine in that state. Even a phone call to an active patient residing in an adjoining state could be a criminal activity (practicing medicine without a license) or result in sanctioning by the state medical licensing board.

Traditionally, medical malpractice suits require an examination of four specific elements often referred to as the "Four D's:" was there a **D**ereliction of **D**uty that **D**irectly caused **D**amages? More specifically, the dereliction refers to a breach of the applicable standard of care (SOC). Two variables determine the traditional standard of care within a given jurisdiction: (1) the means of comparison between the conduct of the defendant-physician and other physicians, and (2) the pool of physicians to which the defendant-physician is compared. These variables can be outcome-determinative in any given medical malpractice case. Under the means of comparison variable, jurisdictions are divided between the custom-based standard and the reasonable-physician standard. Traditionally, courts applied the custom-based standard, which compares the defendant-physician's actions to medical custom. Under this standard, the fact-finder determines whether the defendant has complied with the industry norms. However, many states have moved away from the custom-based standard and adopted the reasonable-physician standard. The reasonable-physician standard requires the fact-finder to determine if a reasonable physician would have followed the defendant-physician's course of action in the same or similar circumstances.

It is the conflict between the "doctrine of sameness" and the traditional medical malpractice approach that

opens the door to significant liability for doctors practicing telemedicine. Most telemedicine laws state that the care delivered via telemedicine will be exactly the same, and held to the same standard, as that delivered in face-to-face encounters. In other words, the law states that any diagnosis made remotely, and any treatment or consultation advice rendered via telemedicine, must be indistinguishable from the usual practice of seeing a patient in person.

More simply said, the effect of these laws is in declaring that the "similar training-similar circumstances" approach is now being altered to be interpreted as similar training-different circumstances. In other words, it appears that the jury will be asked to decide whether or not the defendant doctor did what a similar doctor would have done in a face-to-face encounter. In proving this, expect the plaintiff to call nice, personable, possibly older doctor experts who will testify that they would have laid on hands as millennia of doctors have always done. The plaintiff's experts will likely opine that had an in-person, face-to-face encounter occurred, the diagnosis would have been more accurate or different, or that a physical examination would have yielded a different conclusion and treatment intervention, avoiding the claimed injuries. At that point, the defendant doctor (and insurer) can take out their checkbooks.

In addition, the law requires the same documentation for both types of visits. The need to go back to the file or EMR and complete a note after each telemedicine encounter must be stressed. Too many medical malpractice cases are indefensible, not because of actual malpractice, but rather because the documentation is insufficient to show the doctor's thinking, rationale, deliberations, and actions. Telemedicine, by its very nature, makes contemporaneous documentation more challenging, but that is neither an excuse nor a defense for non-compliance with the SOC regarding documentation. Perhaps something that may help is an addendum

(continued on page 7)



## Ask the Experts

*continued from page 10*

that an examination was “limited” due to the fact that the encounter was via telemedicine, although a savvy plaintiff’s expert will dispute that this is a basis to change the SOC applicable to the case. Therefore, it is important that the documentation indicate what was done, why it was done, and how the diagnosis was made, even with telemedicine, so that an appropriate defense can be made if there is a lawsuit at a later point.

So far, most of these cases are being settled by the insurers, as they are extremely difficult to defend. The reality is that most lay people (jurors) will simply never believe that telemedicine and face-to-face are the same, and they will continue to believe that telemedicine, while convenient, is simply inferior.



### A. Glancy:

I would like to offer her some tips on a practical day-to-day level with the following caveat. There are many areas where, when

members write in to “ask the experts,” I can give an answer based on my 38 years practicing forensic psychiatry and involvement with various organizations. I confess in this case that I am not an expert in telemedicine and so I consulted a friend and colleague, Dr. Pam Hoffman at Yale, who gave me some pointers to pass on to you.

First, as Dr. Kaye has advised, look up and understand the relevant licensure requirements, keeping in mind that these requirements vary from state to state. And, you must be sure you know the location of the person and how they can be contacted at that location. Also be aware that if you are considering prescribing controlled substances there may be different rules and regulations. It is important that you prepare the environment for any telemedicine encounter. This includes consideration of a background. Some virtual backgrounds are problematic due to blurring or

fuzziness that are difficult to tolerate. You can also buy a background, such as a bookshelf full of academic books, which can appear behind you and gives a professional appearance. You should consider how you dress, keeping in mind this is a professional encounter. You may want to rehearse the encounter to ensure that the technology works and perhaps ask for help from a friend or colleague about your presentation.

Second, consider patient selection. This would include consideration about whether the patient has both access to the technology and at least a minor degree of literacy regarding the technology. The patient may need help from a family member (usually their 15-year-old kid) setting up and starting the interview. This does raise the issue of confidentiality. It is within your power to ensure that no others are in the room at your end, except in specified circumstances, but you can only attempt to control whether friends and family members, or even lawyers, are in the room at the other end. Ask the person if they are recording and if this is not okay with you, specify that you are not allowing any recording.

Full and informed consent to the session is as important as it would be for an in-person interview. You have to give consideration about whether this is given in writing, presenting logistical problems, or verbally. If you are recording the interview/encounter, then the disclaimers and consents should be made part of the video record. This should include any usual warnings about mandatory or discretionary duty to warn or disclose. Ensure that you document this carefully. One issue that could conceivably arise is whether you are actually interviewing the intended patient or evaluatee, or if another person has slipped in for the interview. If you have any doubts it is probably best not to proceed. This issue may be particularly apposite if there is an issue of potentially prescribing controlled substances. Asking to see an ID and taking a screen shot is possible.

Another issue that may arise is what you would do if the patient reveals

suicidal or homicidal thoughts to you, or any other emergency arising during the interview. You should have a procedure in mind prior to the interview. This could involve calling emergency services, or contacting friends or relatives. Whatever you choose to do, you should have the means to contact these people prepared in advance should this situation arise. More commonly, there are technological emergencies. This involves problems with Wi-Fi or sound. In this case also you should have some phone numbers ready to see if the problem can be easily resolved.

You may want to do some asking around and research about possible platforms. First, they have to be HIPAA-compliant. Second, it may be important that they can integrate easily into an existing EMR system, which might include appointment scheduling. Perhaps most importantly is that you may require 24/7 technical support.

There are certain things that appear on a video that are more noteworthy than in real life. For instance, it is helpful to make an effort to look into the tiny light of the camera, rather than the image on the screen. It can also be important to measure the space between you and the camera as we sometimes appear bizarre or even frightening if we move right into the camera. When stage actors are moving to television or film, they have to be trained to tone down their expressions and movement, because everything seems “bigger” on a video or film. You may also want to cut down on hand gestures, if this applies to you, as your hands are sometimes enormous on the camera. On some platforms you can test out the camera and the sound in rehearsal and this can give you an idea of how you are perceived by others.

### Take-Home Points:

The alarm bell has been sounded. Doctors need to decide if they want to continue to use telemedicine in either the clinical or forensic arena or both, and if so, what special precautions must be taken to protect the doctor.

*(continued on page 18)*

## The Brave New World

Jacquelyn Coleman, CAE



This is a really unsatisfactory headline for what I plan to talk about in this column. I think I would have gotten in trouble for “The Dark

Side of VAAPL,” however. And it would have been overly dramatic.

I am actually very excited about all the things VAAPL, which stands for “Virtual AAPL,” is going to do. This column is not a complaint.

You can read those details in Dr. Gold's column on page 3. We have COVID to thank because these various projects had been discussed for many years, but there just wasn't the energy or initiative to get them over the finish line.

For background, let me remind you that every 4 years we have to reapply to the Accreditation Council for Continuing Medical Education (ACCME) to be allowed to offer CME credits for our educational activities. Wouldn't you know it – this is the year.

There are two distinct parts of the process: a “Self-Study” that answers questions about our overall CME program, and an examination of all our CME activities to make sure we have followed all the ACCME regulations applicable to that event.

This has always been a stress-filled process. Those of you who have had visits by various accrediting bodies over the years know what I am talking about. The process was entirely upended about 10 years ago, but has been stable for some time, as had our activities, so at least we were able to standardize our approach.

The process hasn't changed but our activities now have. With the exception of the MOC exam, we have not had online activities. The requirements for accrediting online activities are different. As just one example, there is the requirement to keep track of attendance for those

who want CME. This has been very easy with the Annual Meeting and the Forensic Review Course – you show up with your CME certificate filled out, we initial it, and since it has two parts, you have a record and we have a record.

But how do you make a process for a virtual activity? Unlike many larger organizations, AAPL doesn't have a “learning management system” that can track CME activities. There is a search process being conducted now and I am hopeful we will have one soon. Until then we have to address each activity separately, which requires a lot of hands-on work.

But back to the present: by the time you read this, those of you who have taken either the Course by Dr. Scott on Substance Use Disorders and the Law: From High to Homicidal or the Forensic review Course Update will have received a link to a survey that will serve as an evaluation and an application for CME credits. There will be a deadline date to complete the survey. A certain amount of time after the survey's deadline date, we will send CME certificates. I am sure you can understand that we can't individually send certificates upon request. This is just one example of the adaptation required.

Another twist is that each activity we offer is a separate activity. The Annual Meeting and the Review Course are separate activities, as is the MOC self-assessment, so three activities per year. If you read Dr. Gold's column about the things that are planned, each individual course, panel, etc. for which we offer CME is a separate event, and the requirements are the same for a one-hour-credit event and a 32-hour-credit event.

So, let me thank you in advance for your patience, as we look forward to launching a Learning Management system.

Now back to the ACCME, you may remember that each time we are up for reaccreditation, we survey our membership as to your satisfaction

with the CME that has been offered and your learning needs. We will be sending that survey shortly.

And finally, one of the easiest parts of our reaccreditation application is that we can skip over all the parts related to commercial support, since AAPL gets no commercial support. The only part that has been of concern is financial conflict of interest of our planners or presenters. The ACCME is in the process of implementing new standards for commercial support. They are not applicable to this accreditation period, but we expect a whole new process in the next few years.

This column would not be complete without my heartfelt thanks to the AAPL staff for their hard work and dedication over the course of many years but especially in the past 13 months. So, thank you (in alphabetical order) Haley Burns, Sara Elsdon, Marie Westlake, and Sania Zaheer. ☺

### Interested in Advertising in the AAPL newsletter?

**Display:** Display advertising is available in one size only. (4-3/4 wide by 4-5/8 high) The price of a display ad is \$300.00. The ad MUST be camera ready to avoid additional typesetting charges. If ample notice is given, we will typeset your display ad for a charge to be determined by the Editor.

**Classified:** Classified advertising is measured by column inch. A column inch contains approximately 30 words. Only AAPL's standard type and column sizes will be used. The first (3) words of the ad may be in bold-face type, no other modifications are allowed. The rate is \$30.00 per column inch. Classified ads must be under 150 words. If the ad is over 150 words it must be submitted as a display ad. A 50% discount will be given to nonprofit organizations. No other discounts or commissions are allowed. Example ads are available upon request.

#### Advertising deadlines:

November 15 (Winter issue)

March 1 (Spring issue)

July 1 (Fall issue)

**Contact the AAPL Executive Office to obtain the order form.**



## Canada Killings and Autism Spectrum Disorder

Stephen P. Herman, MD



The decision in a tragic case came down on March 3<sup>rd</sup>, 2021 in Toronto. (1) Ontario Superior Court Justice Anne Molloy refused to use the

defendant's real name in her 69-page ruling, because the media had publicized it enough – much to his delight. She did not want to give him the satisfaction of seeing it in her decision.

Toronto began its long journey to cityhood about 13,000 BCE, when a warming period caused glacial ice to retreat north. Human settlers arrived around 9000 BCE. Further warming provided a temperate climate. When Europeans arrived in the 16<sup>th</sup> Century, they brought horrendous diseases, wiping out about half the population of aboriginal peoples of southern Ontario and across the Great Lakes. Europeans also were responsible for many wars among the indigenous people. With the arrival of the Senecas, the area first received its Iroquois name, meaning “where there are trees in water.” This referred to the many weirs constructed to catch fish. The Iroquois were displaced by another indigenous group; then came the French, followed by the British. Canada eventually attained its independence from the British, after years of crime, sickness and other horrors. Often known ironically as “the city that works,” Toronto has its share of the problems found in other cities across North America.

These include the mass murder that occurred on April 23<sup>rd</sup>, 2018, when Mr. Doe, after weeks of planning, drove a rented van on the sidewalk of a major street, purposely running down pedestrians. He killed 10 people and severely injured another 16. The Crown's 10 charges of murder and 16 charges of attempted murder were conceded by the defense. The issue at

trial was whether Mr. Doe was NCR, or Not Criminally Responsible. This Canadian term has replaced the older “insanity defense.” Judge Molloy wrote,

...[NCR] rests on the principle that a person should not be held criminally responsible for something they did when their mind was so deranged that they did not know what they were doing or were incapable of knowing the difference between right and wrong. This could be because: a) they did not know the nature and/or quality of their act (e.g., they believed, because of a delusional disorder, that they were killing Satan, when in fact they were killing their mother); or b) because they lacked the capacity to know that what they were doing was wrong (e.g., they believed they were ordered by God to carry out an act in order to save mankind).

She continued,

...the NCR defense, as codified in the *Criminal Code* and developed in the case law, still consists of two branches: one relating to the “nature and quality of the act” and the other to knowing that the act is “wrong.” Both branches are predicated on the accused having a “mental disorder” that caused the incapacity.

The first branch reference to the “nature and quality” of the act means the physical nature, character, and consequences of the act. Typically, the first branch of the defense arises in cases where a delusion or hallucination experienced while the accused is in a psychotic state causes the accused to do an act that is completely different in its nature and quality from what the accused believed to be the case. Indeed,

this is the most common situation in which the NCR defense arises. That branch of the defense does not arise here. Mr. Doe was fully aware of the nature and quality of his actions...

The focus in this case is on the second branch of the NCR defense, specifically whether Mr. Doe was suffering from a “mental disorder” that rendered him incapable of “knowing” that his acts were “wrong.”

The judge wrote that “mental disorder” is a legal term and does not have to correspond with disorders listed in texts such as the *Diagnostic and Statistical Manual of Mental Disorders*. She added, “The fact that a condition is regarded to be a mental disorder by psychiatrists may be persuasive, but it is not determinative.” The judge also summarized Canadian parliamentary and case law to distinguish between “knowing” and “appreciating.” The former represents the cognitive awareness of an act, whereas the latter implies an analysis of knowledge of or experience with the act. She concluded that “appreciate” is a broader concept than “know.” She also wrote, “An accused cannot be said to ‘know’ that something is ‘wrong’ within the meaning of Canadian statute, if, because of a mental disorder, he lacks the capacity for rational perception and hence rational choice about the rightness or wrongness of the act.”

Further, if an accused, having the capacity to know that society regards his actions as morally wrong, nevertheless commits those acts, he *does* know right from wrong, and cannot be found NCR. And such was her conclusion, for Mr. Doe had been diagnosed with Autism Spectrum Disorder (ASD).

At the time of the attacks, he was still living with his family, in his mid-20s. At an early age, symptoms of ASD became manifest: difficulty interacting with other children, repetitive movements, head banging, speech delay, lack of demonstrable emotion and no eye contact. With speech therapy, he began talking at age 3½.

(continued on page 18)

## Conversion Therapy Ban Overturned by Federal Court

Ryan C.W. Hall, MD

For this “In The Media” column we are going to be discussing the recent ruling on conversion therapy by the 11<sup>th</sup> Circuit Court of Appeals. (1) Given the complexity of this topic and the complicated case law that exists from multiple jurisdictions, this newsletter article should be viewed as a superficial primer on the topic and not an in-depth analysis. This ruling was covered by multiple news outlets, such as NBC, Forbes, and the Sun Sentinel newspaper. (2-4)

The 11<sup>th</sup> District ruling was in relation to a Boca Raton city ordinance and a Palm Beach County ordinance, both of which prohibited conversion therapy on minors. The ordinances both had similar wording applying to any state licensed therapist, but excluded clergy. Both had provisions allowing for “counseling that provides support and assistance to a person undergoing gender transition.” (Ref. 1, p. 864)

Licensed family therapists Robert Otto, PhD and Julie Hamilton, PhD, filed for a preliminary injunction against the ordinances. They noted that their entire practices were speech-based and that the ordinances violated their First Amendment rights. A district court rejected the injunction, which led Otto and Hamilton, with the backing of the Liberty Council, to appeal.

Conversion therapy was defined in the court’s opinion as “sexual orientation change efforts.” (SOCE) (Ref. 1, p. 859) It was noted in the dissent that many major medical societies (World Health Organization, American Academy of Pediatrics, American Psychiatric Association), as well as many therapeutic societies (American Psychological Association, American School Counselor Association), have positions that conversion therapy is harmful to patients. (1) With this stated, the majority opinion noted findings from the 2009 American Psychological Association task force

report on conversion therapy that “nonaversive and recent approaches to SOCE have not been rigorously evaluated” and that “there are individuals who perceive they have been harmed and others who perceive they have benefited from nonaversive SOCE.” (Ref. 1, p. 868) The court also recognized the APA statement that more rigorous research would not likely occur because:

[T]o conduct a random controlled trial of a treatment that has not been determined to be safe is not ethically permissible and to do such research with vulnerable minors who cannot themselves provide legal consent would be out of the question for institutional review boards to approve. (Ref. 1, p. 877)

In addition, the American Psychiatric Association’s decision to remove homosexuality as a disorder from the DSM led to the statement “[t]he change itself shows why we cannot rely on professional organizations’ judgments—it would have been horribly wrong to allow the old professional consensus against homosexuality to justify a ban on counseling that affirmed it.” (Ref. 1, p. 869)

Ultimately the 11<sup>th</sup> Circuit Court of Appeals overturned the lower court’s decision by a 2-1 vote, with Judge Grant writing:

We understand and appreciate that the therapy is highly controversial, but the First Amendment has no carve-out for controversial speech. We hold that the challenged ordinance violates the First Amendment because they are content-based restrictions of speech that cannot survive strict scrutiny. (Ref. 1, p. 859)

The court referenced its prior ruling in *Wollschlaeger*, (5) (addressing the infamous “Docs vs. Glocks”

law), which dealt with regulation or professional speech as a regulation of conduct. Specifically, the court noted:

[C]haracterizing speech as conduct is a dubious constitutional enterprise... labeling certain verbal or written communications “speech” and others “conduct” is unprincipled and susceptible to manipulation... Speech is speech, and it must be analyzed as such for purposes of the First Amendment. (Ref. 1, p. 865)

In addition to referencing their own prior rulings, the court also cited the recent U.S. Supreme Court case of *National Institutes of Family and Life Advocates v. Becerra* (6) (“*NIFLA*”). In that case, the Supreme Court ruled: [Governments do not have] unfettered power to reduce a group’s First Amendment rights by simply imposing a licensing requirement. (Ref. 1, p. 867)

Matt Staver, chairman of Liberty Council, was quoted as saying, “This case is the beginning of the end of similar unconstitutional counseling bans around the country.” (4) Kevin Jennings, the executive officer of Lambda Legal, an LGBTQ advocacy group, was quoted as saying: “Today’s decision is a marked departure from precedent and an incredibly dangerous decision for our youth. So-called conversion therapy is nothing less than child abuse.” (4)

The majority judges, understanding that this may be seen as a controversial ruling, gave additional analysis about how protecting freedom of speech protects the LGBTQ community as well:

This decision allows speech that many find concerning—even dangerous. But consider the alternative. If the speech restrictions in these ordinances can stand, then so can their inverse. Local communities could prevent therapists from validating a client’s same-sex attractions if the city council deemed that message harmful. And the same goes for gender transition—counseling supporting

(continued on page 19)

## Tattoos and Body Piercings in Forensic Assessment and Treatment

Kayla Fisher, MD, JD; Daniel Hackman, MD; and Renée Sorrentino, MD  
Forensic Hospital Services Committee

The prevalence of tattoos and body piercings has increased dramatically over the past several decades. A 2010 Pew Research Center study found that 38% of those between the ages of 18 and 29 had at least one tattoo and 23% had body piercings in locations other than an earlobe. (1) Additionally, the forensic psychiatric population increasingly “wears ink” and sports body piercings. Specifics surrounding these forms of body modification often reflect important details for consideration in forensic assessments and treatment and can influence clinical perceptions.

### Tattoos

A 2016 Harris poll found that three in ten Americans have at least one tattoo, with 70% having more than one. (2) An individual often reports multiple reasons for obtaining a tattoo, some of the most common being a desire to feel unique (44%), wanting to feel independent (33%), and wanting to bring attention to a life experience (28%). (2)

The content, location, size, and number of tattoos, along with when and how the tattoo was obtained, often reveal dimensions that can be helpful in risk assessment and diagnostic considerations. (3) A 2008 study of male forensic psychiatric inpatients found that significantly more patients with tattoos carried a diagnosis of antisocial personality disorder compared to non-tattooed patients. (4) Patients with antisocial personality disorder were also found to have a significantly greater number of tattoos, covering a greater percentage of their body. (4) Additionally, tattooed patients, whether or not they carried a diagnosis of antisocial personality disorder, had significantly higher instances of substance abuse, sexual abuse, and suicide attempts. (4) Similarly, a 2000 study found that tattoos may be a marker for

suicide and accidental death due to shared risk factors of substance abuse and personality disorder. (5) Still other studies demonstrated that tattooed individuals exhibited enhanced risk-taking behavior. (6, 7) In contrast, a study of 289 women found no difference in the amount or extent of body modifications for those with borderline symptomatology compared with those without borderline symptomatology. (8) A 2020 study found that in a forensic context, exte-

*“Ignoring visible tattoos or body piercings may reflect evaluator bias or a reluctance to inquire. However, approaching patients in a nonjudgmental way can facilitate rapport and therapeutic engagement.”*

violent death. (9)

Despite their popularity, studies suggest that many individuals later regret their tattoo (10), with 15-20% considering removal. (11) Approximately 43% of the requests reflect personal reasons, most commonly a change in relationship status. (3) Professional reasons constitute 37% of the requests for removal as the tattoo may hinder employment or other career opportunities. (3) In forensic psychiatric patients, tattoos that reflect gang affiliation, prior beliefs, or prior problematic relationships, can make the recovery process more difficult. Most often, those that want a tattoo removed have found that the tattoo binds them to a past that they want to now separate themselves

from. Inquiring about a patient’s current perceptions about their tattoo can yield important risk and other clinical information. (3)

### Body Piercings

The term “body piercing” refers to the “insertion of jewelry and other objects into artificially made openings in body parts”. (7) While piercing may have been used in the past to identify with a certain group, contemporary body piercings and tattoos tend to express identity, autonomy, and fashion. (12, 13) Bui et al. found the prevalence rates of body piercing between 7% and 14% in the general population, and between 4% and 51% among adolescents or young adults. (7)

Research has explored the association between body piercing and psychopathology. Some studies have shown that body piercing may be a risk marker for adolescents, including as a marker for engaging in antisocial activity. (7, 14, 15) Bui et al. found that body piercing was associated with alcohol use, smoking, and drug use in different populations. They also found that body piercing was associated with high-risk sexual behavior, problem gambling, and even Russian roulette. The findings were not as strong in demonstrating an association between body piercing and depressive symptoms, suicide ideation, and suicide attempts. (7)

Some researchers have cautioned against relying too much on body piercing as a marker for psychopathology or deviant behavior because body piercing may be becoming an increasingly normal practice. (16) However, given the associations with psychopathology that prior research has found, forensic examiners may find it useful to screen for high-risk behaviors in body-pierced subjects. At the very least, inquiring into a person’s piercings may help the forensic examiner have a better understanding of the role that body piercing plays in the expression of that person’s identity.

### Clinical Applications

(continued on page 19)



## Cannabis in the Workplace

Laurence M. Westreich, MD  
Addiction Committee

Rapidly changing cannabis-related laws and cultural norms in the United States have generated enormous confusion for employers and their employees. The addiction professionals, human resources specialists, and labor attorneys responsible for workplace drug programs have similarly struggled with cannabis policies. Even ignoring the clinical effects of cannabis use, every person who has a job, or ever wants to have one, must consider his or her use of cannabis and how that use might affect employability. As of March 2021, 15 states and the District of Columbia had legalized recreational cannabis, (1) while 36 states and the District of Columbia had legalized medical cannabis. (2) Despite these seismic shifts in state law and police procedures, cannabis remains a federal Schedule I substance in the same category as heroin, defined as having no currently accepted medical use and a high potential for abuse. (3) In addition to this widely ignored, but technically enforceable federal law, the hodgepodge of state definitions, municipal exclusions, and local customs present challenges for those who wish to use cannabis and avoid occupational consequences. Lifting of criminal sanctions for the use of marijuana does not necessarily cross over to the civil law matters of hiring, employment, and job termination, a fact many cannabis users have inadvertently discovered. The best way to address this chaotic picture is to understand the specific circumstances of the employee, the requirements (or potential requirements) of the job, the local statutory climate, and the relevant case law.

The use of cannabis by employees has certainly increased over the last two decades, making a coherent response obligatory for employers and the agencies which oversee various workplaces. According to Quest Diagnostics' assessment of their employment drug testing, (4) even before the accelerant effect of COVID-19,

positive workplace drug tests hit a 16-year high in 2019, with a five-year rate increase of 12 percent for workers testing positive for methamphetamine, a 40 percent increase for cocaine, and a 29 percent increase for cannabis. Opiate positive rates declined 49 percent over the same period. Even for those workers in federally mandated safety-sensitive positions, 0.9% of all workers tested were positive for tetrahydrocannabinol (THC), up from 2015's 0.7 percent. In light of the countervailing decrease in employees testing positive for opiates, the increase in cannabis positives among workers is likely associated with an increase in cannabis availability, increased use by employees, and a general – though mistaken – lack of concern about the implications of a positive drug test.

The potential consequences of a positive workplace cannabis drug test range from catastrophic to nil, depending on the jurisdiction where the drug test occurs. State laws protecting workers from sanctions for positive drug tests do not supersede Department of Transportation (DOT) regulations, Department of Defense rules, Nuclear Regulatory Commission rules, or even Federal Drug-Free Workplace designations. (5) Even in non-safety-sensitive work environments, intoxication with/or use of cannabis on the job can result in severe and difficult-to-dispute sanctions. Many states allow for penalties for a positive cannabis drug test without any evidence of intoxication. As an example, even in California and Colorado, private employers not only need not allow medical or recreational use in the workplace, but may terminate employees who have a positive cannabis drug test – even if the use was outside of work hours and with a valid medical marijuana exemption. (6, 7)

The tide may be shifting to the benefit of cannabis-using employees, however. Twenty states now protect, to varying degrees, the employment

rights of cannabis users. These protections range from legislating that a positive test itself cannot establish that an employee is actually impaired, to enforcing some protections for employees with a valid medical marijuana card, to simply barring any discrimination against employees who test positive for, or use, cannabis of any sort. (8) New York City specifically bans pre-employment drug testing, but the statute exempts a long list of putatively safety- (and politically-) sensitive positions: police officers, positions requiring construction safety training, positions involving the care of children or medical patients, positions under federal contracts or grants, positions which require testing as part of a collective bargaining agreement, or DOT-required testing. (9) Nevada (10) and New Jersey (11) similarly prohibit denying employment solely on the basis of a pre-employment drug test positive for THC, although both states similarly exempt employers with safety-sensitive positions from following this rule.

In the 2008 *Ross v. Raging Wire Telecommunications, Inc* suit, (12) the California Supreme Court found that employers need not accommodate an employee's medicinal cannabis use irrespective of the Compassionate Use Act of 1996, (13) which provides that persons using cannabis under the care of a physician are not subject to criminal prosecution by the state. The Court commented that the Compassionate Use Act does not grant cannabis the same status as legal prescription drugs and noted that cannabis remains illegal under federal law, and therefore cannot be "completely legalize[d] for medical purposes." (Ref. 12, p. 387) This case showed typical judicial reasoning of the time, which differentiated medical cannabis from FDA-approved medication, and granted precedence to federal law over state law.

By contrast, in a 2019 Arizona case in which a medical-cannabis-using employee prevailed against their employer, (13) Walmart was found to have discriminated against Carol Whitmire. Ms. Whitmire had a valid

(continued on page 22)

## Beyond the Binary: Documentation and Gender Diversity

Dalia N. Balsamo, MD

Child and Adolescent Psychiatry and the Law Committee,  
Cross-Cultural Committee

On February 19, 2021, The 19<sup>th</sup> reported that a White House spokesperson told them that the Biden administration may soon allow a non-binary “X” gender marker on passports and other legal documents (1). This news has been well received by LGBTQ+ rights advocates. The ACLU started a petition last month asking for executive action that allows non-binary gender markers on federal ID cards and self-attestation (affirming gender identity on identification cards without needing a medical verification letter). The ACLU plans to present the petition to the White House on March 31, which is the International Transgender Day of Visibility (2). The ACLU recently published an article in which a non-binary person shared their experience as one of the first people in the United States with an identification card with an “X” marker. In the article, the author, who is a United States citizen of Japanese descent, mentioned that the Japanese language has been using the term “x-jendā” since the 1990’s to refer to non-binary people and that other countries recognize the X-marker designation (3). New Zealand, Malta, Denmark, and Canada are among countries that allow non-binary people to accurately represent themselves on their passports. Other countries are introducing laws that aim at protecting the rights of non-binary people. Last year, for the first time, a landmark ruling in the United Kingdom granted refugee status on the basis of having a non-binary identity (4).

Conceptualizing gender as non-binary is neither novel nor avant-garde. Many cultures view gender as fluid and as a continuum. The term “Two-Spirit” is a relatively modern term that attempts to describe the supra-binary gender system of some North American Indigenous cultures (5). In South Sulawesi, Indonesia,

the Bugis recognize five genders. In South Asia, Hijras are officially recognized as a third gender. In Samoa, Fa’afafine and fa’afatama are unique gender identities that do not necessarily fall within a gender binary.

In the United States, the legal recognition of a non-binary gender is fairly recent. On June 15, 2017, Oregon became the first state in the United States to allow a non-binary “X” marker on state IDs and driver licenses (6). Several states followed Oregon’s lead shortly thereafter. (7) In October 2017, then-Governor Jerry Brown signed the Gender Recognition Act, making California the first state to introduce a gender-neutral designation on birth certificates (8). There are currently eleven states, plus Washington D.C., that recognize non-binary gender markers on documents. On February 25, 2020, California Representative Ro Khanna introduced the Gender Inclusive Passport Act. This would allow people identifying as non-binary to mark their gender as “X” (9). During his presidential campaign, Joe Biden promised to allow non-binary gender markers on governmental documents.

At the 2020 International Academy for Child & Adolescent Psychiatry and Allied Professions’ World Congress, my colleagues and I presented on the importance of gender-concordance in identification documents (10). ID cards and driver licenses are used in various settings, ranging from interactions with the police, employment, and voting, to entertainment venues. Having an identification document that does not accurately reflect one’s gender identity can have dire consequences for the individual and presents a human rights issue. Both the Parliamentary Assembly of the Council of Europe and the United Nations have advocated for such designations on behalf of non-binary

gender recognition (11). Studies have shown gender-concordant identification documents improve the mental health of transgender individuals (12). In 2019, the American Medical Association published a policy explicitly stating that each individual has the right to determine their gender identity and sex designation on government documents and other forms of identification, including a non-binary designation. The policy also indicates that a medical professional’s verification should not be necessary for such a designation (13).

From a developmental standpoint, validating and supporting a youth’s gender identity plays a crucial role in their overall well-being. An increasing number of youths identify as non-binary (14). Studies have shown that non-binary youth experience less access to gender-affirming care compared to their binary counterparts. They also experience lower levels of support and higher levels of stress (15, 16). One can help in creating a safer environment for these youths by implementing gender inclusive policies in schools and other settings.

While there is yet no definite timeline as to when an “X” gender marker will be added to federal IDs, the current administration seems to be in favor of it. It is interesting to note that United States passports did not have any gender markers until 1975. One could argue that getting rid of the gender marker altogether may be another viable solution. The Netherlands seems to think this way (17). Even if that were to happen, non-binary people have a right to legal recognition and protection. ☯

### References:

- (1) Sosin K. Biden administration suggests it will add “X” gender markers to federal documents. The 19<sup>th</sup>. 19 February 2021. <https://19thnews.org/2021/02/biden-administration-suggests-it-will-add-x-gender-markers-to-federal-documents/> Last accessed 2/28/2021
- (2) Saffronova V. Passports May Soon Include a New Option for Gender Identity. The New York Times. 24 February 2021. <https://www.nytimes.com/2021/02/24/style/gender-neutral-x-passport-ids.html> Last accessed 2/28/2021

(continued on page 20)

## fMRI in the Courtroom: A (Very Brief) Overview

Tyler Durns, MD; Austin W. Blum, MD, JD; and Sanjay G. Adhia, MD

Forensic Neuropsychiatry Committee

On the evening of May 9, 1991, a postdoctoral fellow named Kenneth Kwong ran a new MRI sequence at Massachusetts General Hospital and, remarkably, “saw a bright blob coming out of the visual cortex” (1). This experiment—the first to use blood oxygenation level-dependent (BOLD) functional magnetic resonance imaging (fMRI) in a human subject—led to a surge in neuroscience research that has not abated since. In forensic psychiatry, some commentators have speculated that fMRI may have a role in detecting lies, determining criminal responsibility, and distinguishing chronic pain from malingering. Others are far more circumspect in their predictions, arguing that these technologies have serious limitations. In this column, we discuss how fMRI works, how the images it produces can be misunderstood (by clinicians, judges, and juries alike), and how fMRI evidence has been used in specific legal cases.

The scientific principles of fMRI are simple: (A) more active brain tissues typically require more oxygen than those that are less active, (B) oxygen-poor blood (containing deoxyhemoglobin) responds differently to a magnetic field than oxygen-rich blood, and (C) differences in oxygenation cause a measurable change in the MRI signal (i.e., the BOLD response; see Reference 2 for further review). Thus, fMRI is a measure of the hemodynamic response—an increase in blood flow to active tissues—rather than direct neural activity. These changes in blood oxygenation are measured across the entire brain at a spatial resolution of approximately one mm<sup>3</sup>. The BOLD signal in each of these small, cube-shaped “voxels” (essentially a three-dimensional pixel)—of which the brain has about a hundred thousand—is recorded about every two seconds to capture and demonstrate changes in brain activity

over time. By measuring differences in the BOLD signal during experimental and control tasks (a process called “cognitive subtraction”), researchers can deduce which areas of the brain are more or less active during particular cognitive processes. However, what these data may imply about human behavior is anything but straightforward.

In particular, the association between the BOLD signal and a specific action, symptom, or behavior may be quite weak. And the connection to legal or forensic conclusions like truth or falsehood, guilt or innocence, is weaker still. Although dense brain regions often require high levels of oxygenation and yield a substantial BOLD response, they may make only a limited contribution to a specific cognitive or behavioral function. It is generally assumed that such functions result from local neuronal processing; however, it is unclear whether this assumption holds for complex pathways and structures of the cortex (3). Until scientists better understand how the brain functions to produce cognition and behavior, it will remain difficult to use hemodynamic data to reach specific legal or forensic conclusions.

Some limitations of fMRI are attributable to the technology itself. Neuromodulatory effects on arousal, attention, and memory are slow to receive blood flow and, thereby, weaken the spatiotemporal resolution of BOLD signaling (3). Furthermore, the highly vascularized connective tissue and surface of the brain distort the signal of adjacent neural regions (4). In addition, the BOLD signal—a measure of blood flow—is unable to independently distinguish whether increased flow represents excitatory or inhibitory neural activity (4, 5).

Even if all these technical challenges were solved, a key conceptual obstacle would remain: the unreliability of inferences about an indi-

vidual’s cognitive functions from group data. This group-to-individual (or “G2i”) problem reflects the high levels of interparticipant variability present in both the BOLD response and the location of voxels. Consequently, group-averaged data cannot reasonably be compared with any one person’s data given the high level of variability (6).

Without deeper scientific understanding and broader legal acceptance, the use of fMRI as a modern-day polygraph in court is premature. Nonetheless, the lack of medicolegal consensus has not precluded its use in court, even a decade ago (7). Dr. Steven Laken, CEO of the forensic biotechnology company Cephos, Inc., attempted to introduce an fMRI-based “credibility assessment” in *Wilson v. Corestaff Services, L.P.* (8) and *U.S. v. Semrau* (9). In both cases, Dr. Laken’s testimony was excluded.

In *Wilson*, Dr. Laken’s proposed testimony involved witness credibility in an employment discrimination case. The court stated, “anything that impinges on the province of the jury on issues of credibility should be treated with a great deal of skepticism,” and held that the *Frye* standard (10) was not met.

In *Semrau*, Dr. Laken testified that the defendant’s denial of committing Medicare fraud was credible. After an evidentiary motion, the court noted that Cephos’ tests lacked ecological validity, stating, “there are no known error rates for fMRI-based lie detection outside the laboratory setting, i.e., in the ‘real-world’ or ‘real-life’ setting.” The judge utilized both the Federal Rule of Evidence 702 (11) and *Daubert* (12) factors to reach his conclusion. In summary, the court determined that the error rate of fMRI lie-detection in the “real world” is unknown and that this use of fMRI was prejudicial. Dr. Semrau appealed, arguing that the district court erred in excluding Dr. Laken’s expert testimony (8). The district court’s exclusion of the expert witness was upheld partly due to the lack of “formal research” offered at the *Daubert* hearing.

(continued on page 20)



# Beyond Yoga: Tips for Early Career Forensic Psychiatrists to Maintain Work-Life Balance

*Ariana Nesbit-Bartsch, MD, MBE; Brianne Newman, MD;  
Susan Hatters Friedman, MD; William Newman, MD  
Early Career Development Committee*

At the 2020 Annual Meeting, members of the Early Career Development Committee presented on maintaining work-life balance. Brianne Newman began the panel by reviewing general concepts of physician wellness, resilience, and burnout related to early career psychiatrists. The highlighted message was that the high rates of burnout, depression, and suicide in physicians are more related to an amalgamation of systemic issues in physician training and work environment than shortcomings of individuals. However, as early career forensic psychiatrists, attendees were encouraged to set realistic individual work-life balance goals while helping to facilitate systemic change in their healthcare environment.

Dr. Newman encouraged individuals to reflect on differences between wellness (the state or quality of being in good health as an actively sought goal) versus well-being (the state of being happy, healthy, or prosperous) (1). For most early career physicians, the goal is working toward wellness, which involves allowing self-forgiveness on days when work-life balance skews in the wrong direction. She reviewed character traits that lend to high resiliency in physicians, specifically high cooperativeness, high self-directedness, low harm avoidance, and high persistence (2). She provided a brief overview of the goals delineated in the National Academy of Medicine's consensus study report (3). A multi-pronged approach (addressing individual factors, culture at the department and institutional level, and national advocacy) is necessary to improve the overall experience of practicing medicine. As early career forensic psychiatrists, each attendee has the ability to impact both personal and systemic change. Based on

current rates of physician suicide (4), achieving change is literally a matter of life and death.

Susan Hatters Friedman discussed finding balance in academic forensic psychiatry, and learning when to say "no." She discussed that one's goals and personal definition of success may change at different points in life. Academic careers include teaching, writing, research, clinical practice, forensic practice, and administrative work—a lot to balance with family and one's passions. Suggestions from the literature and personal experience include developing mentoring relationships with senior members of our field whose career (and work-life balance) you respect, as well as peer mentoring relationships.

Dr. Hatters Friedman discussed the fact that women are significantly less likely than men to advance to professorship in American psychiatry (5). Although 42% of psychiatrists are women, only 9% of department chairs are. Similarly, women are underrepresented at the professor level. Various reasons have been proffered for this, including different responsibilities outside of work, lack of role modeling, discrimination, and the impact of part-time work or career breaks (5, 6).

Additional recommendations for success in academia (7) include clear expectations, being realistic, and knowing when to say "no." Wanting to say "yes" to all opportunities, feeling pressure, and building one's CV should be balanced with competing deadlines, impact on workload, stress, and work-life balance. You should consider whether a project is in line with your goals and whether it is something you are passionate about. Having an idea of what you would and would not say "yes" to (in advance) are helpful. If the answer is

"no," don't leave people hanging by delaying.

Ariana Nesbit-Bartsch then presented on finding balance while starting a forensic private practice. She discussed how the standard advice given to new graduates regarding starting a private practice, including never saying "no" to a case, may in some circumstances be incompatible with work-life balance. Suggestions from personal experience as well as advice from other early-to-mid career forensic psychiatrists include being clear about one's priorities inside and outside of work, knowing when to recognize when it's time to back off of work (e.g., when sleep or time with loved ones is routinely being sacrificed), acknowledging that starting a private practice is not a race, and that one's private practice dreams will not be crushed if the early career forensic psychiatrist occasionally turns down a case.

Dr. Nesbit-Bartsch discussed how to find work-life balance while managing student loans. She reviewed data demonstrating the negative consequences of high student debt burdens, including how higher debt is correlated with worse overall mental health (8) and greater stress (9). She reviewed the dilemma that most new graduates face: whether to refinance one's federal loans or rely on the Public Service Loan Forgiveness Program. Suggestions from the literature, as well as from personal experience, include finding a financial advisor who specializes in education and not sacrificing one's well-being and work-life balance in order to quickly pay off loans.

William Newman highlighted the potential benefits of peer support, with an emphasis on boundary violations involving former and current patients. He discussed a personal experience involving being stalked by a former patient and the personal impact of that experience. Dr. Newman reflected on not seeking peer support until well into the experience. He encouraged early career psychiatrists to reach out for help and seek peer support early on when experiencing boundary

*(continued on page 20)*

## Psychiatrists and Firearm Laws: A Disturbing Lack of Knowledge

Joseph R. Simpson, MD, PhD

In the US, federal and state laws governing the possession of firearms by individuals with a history of mental health treatment are extremely complex. A literature examining various aspects of this subject has been gradually accumulating since the first major-journal review appeared in the *American Journal of Psychiatry* back in 2006 (1). More recently, scholarly books that contain extensive discussions of mental health firearm laws have been published (2, 3).

The federal law, as well as many state laws, mandate the loss of the right to possess firearms after a formal commitment to involuntary psychiatric treatment. The precise definition and nuances of this term of art will not be covered in this brief article, but suffice it to say that an involuntary hold that is not an emergency detention or detention for observation, and that is approved by an independent decision-maker (such as a judge, hearing officer, or, in some states, a psychiatrist independent from the treatment team) qualifies. Given the fact that psychiatrists are far and away the category of professional most likely to effectuate such commitments, it would seem reasonable to expect that psychiatrists would have a working knowledge of the basics of mental health firearm laws. Unfortunately, two recent surveys have established that most psychiatrists' knowledge of this topic is far from sufficient. (4, 5)

Newlon et al. (4) surveyed over 500 psychiatrists. The results are striking, with large minorities or even majorities having mistaken beliefs regarding federal law and/or the laws in their state. Asked whether a court-ordered commitment leads to loss of gun rights, 37% incorrectly said it does not; since this is the federal law, it applies regardless of jurisdiction. For respondents in states where a voluntary admission is sufficient to cause the loss of gun rights, 57% incorrectly said it does not.

Some of the comments by respon-

dents to the Newlon et al. survey make it abundantly clear that appropriate training in this area is lacking. One doctor wrote, "I do not know anything about gun rights and mental health," while another said, "I was not aware till this very year that involuntary admission results in revoking of rights to possess firearms." (Ref. 4, p. 161.) A third revealed not only a lack of knowledge of these laws but also of the research on suicide, writing: "... whether an individual has a gun or not doesn't matter. If they are motivated to kill themselves and have the urge to do so, they will find a way to do it...I was NOT aware that firearms could be restricted based off of involuntary commitments..." (Ref. 4, p. 162).

Nagle et al. (5) conducted a survey of nearly 200 South Carolina psychiatrists. They found results similar to the Newlon et al. study. Out of the five mental health firearm law knowledge questions in their survey, three were answered incorrectly by more than half of the respondents; only 61% correctly identified South Carolina's criterion for prohibition, i.e., judicial commitment to a mental hospital. Only what is arguably the most straightforward of the questions, whether a restoration evaluation considers only risk to self, risk to others, or both, was answered correctly by 82% of the psychiatrists. A mere 4% of survey respondents answered all five questions correctly; only an additional 23% got at least four questions right. Forty-one percent answered two or fewer questions correctly.

These studies establish that there is a significant deficiency in the training curriculum of most American psychiatric residency programs for mental health firearm laws. In a previous publication commenting on the Nagle et al. study (6), I suggested that all forensic fellowships should provide training on this subject. However, I now believe that it is necessary for the Accreditation Council for Graduate Medical Education (ACGME) to man-

date at least some level of introductory didactics on the topic for all general psychiatry residency programs. The errors which uninformed psychiatrists may make range from providing wrong information to patients to producing a poorly-reasoned report in a restoration of rights case. Potentially such a report could lead to the denial of restoration to someone who does not pose a danger, or to restoration of rights for someone who is dangerous to themselves or others. Both are an injustice. I sincerely hope that some residency training directors, forensic fellowship directors and experts who have influence with the ACGME read this article and are motivated to change the *status quo*.

Of course, even without a change in ACGME requirements, residency educators can begin the process of exposing their residents to this subject voluntarily. As I explained in my commentary (6), the literature on this topic is now quite robust; this allows every program in the country to develop and deliver a lecture on it (at least) to their trainees. AAPL members affiliated with universities and other general residency programs are well-positioned to volunteer to provide such instruction, and I hope some of you will do so.

We can debate about the merits of mental health firearm laws, but they are unlikely to change much in the years and decades ahead. American psychiatrists as a profession simply can't afford to be ignorant of them anymore. ☪

### References:

- (1) Norris DM, Price M, Gutheil T, Reid WH. Firearm laws, patients, and the roles of psychiatrists. *Am J Psychiatry* 163:1392-6, 2006
- (2) Gold LH, Simon RI. *Gun Violence and Mental Illness*. Washington, DC. American Psychiatric Association Publishing, 2016
- (3) Pirelli G, Wechsler H, Cramer RJ. *The Behavioral Science of Firearms; A Mental Health Perspective on Guns, Suicide and Violence*. New York, NY. Oxford University Press, 2019
- (4) Newlon C, Ayres I, Barnett B. Your Liberty or Your Gun? A Survey of Psychiatrist Understanding of Mental Health Prohibitors. *J Law Medicine Ethics*, 48: 155-163, 2020

(continued on page 21)

## When Your Evaluee Subscribes to QAnon...

Daniel Mundy, MD

Human Rights and National Security Committee

On March 13<sup>th</sup>, 2019, a 24-year-old Staten Island man allegedly shot and killed a senior member of the Gambino crime family. At his first court appearance, he had a large “Q” written on his palm, as well as the phrase “MAGA Forever.” His defense argued it was meant to be a citizen’s arrest of a member of the “Deep State” (1, 2).

On April 29<sup>th</sup>, 2020, a 37-year-old woman from Illinois who had first encountered the phenomenon known as QAnon 20 days earlier live-streamed her drive to New York City while threatening to kill Joe Biden for his involvement in a “Deep State” sex trafficking ring. She is alleged to have tried to approach the *USNS Comfort*, and she was apprehended on a service road erroneously approaching the *USS Intrepid* (1).

On November 6<sup>th</sup>, 2020, two Virginia men, aged 42 and 61, drove in a silver hummer to Philadelphia where a Presidential election—determining vote tally was taking place. They each allegedly carried pistols illegally in Philadelphia, and it was reported they were operating under the belief that “fake ballots” were being counted (3).

On January 6<sup>th</sup>, 2021, as Congress prepared to certify the Presidential election results, thousands marched towards the US Capitol in an attempt to “Stop the Steal.” Rampant through the crowds were references to “Q,” the mysterious and anonymous figure who led many to believe that President Trump would remain in power. Even after he left office, some held on to the belief that a “real” inauguration of President Trump would be held instead on March 6, 2020.

Although the motivation behind these events may vary wildly, a common factor is shared—that which was prominently displayed on hats and stickers: the letter Q, for the prophet of the QAnon movement.

Between the time of Q’s first post on December 28<sup>th</sup>, 2017 and the

present, the QAnon movement has transitioned from a fringe conspiracy theory to a sociopolitical movement. Between the latter half of February and the first week of September 2020, the number of adults who had “heard about QAnon” increased from 23% to 47% (4). This likely increased as the election approached, especially given that elected members of Congress (5) and the President (6) shared positive thoughts about the group. The FBI specifically referenced QAnon as a likely motivation for extremist violent activity in a bulletin published in May 2019 (7).

Rooted in “PizzaGate,” QAnon appropriately meets a definition of a conspiracy theory: the unnecessary assumption of conspiracy when other explanations are more probable (8). To an uninformed psychiatrist, the tenets of Q could easily find their way into a slow-pitch involuntary admission note:

Thought Content: Patient states he interprets hidden messages on internet from “Q.” Patient states Trump fighting pedophilic sex trade run by Satanic Democrat “Deep State.” Patient asserts “Coming Storm” and “Great Awakening” will happen in near future, states military takeover will occur, + thoughts of violence.

These are the tenets of QAnon, and it is critical for the forensic psychiatrist to be prepared to assess whether or not an evaluee’s stated belief in QAnon results from a mental illness, and if not, offer alternative explanations for their motivation.

Some of the tenets, such as the “Deep State,” are non-partisan and debatably paranoid (9, 10), while others (Satanic pedophiles) are more fantastic. To this author’s knowledge, none of the tenets can clearly be categorized as “bizarre” as specified in the DSM, and this may complicate

our ability to easily identify psychosis. Nonetheless, psychosis and schizotypy both correlate with one’s likelihood to adopt a conspiracy theory (14, 15).

We must consider QAnon a cultural belief, especially given its presence on the Internet (11) and its highly partisan following (12, 13). We stand to benefit from familiarizing ourselves with its associated beliefs in efforts to identify the cultural norms, including normative paradoxical/irrational arguments, such that we may more readily identify anomalies suggestive of mental illness.

As some rigidly relish and obsess over these beliefs to the point of violent action, it behooves us to consider an actor laboring under an Extreme Overvalued Belief rather than a delusion (15). Early research demonstrates forensic psychiatrists’ ability to make this distinction (11).

Lastly, this writer advocates considering that the evaluee may *assert* that they follow QAnon, whereas in reality they neither accept nor believe it at all. This should be considered in cases where an evaluee stands to benefit financially or in political influence from being identified as a QAnon follower (similar to malingering), or in a situation where an evaluee psychologically benefits from the group membership (similar to factitious disorder). A note on group membership and tribalism, it is worth considering that an evaluee may ostensibly adhere to QAnon for the purpose of angering a member of a perceived rival party; a web search for the phrase “troll the Libs/Dems” returns untold webpages specifically on this topic.

Interestingly, limitations by major social media outlets collectively led to the birth of alternative online communication platforms like Parler – the long-term impact of which remains to be seen. While it is quite possible that QAnon will disappear as quickly as it spread, similar belief systems are bound to arise and spread in this age of polarization, misinformation, and Internet dissemination. It is an important prototype in considering future conspiracy theories and those motivated to action by them. ☯

(continued on page 21)



## CURES Act

*continued from page 4*

the APA (7), and the ONC (8) have provided additional guidance. The CURES Act's major goal, to facilitate information sharing between electronic records systems, is laudatory. However, the regulations' complexity will almost certainly lead to unexpected consequences that may negatively affect patient care. Luckily, the Act does not apply to electronic records kept for forensic evaluation, as like with HIPAA there are exceptions for records kept for both forensic and correctional practice. ☯

### References:

- (1) Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 1996
- (2) 45 CFR § 164.524 – Access of individuals to protected health information
- (3) <https://www.healthit.gov/curesrule/>
- (4) Klein JW et al. Your Patient Is Now Reading Your Note: Opportunities, Problems, and Prospects. *American Journal of Medicine*. 129:1018-1021, 2016. DOI: <https://doi.org/10.1016/j.amjmed.2016.05.015>
- (5) [www.ama-assn.org/system/files/2020-10/information-blocking-part-1.pdf](http://www.ama-assn.org/system/files/2020-10/information-blocking-part-1.pdf)
- (6) [www.ama-assn.org/system/files/2020-10/info-blocking-compliance.pdf](http://www.ama-assn.org/system/files/2020-10/info-blocking-compliance.pdf)
- (7) [www.psychiatry.org/psychiatrists/practice/practice-management/health-information-technology/interoperability-and-information-blocking](http://www.psychiatry.org/psychiatrists/practice/practice-management/health-information-technology/interoperability-and-information-blocking)
- (8) <https://www.healthit.gov/curesrule/resources/information-blocking-faqs>

## Ask the Experts

*continued from page 7*

Prior to making any diagnosis, the doctor must be certain of their opinion and certain that an in-person examination wouldn't be likely to provide any additional information that might be beneficial in making a diagnosis or in guiding treatment. Ask yourself, if the patient were in front of you, would you check vitals or do any type of physical examination?

If the answer is yes, this may not be a good telemedicine encounter. For a psychiatrist, this might mean that checking for cogwheel rigidity as a side effect of medication isn't

possible; for medications that have specific recommendations from the FDA for ocular exams, that these can't be done; and for eye exams, it is not really possible to look for saccadic eye movements via an iPad/cell phone camera.

Telemedicine is not going away, and offers substantial benefits to patients, doctors, and society. However, if doctors are held to the same SOC as in-person encounters, they need to be vigilant as to what cases they are willing to accept. Patients, legislators, and the public need to be educated as to the reality of the differences between in-person medical encounters and telemedicine "visits" and should be warned and taught that they are not really the same. Every patient should be given the opportunity for in-person consultation when possible. The doctor should note the patient's consent to proceed with the telemedicine approach, but still be ready to admit that they cannot reach a diagnosis or prescribe a treatment if the information learned during the electronic appointment suggests an in-person visit is needed. ☯

## Canada Killings

*continued from page 9*

He had violent temper tantrums which disappeared before he started school. When he was five years old, he was diagnosed with Pervasive Developmental Disorder (PDD), the term now replaced by ASD.

As he grew up, Mr. Doe faced many challenges typical of someone on "the [autism] spectrum." However, he was very intelligent, and managed to graduate from high school in good standing and completed college with a degree in computer programming. Yet, he always had problems with social interactions, spoke in a monotone, struggled with maintaining normal eye contact, and often described things by focusing on minutiae, meanwhile missing the bigger picture.

But could the defense use Doe's disorder to convince the judge he was NCR? The defense retained two forensic psychiatrists and the Crown,

one. There were forensic psychologists as well. As might be expected, the experts differed on whether or not Mr. Doe's ASD and the facts of the case satisfied the requirements to be declared NCR.

In her decision, Judge Molloy skillfully critiqued the testimony of the experts for both sides. She reserved most of her negative criticism for one of the defense psychiatrists. That doctor, she said, had ignored what Doe told him: that if he could, he'd apologize to the victims and their families, and admit that what he had done was to gain notoriety in order to make himself look powerful. Mr. Doe also told this psychiatrist that he realized his plan was stupid and, ironically, made him look weak compared to the victims and their families. [Despite this seeming acknowledgment, other statements Doe made to the experts indicate that even after his arrest, he continued to desire press coverage and notoriety.] The defense psychiatrist, despite what Doe told him, opined that the accused actually meant that he did *not* have any understanding of what he had done, nor that it was wrong. Unfortunately, this psychiatrist did not take contemporary notes. Instead, he interviewed Doe with a computer, changing words here and there, adding or subtracting words at a later date.

The judge did not disagree with the diagnosis of ASD. She took note of his fascination with violent video games and fantasies of mass murder. She accepted the defense's conclusion that Doe lacked empathy regarding his victims. However, she concluded, "...Mr. Doe was capable of rational thought, particularly given the length of time he spent planning this attack...the NCR defense cannot be stretched to encompass Mr. Doe's situation." She also found that his hiding the act from everyone beforehand – including his parents – demonstrated his understanding that people would be appalled and would try to stop him.

Judge Molloy concluded,

...Mr. Doe knew it was legally wrong to kill people. He also

*(continued on page 22)*

## Conversion Therapy

*continued from page 10*

a client's gender identification could be banned. It comes down to this: if the plaintiffs' perspective is not allowed here, then the defendants' perspective can be banned elsewhere. People have intense moral, religious, and spiritual views about these matters—on all sides. And that is exactly why the First Amendment does not allow communities to determine how their neighbors may be counseled about matters of sexual orientation or gender. (Ref. 1, p. 871)

As noted by Kevin Jennings, other federal jurisdictions, such as the 3<sup>rd</sup> and 9<sup>th</sup> Circuit Courts of Appeal, have ruled on similar cases without finding that conversion therapy bans violated the First Amendment. The California case of *Pickup v. Brown* ruled the bans constitutional due to seeing the laws as regulating professional conduct, which falls under a rational basis standard of scrutiny. (7) The 3<sup>rd</sup> Circuit Court ruling in *King v. Governor of the State of New Jersey* concluded that the law regulated speech, but only professional speech and, therefore, was subject to intermediate scrutiny. (8) The 11<sup>th</sup> Circuit in this current ruling basically claims that both the 3<sup>rd</sup> and 9<sup>th</sup> Circuits rulings are flawed from not using strict scrutiny, as applied to professional speech, especially in light of the Supreme Court ruling in *NIFLA*:

*NIFLA* disapproved of both courts' [3<sup>rd</sup>, 9<sup>th</sup>] willingness to "except professional speech from the rule that content-based regulations of speech are subject to strict scrutiny." Speech is not unprotected merely because it is uttered by "professionals." (Ref. 1, p. 867, internal citations omitted)

Circuit Judge Martin, in her dissent citing *EMW Women's Surgical Ctr., P.S.C. v. Beshear*; (9) noted:

[S]trict scrutiny is not the proper lens of analysis for "regulations

of professional conduct that incidentally burden speech." An intermediate form of scrutiny is appropriate for reasonable regulations on the practice of medicine. It may be possible to distinguish between medical regulations and speech restrictions by asking whether the affected speech is "auxiliary to" or "inconsistent with" the practice of medicine, in which case the highest level of scrutiny is not required. (Ref. 1, p. 873)

The attorneys for the City of Boca Raton and Palm Beach County were quoted as calling the dissent "well-reasoned," and that they were weighing their legal options. (2) This ruling will likely be revisited in some way. Whether the next action will be an *en banc* examination by the 11<sup>th</sup> Circuit, or the Supreme Court granting certiorari remains to be seen. (3) Although the Supreme Court did not hear challenges to the 3<sup>rd</sup> and 9<sup>th</sup> Circuits' rulings previously, the 11<sup>th</sup> Circuit ruling, as it stands, specifically calls those jurisdictions' legal logic into question. The fact that there is now disagreement between federal appellate courts, in part based on interpretation of a more recent Supreme Court ruling, will likely make it difficult for the Supreme Court not to get involved at some point. ☩

### References:

- (1) *Otto v. City of Boca Raton*, 981 F.3d 854, (11<sup>th</sup> Cir. 2020)
- (2) [Reuters]: [Federal court strikes down conversion therapy bans in Florida](https://www.nbcnews.com/feature/nbc-out/federal-court-strikes-down-conversion-therapy-bans-florida-n1248518). NBCNews.com. Nov. 22, 2020, available at: <https://www.nbcnews.com/feature/nbc-out/federal-court-strikes-down-conversion-therapy-bans-florida-n1248518> accessed on November 26, 2020
- (3) Durkee A: [Trump Judges Strike Down Bans On LGBTQ 'Conversion Therapy'](https://www.forbes.com/sites/alison-durkee/2020/11/20/trump-judges-strike-down-bans-on-lgbtq-conversion-therapy/?sh=613b33663d7). Forbes.com. November 20, 2020, available at: <https://www.forbes.com/sites/alison-durkee/2020/11/20/trump-judges-strike-down-bans-on-lgbtq-conversion-therapy/?sh=613b33663d7> accessed on November 26, 2020
- (4) Olmenda R: *Conversion therapy ban struck down: Appeals court calls it 'infringement on First Amendment rights'*. South Florida Sun Sentinel. November

- 22,2020, available at: [https://enewspaper.sun-sentinel.com/infinity/article\\_share.aspx?guid=924bc565-2b7b-4543-b639-d5c8043e433e](https://enewspaper.sun-sentinel.com/infinity/article_share.aspx?guid=924bc565-2b7b-4543-b639-d5c8043e433e) accessed November 26, 2020
- (5) *Wollschlaeger v. Governor of Florida*, No. 12-14009 (11<sup>th</sup> Cir., 2017)
  - (6) *National Institutes of Family and Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018)
  - (7) *Pickup v. Brown*, 740 F.3d 1208, (9<sup>th</sup> Cir. 2014)
  - (8) *King v. Gov. of New Jersey*, 767 F.3d 216 (3<sup>rd</sup> Cir. 2014)
  - (9) *EMW Women's Surgical Ctr. v. Beshear*, 920 F.3d 421, 447 (6<sup>th</sup> Cir. 2019)

## Tattoos

*continued from page 11*

A complete mental status examination includes a description of the physical appearance of the patient. Visible body modifications such as tattoos and body piercings should be included. An understanding of such body modifications should be elicited during the forensic evaluation. Asking a patient to explain the meaning of the modification and how it relates to their identity provides an opportunity to further conceptualize the individual. Ignoring visible tattoos or body piercings may reflect evaluator bias or a reluctance to inquire. However, approaching patients in a non-judgmental way can facilitate rapport and therapeutic engagement. (3)

Inquiring about tattoos and piercings should not be limited to visible modifications but should include general questions about covered or removed modifications. A careful inquiry into the nature of these modifications and their significance to the individual can provide important insights.

The following case examples demonstrate the usefulness of exploring body modifications in forensic evaluations:

- An individual was charged with shooting a stranger in a convenience store after engaging in an argument in the parking lot. The individual described a long history of impulsive behaviors and wore a tattoo of a bomb with

*(continued on page 21)*

## Beyond the Binary

*continued from page 13*

- (3) Sakurai S. I'm Nonbinary. My Passport Should Show That. ACLU News & Commentary. 27 January 2021. <https://www.aclu.org/news/lgbt-rights/im-nonbinary-my-passport-should-show-that/> Last accessed 2/28/2021
- (4) Kelly N. 'I felt like I was born again': first non-binary person granted UK refugee status. The Guardian. 30 December 2020. <https://www.theguardian.com/world/2020/dec/30/i-felt-like-i-was-born-again-first-non-binary-person-granted-uk-refugee-status> Last accessed 2/28/2021
- (5) Robinson M. Two-Spirit Identity in a Time of Gender Fluidity. J Homosex. 2020;67(12):1675-1690.
- (6) Segal C. Oregon becomes first state to add gender-neutral option on driver's license. PBS News Hour. Jun 15 2017. <https://www.pbs.org/newshour/nation/oregon-non-binary-gender-neutral-option-licenses>. Last accessed 2/28/2021.
- (7) Siegel R. New gender-neutral identifiers on IDs signal to nonbinary D.C. residents that they belong. The Washington Post. 21 June 2017. [https://www.washingtonpost.com/local/trafficandcommuting/new-gender-neutral-identifiers-on-ids-signal-to-nonbinary-dc-residents-that-they-belong/2017/06/21/43361b80-55e3-11e7-a204-ad706461fa4f\\_story.html](https://www.washingtonpost.com/local/trafficandcommuting/new-gender-neutral-identifiers-on-ids-signal-to-nonbinary-dc-residents-that-they-belong/2017/06/21/43361b80-55e3-11e7-a204-ad706461fa4f_story.html) Last accessed 2/28/2021
- (8) Katz B. California Becomes First State to Introduce Gender-Neutral Birth Certificates. Smithsonian Magazine. October 20, 2017. <https://www.smithsonianmag.com/smart-news/california-becomes-first-state-introduce-gender-neutral-birth-certificates-180965343/> Last accessed 2/28/2021
- (9) H.R. 5692. Gender Inclusive Passport Act. 116<sup>th</sup> Congress (2019-2020). <https://www.congress.gov/bill/116th-congress/house-bill/5962/text> Last accessed 2/28/2021
- (10) Stevens J, Balsamo DN, Tomita KK, et al. Sex and paperwork: The ethics of identification documents that misidentify one's sex and gender. IACAPAP 2020 Singapore Virtual Congress. 3 December 2020.
- (11) Richards C, Bouman WP, Seal L, et al. Non-binary or genderqueer genders. Int Rev Psychiatry. 2016;28(1):95-102.
- (12) Scheim AI, Perez-Brumer AG, Bauer GR. Gender-concordant identity documents and mental health among transgender adults in the USA: a cross-sectional study. Lancet Public Health. 2020;5(4):e196-e203.
- (13) H-65.967. Conforming Sex and Gender Designation on Government IDs and Other Documents. American Medical Association.

Last Modified 2019.

- (14) Diamond LM. Gender Fluidity and Nonbinary Gender Identities. Child Dev Perspectives. 2020;14(2): 110-115.
- (15) Chew D, Tollit MA, Poulakis Z, et al. Youths with a non-binary gender identity: a review of their sociodemographic and clinical profile. Lancet Child Adolesc Health. 2020 Apr;4(4):322-330.
- (16) Todd K, Peitzmeier SM, Kattari SK, et al. Demographic and Behavioral Profiles of Nonbinary and Binary Transgender Youth. Transgend Health. 2019 Oct 21;4(1):254-261.
- (17) Goshal N, Knight K. Netherlands Sees No Role for Gender Marker on ID Documents. Human Rights Watch. July 8, 2020. <https://www.hrw.org/news/2020/07/08/netherlands-sees-no-role-gender-marker-id-documents> Last accessed 2/28/2021

## fMRI

*continued from page 14*

The level of acceptable ambiguity in the BOLD response remains unclear for scientific and medicolegal contexts. At present, there is concern that the capabilities of fMRI in lie detection and other areas of interest in forensic psychiatry have been overstated (13, 14). In fact, the American College of Radiology maintains that fMRI has not yet attained the required threshold of evidence to merit routine testimonial basis in evaluations of traumatic brain injury, post-traumatic stress disorder, dementia, and other neuropsychiatric conditions (15). Therefore, although fMRI seems to be a promising forensic evaluation tool, its practical utility in evaluations remains limited. (f)

### References:

- (1) Athinoula A. Martinos Center for Biomedical Imaging. Ken Kwong and the introduction of noninvasive fMRI [Internet]; 2016. Available from: <https://www.martinos.org/ken-kwong-and-the-introduction-of-non-invasive-fmri/>. Accessed December 13, 2020
- (2) Aguirre GK. Functional neuroimaging: technical, logical, and social perspectives. Hastings Cent Rep. 2014;Spec No:S8-18
- (3) Logothetis NK. What we can do and what we cannot do with fMRI. Nature. 2008 Jun 12; 453(7197):869-878
- (4) Turner R. Uses, misuses, new uses and fundamental limitations of magnetic resonance imaging in cognitive science. Phi-

- los Trans R Soc Lond B Biol Sci. 2016; 371(1705):20150349
- (5) Lee JH, Durand R, Gradinaru V, et al. Global and local fMRI signals driven by neurons defined optogenetically by type and wiring. Nature. 2010 June; 465:788-792
- (6) Woodruff, William A. Evidence of lies and rules of evidence: the admissibility of fMRI-based expert opinion of witness truthfulness. N.C. J.L. & Tech. 2014 October; 16(1):105-252
- (7) Langleben DD, Moriarty JC. Using brain imaging for lie detection: where science, law, and policy collide. Psychology, Public Policy, and Law. 2013; 19(2):222-234
- (8) *Wilson v. Corestaff Servs LP*, 900 N.Y.S. 2d 639, 2010
- (9) *U.S. v. Semrau*, 693 F.3d 510 (6th Cir. 2012)
- (10) *Frye v. U.S.* 293 F. 1013 (D.C. Cir. 1923)
- (11) Title 28 U.S.C. § 702, 2010
- (12) *Daubert v. Merrell Dow Pharmaceuticals Inc.*, 509 U.S. 579 (1993)
- (13) Langleben DD, Dattilio FM. Commentary: the future of forensic functional brain imaging. J Am Acad Psychiatry Law. 2008; 36(4):502-504
- (14) Appelbaum PS. Law & psychiatry: The new lie detectors: neuroscience, deception, and the courts. Psychiatr Serv. 2007; 58(4):460-462
- (15) American College of Radiology. ACR Appropriateness Criteria [Internet]; 2021. Available from: <https://acsearch.acr.org/list>. Accessed November 20, 2020

## Beyond Yoga

*continued from page 15*

violations. He also presented some of the common psychological sequelae to professionals who are victims of stalking (10). (f)

### References

- (1) "Wellness" and "Well-being." Merriam-Webster's Collegiate Dictionary, Edition 10. Merriam-Webster Incorporated, 1999
- (2) Eley DS, Leung J, Hong BA *et al.* Identifying the Dominant Personality Profiles in Medical Students: Implications for Their Well-Being and Resilience. PLoS One 5(8): e0160028, 2016
- (3) National Academy of Sciences, Engineering, and Medicine. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press, 2019
- (4) Najjar D. Are Doctors Really at Highest

*(continued on page 21)*



## Firearm Laws

*continued from page 16*

- (5) Nagle ME, Joshi KG, Frierson R, et al. Knowledge and Attitudes of Psychiatrists About the Gun Rights of Persons With Mental Illness. *J Am Acad Psychiatry Law* 49: 28-37, 2021
- (6) Simpson JR. The Need for Systematic Training on Gun Rights and Mental Illness for Forensic Psychiatrists. *J Am Acad Psychiatry Law* 49: 38-41, 2021

## QAnon

*continued from page 17*

### References:

- (1) Amarasingam A, Argentino M: The QAnon conspiracy theory: A security threat in the making? *CTC Sentinel*, 13:37-44, 2020
- (2) Watkins, A. He wasn't seeking to kill a mob boss. He was trying to help Trump, his lawyers say. *New York Times*, July 21<sup>st</sup>, 2019. Available at <https://www.nytimes.com/2019/07/21/nyregion/gambino-shooting-anthony-comello-frank-cali.html>. Accessed November 10, 2020
- (3) Winter T, Collins B, Arkin D, et al. 2 men arrested near Philadelphia vote center had QAnon paraphernalia, AR-15 in car. *NBC News.com*. Available at <https://www.nbcnews.com/news/us-news/2-men-detained-after-police-learn-possible-threat-philadelphia-vote-n1246774>. Accessed November 10, 2020
- (4) Pew Research American News Pathways. Available at [https://www.pewresearch.org/pathways-2020/qahrd/total\\_us\\_adults/us\\_adults/](https://www.pewresearch.org/pathways-2020/qahrd/total_us_adults/us_adults/). Accessed November 8, 2020
- (5) Greenspan, R: The first QAnon-supporting congressional candidate has been elected to Congress. *Business Insider.com*, November 2020. Available at <https://www.businessinsider.com/marjorie-taylor-greene-qanon-candidate-elected-to-congress-2020-11>. Accessed November 7, 2020
- (6) Hains, T: NBC's Savannah Guthrie Asks Trump To Denounce QAnon, Trump: "They Are Very Much Against Pedophilia". *Realclearpolitics.com*, October 15<sup>th</sup>, 2020. Available at [https://www.realclearpolitics.com/video/2020/10/15/nbc\\_savannah\\_guthrie\\_asks\\_trump\\_to\\_denounce\\_qanon\\_trump\\_they\\_are\\_very\\_much\\_against\\_pedophilia.html](https://www.realclearpolitics.com/video/2020/10/15/nbc_savannah_guthrie_asks_trump_to_denounce_qanon_trump_they_are_very_much_against_pedophilia.html). Accessed November 7
- (7) Anti-Government, Identity Based, and Fringe Political Conspiracy Theories Very Likely Motivate Some Domestic Extremists to Commit Criminal, Sometimes Violent Activity. *FBI Phoenix Field Office*, 2019. Available at [https://en.wikisource.org/wiki/Anti-Government,\\_Identity\\_Based,\\_and\\_](https://en.wikisource.org/wiki/Anti-Government,_Identity_Based,_and_)

- [Fringe\\_Political\\_Conspiracy\\_Theories\\_Very\\_Likely\\_Motivate\\_Some\\_Domestic\\_Extremists\\_to\\_Commit\\_Criminal\\_Sometimes\\_Violent\\_Activity](https://en.wikisource.org/wiki/Fringe_Political_Conspiracy_Theories_Very_Likely_Motivate_Some_Domestic_Extremists_to_Commit_Criminal_Sometimes_Violent_Activity). Accessed November 2, 2020
- (8) Brotherton R, French CC, Pickering AD: Measuring belief in conspiracy theories: The generic conspiracist beliefs scale. *Frontiers in Psychology*, 4:279, 2013
- (9) Logfgren, M: Essay: Anatomy of the Deep State. *Billmoyers.com*, February 21<sup>st</sup>, 2014. Retrieved from <https://billmoyers.com/2014/02/21/anatomy-of-the-deep-state>. Accessed November 6, 2020
- (10) Gidda, M. Edward Snowden and the NSA files – timeline. *The Guardian*, June 23<sup>rd</sup>, 2013. Available at <https://www.theguardian.com/world/2013/jun/23/edward-snowden-nsa-files-timeline>. Accessed August 22, 2018
- (11) Rahman T, Hartz SM, Xiong W, et al: Extreme Overvalued Beliefs. *Journal of the American Academy of Psychiatry and the Law*, 48(3):319-326. 2020
- (12) Beer, T: Majority Of Republicans Believe The QAnon Conspiracy Theory Is Partly Or Mostly True, Survey Finds. *Forbes.com*, September 2<sup>nd</sup>, 2020. Available at <https://www.forbes.com/sites/tommybeer/2020/09/02/majority-of-republicans-believe-the-qanon-conspiracy-theory-is-partly-or-mostly-true-survey-finds/?sh=21a364285231>. Accessed November 8, 2020
- (13) Uscinski, JE, Parent JM: *American conspiracy theories*. New York, NY: Oxford University Press, 2014
- (14) Dagnall N, Drinkwater K, Parker A, et al: Conspiracy theory and cognitive style: a worldview. *Frontiers in Psychology*, 6:206, 2015
- (15) Rahman, T: Extreme overvalued beliefs: How violent extremist beliefs become "normalized". *Behav Sci (Basel)*, 8:1. 2018

## Beyond Yoga

*continued from page 20*

- Risk for Suicide? *Medscape Psychiatry*. February 5, 2020
- (5) Sheikh MH, Chaudhary AMD, Khan AS et al. Influences for gender disparity in academic psychiatry in the United States. *Cureus* 10, 2018
- (6) Dutta R, Hawkes SL, Iversen AC et al. Women in academic psychiatry. *The Psychiatrist* 34:313-317, 2010
- (7) Bostwick JR: Success in academia: tips for balancing clinical and faculty roles. *Mental Health Clinician* 1(10): 239-241, 2012
- (8) Pisanello MS, Asahina AT, Bacchi S, et

- al.: Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review. *BMJ Open* 9: e029980, 2019
- (9) Chisholm-Burns MA, Spivey CA, Jaeger MC, et al.: Associations between pharmacy students' attitudes toward debt, stress, and student loans. *Am J Pharm Educ* 81(7): 5918, 2017
- (10) Maran DA, Varetto A: Psychological Impact of Stalking on Male and Female Health Care Professional Victims of Stalking and Domestic Violence. *Front Psychol* 13(9):321, 2018

## Tattoos

*continued from page 19*

- words underneath that read "zero to a hundred."
- A plaintiff in an emotional damages case presented with multiple, symmetric body piercings on her face. Plaintiff described a need to correct "facial asymmetry," which she reported had been there since childhood. Diagnostic considerations included body dysmorphia.
  - A man charged with child molestation, who met criteria for pedophilic disorder, had multiple tattoos on his arms of women, breasts and buttocks. He described these tattoos as "undoing" his true sexual interests.

Although the research examining tattooing and body piercing to date is sparse, it does provide useful information for risk assessment and suggests associations with psychiatric symptoms which can prove helpful in medicolegal assessments. (4, 8, 12) A thorough review of these body modifications, including the number of modifications, how and when they were obtained, and what meaning the individual currently ascribes to them, provides forensic psychiatrists with additional tools with which to assess important life events, risk factors, and individual traits that can prove critical in the forensic psychiatric evaluation. ☯

### References:

- (1) Pew Research Center. (2010). Millen-

*(continued on page 23)*

## Canada Killings

*continued from page 18*

knew that his plan to run down and kill people constituted first-degree murder and that, if arrested, he would go to jail for the rest of his life...he knew that the vast majority of people in society would find an act of mass murder to be morally wrong...he had a functioning, rational brain, one that perceived the reality of what he was doing, and knew it was morally wrong by society's standards, and contrary to everything he had been taught about right and wrong. He then made a choice. He chose to commit the crimes anyway, because it was really what he wanted to do... Lack of empathy for the suffering of victims, even an incapacity to empathize for whatever reason, does not constitute a defense...

Needless to say, Mr. Doe was not found NCR.

This case is instructive. It reminds us that a "mental disorder," as legally defined, is not automatically equivalent to DSM criteria. More specifically, people with Autism Spectrum Disorder charged with a crime must be assessed on a case-by-case basis. ASD in and of itself cannot be used as a defense in a criminal trial. Histories of children diagnosed with ASD vary and symptomatic manifestations are not immutable, though their diagnosis may continue. Lack of empathy in these children and adults is not the equivalent of psychopathy. In criminal as well as civil matters, forensic psychiatrists must be mindful of these truths. (f)

### Reference:

(1) *R. v. Minassian*, 2021 ONSC 1258

## Cannabis

*continued from page 12*

Arizona medical cannabis card for treatment of sleep problems. After a minor workplace injury, Whitmire was seen in a medical clinic and given

a urine drug screen which found THC at a level greater than 1000 ng/cc. Walmart alleged that "(her) positive drug test result for marijuana indicated that she was impaired by marijuana during her shift that same day."

Whitmire was eventually terminated on the basis of the positive drug test and filed suit, alleging that she had been discriminated against in violation of state anti-discrimination laws. The Court agreed, reasoning that "without any evidence that Plaintiff used, possessed or was impaired by marijuana at work...it is clear that Defendant discriminated against Plaintiff...by suspending and then terminating Plaintiff solely based on her positive drug test..." The relatively high level of THC went unaddressed as a marker of workplace impairment.

The evolving federal and state law postures toward workplace-related cannabis matters, combined with the scattershot case law on the subject, necessitate management by the clinicians and labor attorneys who respond to cannabis use and testing in the workplace. Regardless of the details of a workplace cannabis policy, it must be carefully designed to include a clear mission and set of expectations, a defensible testing protocol, offers of clinical assistance to employees who need it, defined consequences for positive THC tests, and a policy which allows eligible employees to return to work. (15) This sort of intentional workplace cannabis policy, designed with the collaborative effort of addiction professionals, human resources specialists, and labor attorneys, will produce the most workable cannabis policy for all parties involved. (f)

### References:

- (1) Sutton S: New Jersey legalizes cannabis after years of failed efforts and toxic negotiations. Politico. February 22, 21. <https://www.politico.com/states/new-jersey/story/2021/02/22/new-jersey-legalizes-cannabis-after-years-of-failed-efforts-and-toxic-negotiations-1364873> Accessed February 27th 2021
- (2) State Medical Marijuana Laws, National Conference of State Legislatures. Available at <https://www.ncsl.org/research/health/>

[state-medical-marijuana-laws.aspx](#) Accessed February 27th 2021

- (3) Title 21 Code of Federal Regulations. Part 1308 – Schedules of Controlled Substances §1308.11 Schedule I.
- (4) Workforce Drug Testing Positivity Climbed to Highest Rate in 16 Years, New Quest Diagnostics Drug Testing Index Analysis Finds. August 25, 2020. Available at [https://www.questdiagnostics.com/home/physicians/health-trends/drug-testing\\_Accessed February 27th 2021](https://www.questdiagnostics.com/home/physicians/health-trends/drug-testing_Accessed February 27th 2021)
- (5) Medical Review Officer Certification Council. The Medical Review Officer's Manual, Fifth Edition. OEM Press, Beverly Farms, MA, 2015, pp. 14-16
- (6) Cal. Health & Safety Code §§ 11362.5, 11362.7 to 11362.9; Cal. Health & Safety Code §§ 11362.1 to 11362.45
- (7) Colo. Const. art. XVIII, §§ 14, 16; *Coats v. Dish Network, LLC*, 350 P.3d 849 (2015)
- (8) NORML: State Laws Protecting Marijuana Users Employment Rights. State Laws Protecting Marijuana Users' Employment Rights – CANORML <https://www.canorml.org/employment/state-laws-protecting-medical-marijuana-patients-employment-rights/Accesed February 27th 2021>
- (9) New York City Adopts Law Prohibiting Pre-Employment Testing for Marijuana. National Law Review. Friday, Volume XI(69) May 10, 2019 Available at <https://www.natlawreview.com/article/new-york-city-adopts-law-prohibiting-pre-employment-testing-marijuana> Accessed February 27th, 2021
- (10) BDR 53-29. Revises provisions governing employment practices. February 13, 2019 <https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6191/Overview> Accessed February 27th, 2021
- (11) Recreational Marijuana is Legal in New Jersey: what Employers need to Know. National Law Review, Volume XI(69) February 23, 2021 Available at <https://www.natlawreview.com/article/recreational-marijuana-legal-new-jersey-what-employers-need-to-know> Accessed February 27th, 2021
- (12) *Ross v. RagingWire Telecommunications, INC.*, 174 P. 3d 200-Cal: Supreme Court 2008
- (13) California Health & Safety Code section 11362.5
- (14) *Carol M. Whitmire v. Walmart Stores Incorporated*. No. CV-17-08108-PCT-JAT February 7th, 2019
- (15) Hazle MC, Hill KP, Westreich LM: Workplace cannabis policies" a moving target. Cannabis and cannabinoid research. 13 Nov 2020 <https://doi.org/10.1089/can.2020.0095>

## Tattoos

continued from page 21

- nials: A portrait of generation next. www.pewresearch.org/millennials
- (2) The Harris Poll. (2016). Tattoo takeover: Three in ten American have tattoos, and most don't stop at just one. www.theharris-poll.com
- (3) Klein CA, Kenedi C. Understanding tattoos in medicolegal assessments. *J Am Acad Psychiatry Law* 45:93-101, 2018
- (4) Cardasis W, Huth-Bocks A, Silk KR: Tattoos and antisocial personality disorder. *Personal Ment Health* 2:171-82, 2008
- (5) Dhossche D, Snell KS, Larder S. A case-control study of tattoos in young suicide victims as a possible marker of risk. *J Affect Disord* 59:165-168, 2000
- (6) Armstrong M, Pace-Murphy K. (Tattooing: Another risk-behavior in adolescents warranting national health teaching. *Appl Nurs Res* 10, 181-189, 1997
- (7) Bui E, Rodgers R, Cailhol L, Birnes P et al. Body piercing and psychopathology: A review of the literature. *Psychother Psychosomatics*, 79: 125-129, 2010
- (8) Hohner G, Teismann T, Willutzki U. Tattoos and piercings: motives for body modification from borderline symptomatology. *Psychother Psych Med* 64:63-69, 2014
- (9) Byard RW. Manner of death in individuals with expletive tattoos, *J Forensic Leg Med* 71: 101931, 2020
- (10) Burriss K, Kim K. Tattoo Removal. *Clin Dermatol* 25: 388-92, 2007
- (11) Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. *J Am Acad Dermatol* 55:413-21, 2006.
- (12) Stirn A, Oddo S, Peregrinova L et al. Motivations for body piercings and tattoos—The role of sexual abuse and the frequency of body modifications. *Psychiatry Res*, 190: 359-363, 2011 doi:10.1016/j.psychres.2011.06.001
- (13) Wohlrab S, Stahl J, Kappeler PM. Modifying the body: Motivations for getting tattooed and pierced. *Body Image* 4:87-95, 2007
- (14) Deschesnes M, Finès P, Demers S. Are tattooing and body piercing indicators of risk-taking behaviours among high school students? *J Adol* 29: 379-393, 2006
- (15) Suris JC, Jeannin A, Chossis I et al. Piercing among adolescents: Body art as risk marker--A population-based survey. *J Fam Prac* 56:126-130, 2007
- (16) Preti A, Pinna C, Nocco S et al. Body of evidence: Tattoos, body piercing, and eating disorder symptoms among adolescents. *J Psychosom Res* 61: 561-566, 2006

## PART-TIME PRACTICE? PAY PART-TIME RATES



PRMS® ensures that psychiatrists working 20 hours per week or less receive the same unrivaled protection and service as those practicing full-time – **at rates up to 60% off.**

**RICHARD STAGNATO**  
ACCOUNT MANAGER



More than an insurance policy

(800) 245-3333  
PRMS.com/PartTime  
TheProgram@prms.com



Actual terms, coverages, conditions and exclusions may vary by state. Insurance coverage provided by Fair American Insurance and Reinsurance Company (NAIC 35157). FAIRCO is an authorized carrier in California, ID number 3715-7. www.fairco.com.

### SEEKING CLINICIANS AND FELLOWS FOR RESEARCH PARTICIPATION (COMPENSATED)

We seek participants for a study of clinical decision-making in forensic evaluations. Participants must be clinicians in the U.S. with a terminal doctoral degree (e.g., M.D., Ph.D., Psy.D.) and some form of field experience in forensic evaluation (supervised or unsupervised). Those currently in supervised practice (post-docs, fellows, residents) are eligible.

Participants review online case materials and conduct a mock criminal responsibility evaluation (prior criminal responsibility evaluation experience not required). Approximately 60-90 minutes to complete.

Participants receive \$150.00 in compensation.

To participate, follow the link below (or paste into your Internet Browser):

<http://tinyurl.com/PsychLawStudy>

Questions may be referred to the co-PIs:

Anthony Perillo, Ph.D. ([aperillo@iup.edu](mailto:aperillo@iup.edu))  
Jennifer Perillo, Ph.D. ([jperillo@iup.edu](mailto:jperillo@iup.edu))

Indiana University of Pennsylvania  
Department of Psychology  
1020 Oakland Ave.  
Indiana, PA 15705

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the protection of human subjects ([irb-research@iup.edu](mailto:irb-research@iup.edu); 724-357-7730).





**AAPL Newsletter**  
American Academy of Psychiatry and the Law  
One Regency Drive  
PO Box 30  
Bloomfield, Connecticut 06002

Joseph R. Simpson, MD, PhD, Editor

Non-Profit Org  
U.S. POSTAGE  
**PAID**  
HARTFORD, CT  
PERMIT NO. 5144