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American Academy of Psychiatry and the Law
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2010 Presidential Address

Stephen Billick, MD: Being True to Psychiatry

Kevin V. Trueblood, MD

When Robert Sadoff, MD, was unable to introduce Dr. Billick as planned, Dr. Billick instead "introduced" Dr. Sadoff to us, largely by describing what an inspiring and generous mentor Dr. Sadoff, "one of the founders of AAPL," had been to him since he was a psychiatry resident at the University of Pennsylvania. Dr. Billick then asked, "So, who am I?" During the next few minutes, Dr. Billick guided us along a journey in which he introduced himself and laid the foundation for what was to follow, i.e., his advice for "being true to psychiatry," While providing personal anecdotes and observations along the way, he described himself first as a "member of the human race" and then as "an American." He stated that he felt an obligation to help others and that he hoped the world would be "just slightly better because I passed through it." After discussing how his ancestors had helped to found this country, he stated, "I feel a part of this country and a part of the great hope that this country gives to the world." He explained how much the civil rights movement had meant to him since he was a boy.

Dr. Billick next discussed how much he enjoyed practicing clinical psychiatry and forensic psychiatry; in both areas, he works with children, adolescents, and adults. He marveled about how interesting and fulfilling the field of psychiatry is, and explained how he responded to other specialists who like to "spoof at" psychiatrists. He stated that he also enjoyed teaching, an activity for which he has received numerous awards. He currently teaches at two forensic psychiatry programs; he also taught at St. Vincent's Hospital until it closed in June, 2010. After describing his professional memberships and activities, he colorfully explained that he had been knighted by the Queen of England despite having "descended from some of her majesty's more disloyal subjects." He also described his reasons for learning to speak French at this point in his life. In closing his self-introduction, Dr. Billick described himself as a "farm boy from Wisconsin" who loves being an American, being alive, and being a forensic psychiatrist.

At that point, Dr. Billick asked, "So what do we need to remember when we think about forensic psychiatry?" He advised, "We are psychiatrists who have a subspecialty in forensic psychiatry, not forensic psychiatrists who have a subspecialty in psychiatry. We are psychiatrists. We are physicians." Dr. Billick explained that as forensic psychiatrists, we establish the psychiatric question(s) within a legal context, perform a psychiatric evaluation, and explain to the legal expert what our psychiatric opinion is. As part of our assessment, just like other physicians, we perform a history and physical examination (called a mental status examination), review records, and refer for testing and consultations (e.g., laboratory tests, imaging, and neuropsychological testing) as needed. He advised that as a forensic psychiatrist "you are not an adversarial member of the legal team."

In contrast to the legal process which is adversarial, Dr. Billick described the medical process as "the application of existing scientific knowledge to the individual in question." For this reason, he explained, it is common for psychiatrists hired by opposing sides to arrive at the same conclusion. In court, forensic psychiatrists advocate for their psychiatric opinions, which have been arrived at through psychiatric science. Their job

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Stephen Billick, MD, displays his silver AAPL award as he gladly hands over the mantle of leadership to Peter Ash, MD.

American Academy of Psychiatry and the Law

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COVER STORY

Dr. Billick

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is to "help the court understand the relevant psychiatric issues," not to "go into court and to win it for the attorney."

Dr. Billick explained that forensic psychiatrists, including respected colleagues, may arrive at different opinions in a case, just like cardiologists or engineers may disagree in their opinions. He stated that this does not mean that there is something wrong with psychiatry. He also advised, "You can disagree without having to become disagreeable. You can disagree with your colleagues and still be respectful." He described how he had once responded in court when asked, "Doctor, do you know Doctor X? Would you consider him to be a good forensic psychiatrist?" Dr. Billick replied, "No, I would actually consider him to be an excellent forensic psychiatrist. . ."

"...forensic psychiatrists, including respected colleagues, may arrive at different opinions in a case, just like cardiologists or engineers may disagree in their opinions"

By discussing case examples from his practice, Dr. Billick challenged the commonly held belief that psychiatric treatment and forensic evaluation roles must always be kept separate. In the first case example, Dr. Billick explained how his role expanded from that of a treating psychiatrist, while in his second example, his role expanded from his initial role as forensic psychiatrist. In both examples, Dr. Billick explained how his role had logically changed, with the patient/evaluee benefiting from his serving a dual role.

After stating that there are many opportunities in forensic psychiatry to be therapeutic, he asked, "And why wouldn't you want to be therapeutic if you could be?" He described how he has offered therapeutic interventions during various forensic evaluations, e.g., child custody cases, child abuse and neglect cases, and NGRI cases.

Dr. Billick discussed the importance of being a "professional" and avoiding bias. He advised, "Remain professional in your relationships with those you evaluate for forensic contexts." He distinguished "boundary violations," which you should definitely avoid, from "boundary crossings" which you should avoid if you can. .

Dr. Billick concluded is speech with perhaps what he considered his most important advice: "Be a physician and a psychiatrist. Help the nonmedical individuals understand the role of the psychiatric physician in a forensic setting. Stick to the current understanding of psychiatric science, and thank you."

MUSE & VIEWS

A Dentist Is Fingered for Fraud

Dr. John Rende, a 38-year-old Florida dentist, agreed to allow two brothers to cut off a finger with an axe and claim it was an accident. He collected a $1.3 million lump-sum settlement from one brother's homeowner's policy, and filed under his own disability policy as well. Rende used some of the money to buy a yacht, which he named "Minus One." He and his brothers pleaded guilty and are currently in jail.

Source: http://www.freemaninstitute.com/hall_of_shame.htm

Submitted by Charles Scott, MD

Boxed in a Box: Protecting Inmates and Clinicians

Charles C. Dike, MD, MPH, MRCPsych

It is time to walk through the double iron doors that would lead me into the maximum security psychiatric hospital where I work. Of course, I have locked away my phone and other metals on my person - also known as contraband - in my office which, mercifully, is outside the enclosure of the maximum security hospital. I have even taken off my tie; a relatively new initiative from the risk committee is for all neck ties to be removed before walking into the units of the hospital. I will not even attempt to discuss the furor this initiative caused among some psychiatrists and psychologists who saw the wearing of a tie to work as an integral part of their identity; some are still learning to be comfortable with their new self, while still going through a withdrawal syndrome from their old self. I remember the case of a psychiatrist who, upon being asked to participate in a high powered case conference on one of his high profile patients, insisted on putting on his suit and tie. In his mind, an important clinical event such as was at hand required a professional presentation, which included wearing a tie! Who am I to judge?

Okay, I shall not be distracted. Have I talked about going through a metal detector, in addition to being "wanded" by the hospital police, before getting in between the two iron doors? Yes, I have gone through the detectors, and thankfully, have been cleared to proceed. Now, however, I am in between the metal doors and facing a bullet proof glass structure through which the agency police observe me, even if for a brief moment. Then one iron door opens and Voila! I am inside the maximum security hospital environment.

Once inside, each unit (or ward, in regular hospital parlance) is self-contained – everyone has been trained to be sure to lock the doors after them, before proceeding into or through the unit. Once inside, you are locked in until it is time to leave. Once inside, it is you and the patients sharing the same space; you and some of the most dangerous patients, a small proportion of whom were delivered to the hospital right out of the custody of the Department of Correction, including from the super max prison. Such is life.

There is only one way out, through the double iron doors described above. I have heard some staff members describe the dread they feel going into work – "like being locked up in prison." Watching staff members walk out of the double iron doors after their shift tells the story. Some staff members exhale deeply as if they had held their breath throughout their shift, and you can see their shoulders drop in sheer relief. You can almost hear them yell out in their heads: Free at last! They will savor their "freedom" to the utmost, until it is time for another shift. Little wonder people count down to their retirement (20 years of hazardous duty), to the last minutes and seconds. No introduction of themselves to new staff members is complete without a statement of how long they have left to retire!

If staff members, who are mostly mentally stable, have homes to retire to after work and are able to engage in hobbies, feel this way about 8 hours of voluntary enclosure, I wonder how mentally unstable patients involuntarily housed in prisons or jails, and subsequently placed in cages due to risk of harm to self or others feel. A couple of articles published in the LA Times on December 28 and 29 described their plight. Titled "Objections raised to caging inmates during therapy," and "A parody of therapy" respectively, the articles start with a shocking picture of a music therapist conducting a group therapy session with two inmates who are in different cages the size of telephone booths. The music therapist was of course not in a cage while these individuals who have now clearly drifted downward into sub-human category due to the twin ravages of mental illness and criminal behavior were. It would have been quite hilarious, were it not for the seriousness of the situation. In fact, a commentator wryly observed; "Singing folk songs to a criminally insane man who's sitting inside of a cage the size of a phone booth? Is this an SNL skit?" Even monkeys locked up in cages at the zoo have not looked so pitiful and pathetic. Was there any thought to feelings of claustrophobia in these individuals, or were their anxious and agitated lashing out behaviors in response to feeling closed in seen as confirmation of their high potential for aggression and assaults, and hence, justification to "cage" them? How could one justify keeping paranoid and frightened individuals in those cages? There were comments reportedly made by some staff members that these cages were more humane than placing people in restraints. I wonder…

In this issue, a commentary describes the use of cages for suicidal inmates in a Louisiana jail. Of course, I understand the need to keep mental health professionals and inmates/patients safe. However, I couldn't suppress the sadness the picture roused in me. There must be a better way. Exchanging humanity for treatment seems contrary to the "Do no harm" oath we all swore to. Something must give!

MUSE & VIEWS

An "indignant" wife testifies in court!

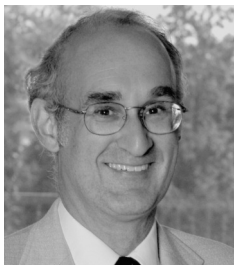
Q. Did you tell your lawyer your husband had offered you indignities?
A. He didn't offer me nothing; he just said I could have the furniture.

Source: http://www.freemaninstitute.com/court.htm

Submitted by Charles Scott, MD

Learning From Colleagues

Peter Ash, MD, President



When I first began attending AAPL meetings in the early 1980s, AAPL was much smaller, and there was a tradition that breakfast was provided for all meeting attendees in the hotel lobby. The group was small enough that it was easy to talk to anyone who was there. For me, starting out in forensic psychiatry, coming from a university that didn't have a forensic fellowship, and feeling lost at the even-then huge APA meetings with their multiple hotels and shuttle buses, the collegial feeling of that small group was inviting and heartwarming, and crucial to me in forming and sustaining a professional identity as a forensic psychiatrist. Since then, to me, the essence of AAPL has been learning from colleagues. We learn formally in the meeting rooms; we learn informally in the halls.

AAPL has grown enormously since those early days, and the morning group breakfasts are no more, but the spirit of learning from colleagues is still strong. Our October Tucson meeting, attended by about 700 participants – more than a third of our members – was a great success. In addition to a rich panoply of courses, workshops, posters, papers, and panels, we had many special events: a mock trial, a special presentation on the Arizona immigration law, two Isaac Ray lectures, and three debates. Even the Sunday presentations were well attended. There were lively discussions in the hall, around the fires on the patio, and on walks among the Saguaro cacti in the hills across from the hotel. I always leave an AAPL meeting rejuvenated and fired up with new ideas.

Much of AAPL's work is in committees. At the recent AAPL meeting I met with the each of the chairs of our 20 special committees, and I was very impressed that all of the committees are working well, getting their *Newsletter* articles completed, and planning exciting projects for the coming year. I hope to support the fine work our committees have been doing, and I encourage the committees to meet in Hawaii in May at the AAPL Semiannual Meeting on the Saturday of the APA meeting. I look forward to seeing you at in the meeting rooms and on the beach.

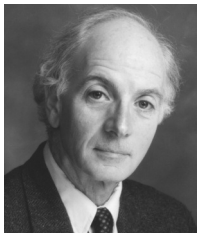
Among the many projects components of AAPL are pursuing, we have 5 initiatives that I would like to highlight, areas where I hope to see significant progress in the coming year:

- Maintenance of certification (MOC) is a new, confusing process that affects all of us who are Board-certified. Debra Pinals, MD, and a Task Force of the Education Committee, worked very hard in the months before the Tucson meeting to compose a 110 question examination that will fulfill the self-assessment component for those recertifying before 2014. More than 100 members took the test the Wednesday before the meeting. In the coming year, the Task Force will be working on assisting members with meeting the other MOC requirements, including the requirement for an assessment of Performance in Practice (PIP). PIP requires a practitioner to compare data about actual patients from his or her practice to standards set out in professional Practice Guidelines. As members become familiar with the new MOC requirements, I am sure they will appreciate the ways in which AAPL is working to help with their recertification.
- The AAPL Institute on Education and Research has been actively funding projects, and we will continue to support their work.
- To further foster forensic research, we're working to put together collaborations with other organizations. Robert Trestman, PhD, MD, is coordinating a collaborative effort with the American Psychology-Law Society (APLS) that will promote co-investigator relationships between members of APLS and AAPL. This should be of particular benefit to our more junior members. Edward Mulvey, PhD, immediate past President of APLS, joined us at a panel in Tucson, and Dr. Trestman will be presenting at the APLS meeting in March. We hope to have a clear collaborative plan reviewed by both organizations by the fall.
- AAPL Practice Guidelines have been valuable to members and to the public, and now, they have also become important in the Performance in Practice component of the MOC requirements. At the Executive Council meeting in October, we decided that AAPL will develop a new Practice Guideline on conducting a forensic evaluation. Graham Glancy, MB, is heading the task force writing group.
- I believe that the accumulated published wisdom of AAPL, as reflected in the now 37 year archives of the AAPL Journal, should be available to the entire world. We now have a plan to put it all online, a plan that I am optimistic we can complete in the coming year. Neil Kaye, MD, has one of the very few private collections of old AAPL journals going back to Vol. 1, No.1, and he has generously offered to sacrifice their bindings so they can be scanned. Mark Hauser, MD, our website editor, will be working to get the scans published on the web.

I look forward to supporting these initiatives, and in helping to develop new ones. AAPL is in fine shape: the meetings are intellectually rich, the organization is fiscally sound, and collegiality is strong. I appreciate your efforts, I welcome your suggestions, and I look forward to working with all of you in the months ahead.

Prosecutorial Access to Nontestifying Defense Experts

Howard Zonana, MD, Medical Director



In preparing psychiatric reports for defense counsel, forensic psychiatrists are generally careful to include a confidentiality section that attempts to say that the evaluation is initially confidential, under the attorney-client privilege or work product rules, and that it will remain so unless the attorney requested a report and/or testimony. Does this reflect a clear legal standard? Like many legal rules, there are some notable exceptions.

In reviewing Pope v. Texas, a case from the Texas court of Criminal Appeals in 2006,[1] it was instructive to be reminded of some distinctions that the law has made with regard to expert witnesses, attorney-client privilege, and work product rules.

In this nonpsychiatric case, a DNA expert, Dr. B., was disclosed to the state as a potential expert witness for the defense. At the time of trial he was not called to testify, but the defense challenged the State's DNA experts regarding the validity of their methods used to analyze the sample. The State argued that the cross examination opened the door and that the state's experts could now be questioned about their knowledge of Dr. B. The court permitted the questioning as long as it was not mentioned that the defense had hired him. This allowed the state to say in its closing argument:

> "And don't you know, don't forget this, if they had one person, one expert who knew anything about DNA and the testing procedures, they would have put somebody on that witness stand today. . . . [Appellant's objection overruled] And don't you know, Benjamin or anybody else, and Jamie testified, yes, all of these notes were sent to him. Now, do you think he just threw them in the trash? I think it's probably reasonable to conclude that perhaps he looked at them. And don't you know that if he had any quarrel whatsoever with the results these people at GeneScreen obtained, that he'd have decorated that witness stand and said, you can't believe anything."

The appellate court, in its review, went on to clarify the distinction between the scope of the attorney client work-product doctrine and that of attorney-client privilege.[2] The work product doctrine is not as protective as it is not a privilege and can be overcome in certain situations. The court also distinguished between consulting experts and testifying experts and how the opinions of a consulting expert whose views have not been shared with the testifying expert are not discoverable.

However, in this case the court went on to create a new category of nontestifying expert. They said that since Dr. B was never "de-designated," as a testifying expert, his identity and qualifications were not protected by any work product doctrine. In addition, since the defense had filed a formal motion asking the court to directly send documents to him for review, it was also not protected. The solution for them was simple: "investigate first, consult second, designate third."

> "The designation of a potential expert witness under *article 39.14(b)* is an act similar to crossing the Rubicon in that it may waive many of the protections otherwise provided by the work-product doctrine, although it will not waive any confidential communications under the attorney-client privilege"[3]

While there are many legal issues that can be raised with this case, I use it to introduce some potential problems for psychiatrists. Is it possible for the prosecution to call a defense psychiatric witness who was not called to testify? The short answer is that it may be possible in some circumstances in some jurisdictions.

In Ake v. Oklahoma, the Supreme Court guaranteed a due process right for criminal defendants to obtain expert psychiatric assistance. It has remained unsettled whether the prosecution may have access to any report generated by those experts. Cases that were decided before Ake went in both directions and were decided on nonconstitutional grounds.

A leading case for preservation of the privilege was U.S. v. Alvarez in which Dr. R. Sadoff was appointed at defense counsel's request to evaluate a man charged with kidnapping and conspiracy to kidnap. Following his evaluation, he concluded that the defendant did not meet the criteria for an insanity defense. The defense counsel, nonetheless, decided to go forward with the defense but not call Dr. Sadoff. The prosecution, however, subpoenaed him. When the defense moved to quash, the court denied the motion and permitted Dr. Sadoff to testify over objection.

After conviction, the appellate court overturned the conviction ruling that the admission of the testimony was an error. Judge Gibbons argued:

> "The issue here is whether a defense counsel in a case involving a potential defense of insanity must run the risk that a psychiatric expert whom he hires to advise him with respect to the defendant's mental condition may be forced to be an involuntary government witness. The effect of such a rule would, we think, have the inevitable effect of depriving defendants of the effective assistance of counsel in such cases. A psychiatrist will of necessity make inquiry about the facts surrounding the alleged crime, just as the attorney will. Disclosures made to the attorney cannot be used to furnish proof in the government's case. Disclosures made to the attorney's expert should be equally unavailable, at least until he is placed on the witness stand. The attorney must be free to make an informed judgment with respect to the best course for the defense without the inhibition of creating a

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Prosecutorial Access

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potential government witness." The court rejected the argument that the defendant, raising the insanity defense, waived the privilege. The court also held that the admission of the testimony was not harmless error.

But, other decisions have permitted the prosecution access to nontestifying psychiatric experts. A major case was U.S. ex rel Edney v. Smith.[4] Facing charges of kidnapping and murder of an eight-year-old daughter of a former girlfriend, the defense argued insanity and called an expert. The court permitted the government to call a defense witness hired for trial preparation but not called by the defense. At that time New York had a rule that stated:

"where insanity is asserted as a defense and * * * the defendant offers evidence tending to show his insanity in support of this plea, a complete waiver is effected, and the prosecution is then permitted to call psychiatric experts to testify regarding his sanity even though they may have treated the defendant.[5]

Thus the court ruled that the defendant waived any claim of attorney–client privilege by offering expert testimony on the insanity issue. The court was aware that most other opinions did not support waiver but it felt that the error did not rise to a constitutional violation. It also was aware this was an unsettled issue but was also persuaded by the counterbalancing interest of the state in accurate fact finding.

In the early 1990s, two review articles reviewed the literature and made opposing recommendations;[6] one suggesting the privilege should be quite strict in precluding prosecutorial discovery. That author also felt that the mere assertion of an insanity defense should not constitute a waiver.

The second article by Imwinkelried took a less strict view. His proposal was that the communications from the defendant to the psychiatrist should be protected but the psychiatric expert's report was not privileged even if the expert was not testifying. It was attorney client work product and he felt that if the prosecution had a compelling need for the information, it should be released.

There have been a number of other cases where this issue has been reviewed. In Lange v. Young, the Seventh Circuit Court of Appeals denied Lange's application for a writ of habeas corpus, in part, by not supporting his claim that the government violated his constitutional right to counsel by calling a psychiatrist who was originally retained by defense counsel. The psychiatrist was initially consulted in the preparation of an insanity defense for a murder charge and concluded that the defendant did not qualify. He was not retained. At a second trial looking at the sanity question, the government called him as their witness. The trial court permitted him to testify, ruling that the attorney-client privilege did not bar the testimony. As a matter of State law the Wisconsin Court of Appeals held that the attorney-client privilege does not extend to statements made by the client to a psychiatrist or to the opinion of the psychiatrist based upon those statements. Wisconsin law states there is no psychiatrist privilege if a person uses his mental condition as a defense in civil or criminal matters, in its confidentiality and privilege statute for psychiatrists.[7] The court did not distinguish a forensic psychiatrist employed by defense counsel from a treating psychiatrist. There is also an exception to the psychiatric privilege if the court orders the evaluation.[8]

"These were all cases before the U.S. Supreme Court decided Jaffee and announced a psychiatric privilege in federal courts, but as recent cases indicate, the controversy has not disappeared."

In sum, courts have split on this question. Some courts hold that when a defendant asserts an insanity defense, the attorney-client privilege is waived or otherwise does not apply as to a nontestifying defense-retained examining psychiatrist. Examples of such holdings include: *Haynes v. State,* 103 Nev. 309, 739 P.2d 497 (1987); *State v. Craney,* 347 N.W.2d 668 (Iowa), *cert. denied,* 469 U.S. 884 (1984); *People v. Edney,* 39 N.Y.2d 620, 350 N.E.2d 400, 385 N.Y.S.2d 23 (1976); *State v. Carter,* 641 S.W.2d 54 (Mo. 1982), *cert. denied,* 461 U.S. 932 (1983). Others have held that the attorney-client privilege applies. Examples in favor of this view include: *United States v. Alvarez,* 519 F.2d 1036 (3d Cir. 1975); *Houston v. State,* 602 P.2d 784 (Alaska 1979); *People v. Lines,* 13 Cal. 3d 500, 531 P.2d 793, 119 Cal. Rptr. 225 (1975); *Miller v. District Court,* 737 P.2d 834 (Colo. 1987); *State v. Pratt,* 284 Md. 516, 398 A.2d 421 (1979).

These were all cases before the U.S. Supreme Court decided Jaffee[9] and announced a psychiatric privilege in federal courts, but as recent cases indicate, the controversy has not disappeared.

In conclusion, it is important to know what the rules are in the jurisdiction of the evaluation; blanket statements may not hold up. Courts seem more concerned about the possibility of malingering in psychiatric cases when deciding not to maintain the privilege. These cases are of interest in exploring the nuances of attorney–client privilege, work product doctrine, and the forensic roles of consulting and testifying experts with the peculiar variation of designating an expert, which may change the confidentiality status of the expert's work even if he/she is not called.

References:

1. Pope v State, 207 S.W. 3d 352 (2006); writ of Cert. denied 549 U.S. 1350 (2007)
2. Pope v State, ibid at 357-358. The attorney-client privilege is an evidentiary privi-

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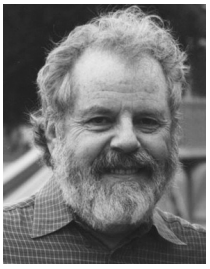
Passing Judgment: Serving As An Expert in Malpractice Cases

Stephen P. Herman, MD



Medical malpractice. Those horrid words send a bolt of fear down our spines, with thoughts of a career ruined, embarrassment around colleagues and a permanent plaque on the wall of miscreants in the National Practitioner Data Bank.

But, forensic child and adolescent psychiatrists, during the course of their careers, are likely to be called as expert witnesses in malpractice cases brought against other child psychiatrists. Frequently, an attorney representing either side may seek an expert outside the defendant's geographic area, to avoid turning to the same medical community as the "accused." You may be contacted by the attorney for the plaintiff physician or the attorney representing the defendant. As with all cases, the forensic expert should consider herself an independent evaluator, no matter which attorney calls.

An attorney for the plaintiff may contact you even before a case slithers its way through the court for a short review of documents with the goal of your opining on whether there is a case in the first place. A plaintiff's attorney, usually working on a contingency basis, is loathe to accept a case without substance.

The potential expert witness should make sure he/she is qualified to assist in a case. For example, if you have little or no hospital experience, it makes sense to tell the attorney that you might not be the strongest expert for a case involving the inpatient treatment of a child. Or, you might not be the best person to whom the attorney should turn with a case involving complicated issues in child psychopharmacology. On the other hand, an attorney may prefer a forensic expert first and foremost - someone familiar with the legal system and not intimidated by the rough and tumble nature of litigation.

Example: A child psychiatrist was contacted by a plaintiff's attorney who represented a young man for whom another psychiatrist had prescribed a stimulant for ADHD for years. Although the client was now 21, the attorney's thinking was he would do better with an expert very familiar with this condition and the proper way to prescribe medication. He called a forensic child psychiatrist.

The plaintiff had moved to another state. The defendant psychiatrist never referred the patient to another psychiatrist and was very vague - according to the medical records - about whether and when his patient should continue to take the stimulant. The plaintiff entered a graduate program in architecture. On his own, he increased his dose of the stimulant, fearing he would not be able to concentrate in school. No physician was monitoring the medication use. The student became hyperirritable, spoke out against his teachers, and became psychotic. One day in school, he destroyed a model building being worked on by other students. He also threatened to harm one of his teachers. He had a bit of insight left and went to an emergency room. He was hospitalized on a psychiatry ward for two days and then, asymptomatic, he was released. However, he was dismissed from the graduate school. He contacted an attorney and the attorney called you. Was the psychiatrist negligent? Would you help the attorney?

"...if you have little or no hospital experience, it makes sense to tell the attorney that you might not be the strongest expert for a case involving the inpatient treatment of a child."

An important concept for the forensic psychiatrist is to understand what the standard of care was in the community of doctors at the time the alleged negligence occurred. How did other psychiatrists treat the illness or condition?

You might be called by the attorney for the defense. Again, your job is to make an independent assessment. If you conclude the client might very well be negligent, you must share this with the defendant's lawyer. Upon hearing this sort of news, the defense might still be grateful to be able to understand the deficiencies in his case. That could lead to a successful settlement conference. On the other hand, some attorneys, hearing your bad news, might shop around for another expert to say what the attorney wants to hear.

Example: You are contacted by a defense attorney for a psychiatrist accused of malpractice. You learn that without supporting in his records his diagnosis of a 10-year-old child with schizophrenia, he nevertheless placed the child on an antipsychotic medication which caused a life-threatening event. The lawyer's theory of the case was that the psychiatrist had explained his diagnosis to the parents and carefully provided information for them to determine that the child ought to be placed on the medication. Also, the concept he would get across to a possible jury would be that the doctor had warned the mother about the side effects of the drug and that what occurred was a negative outcome - not malpractice. The physician just did not document this. What would you tell the attorney?

Serving as an expert in a med-mal case can be very dicey. And, we have all made mistakes. The attorney will certainly want to know whether you have ever faced a malpractice suit or a complaint to a state medical board. Your credentials need to be impeccable. These cases are often complicated and emotionally draining for the expert. However, this is another way to assert and maintain professional standards, to assist doctors unfairly accused of malpractice or to aid those directly hurt when those standards are breached.

Bryan Stevenson, Esq.:

Reevaluating Juvenile Culpability and Evolving Standards of Decency

Sylvester Smarty, MD

Bryan Stevenson, Esq. gave a talk following lunch at the Annual Meeting of AAPL on Saturday October 23, 2010. An alumnus of Harvard Law School, he is Professor of Law at New York University (NYU) School of Law, and nationally recognized as one of the leading advocates of a fair approach to the punishment of juveniles charged with violent crimes. His talk centered on the need for the American judicial system to have a more lenient approach to the punishment of youth charged with violent crimes. He also advocated for a greater role by psychiatrists and psychologists in helping courts formulate appropriate standards for juvenile culpability and punishment.

Mr. Stevenson reviewed some statistics related to the increased rate of incarceration in the United States and its consequences, especially within minority groups. He reported that 2.3 million people were incarcerated nationwide, and another 5 million were on probation. The consequences of this "mass incarceration" have been particularly tough on minority communities. For example, 37.5% of African Americans in the state of Alabama are currently ineligible to vote because they have a criminal record. Mass incarceration has resulted in a sense of hopelessness and lack of aspirations in the minority communities. Consequently, a majority of African American youth do not expect to be alive or "free" by their twenty-first birthday.

Mr. Stevenson attributed the trend towards mass incarceration to political pressure; most politicians believe that being viewed as "tough on crime" helps win elections. This belief has fostered a number of programs, such as war on drugs, which have led to the incarceration of millions of individuals with a major drug use problem. Another example is the "Three Strikes and You Are Out" program in several states that causes convicted felons to be sentenced to life imprisonment without parole for minor crimes such as stealing a piece of candy, because they had two prior convictions.

Mr. Stevenson observed that in the 1980s, political pressure caused some politicians to put forth ideas that the juvenile justice system was inadequately equipped to deal with a new breed of children called "super predators." These were youth charged with violent and often gruesome crimes such as serial murder and rape. New laws were subsequently passed in several states that made it mandatory for youth charged with such crimes to be tried as adults in adult court. Consequently, many youth were sentenced to "death in prison" for such crimes. "Death in prison" was defined as being sentenced to life imprisonment without parole or being sentenced to many years in prison without option of parole. In his opinion, this trend of trying children in adult court and sentencing them to "death in prison" has been "a tragedy," and has led many legal scholars to question society's approach to juvenile culpability.

> *"...81% of children 'sentenced to die' in prison are either African Americans or Hispanics, a trend that goes against the notion of fair justice - race should not be a basis to conclude that any child is 'beyond redemption.'"*

Mr. Stevenson told the success story of an eleven year old boy to buttress his point. The boy lived with his mother who was repeatedly abused by her boyfriend. One night, he shot the mother's boyfriend while he was sleeping because he was tired of witnessing him abuse his mother. He was subsequently charged with murder in adult court - his victim was a Deputy Sheriff. When he (Mr. Stevenson) visited the boy at the county jail, he learned that he had been repeatedly raped by various individuals. The courts were petitioned and the boy was ultimately tried through the juvenile court system. The same boy recently graduated from college.

Mr. Stevenson observed that the move by some states to legalize the execution of children in the early twentieth century was politically driven. This move was challenged in the Supreme Court in 1980 but the Court ruled that it was not cruel and unusual treatment to execute youth convicted of violent crimes. However, the fight to abolish the death penalty for mentally retarded individuals and for children finally paid off in *Atkins v. Virginia* (2002), and in *Roper v. Simmons* (2005) in which the Supreme Court held that the death penalty for mentally retarded individuals, and for children respectively, constituted cruel and unusual punishment and, therefore, was unconstitutional. In the latter case, the Court reversed itself. According to Mr. Stevenson, such decisions were possible because the intellectual capability of children and mentally retarded individuals had "measurable biological parameters"; the finding that the brain of children was not fully developed contributed immensely to the Court's ruling.

Mr. Stevenson postulated that sentencing criminals to life in prison without parole is based on the premise that such individuals cannot be rehabilitated. However, such sentences in children are unjustified because scientific evidence shows that they are still

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Helen Mayberg, MD:

The Brain on Trial

Victoria Dreisbach, DO

At the 41st AAPL Annual Meeting, the luncheon addresses began with a fascinating lecture by Helen Mayberg, MD, Professor of Neurology and Psychiatry, and the Dorothy Fuqua Chair in Psychiatric Imaging and Therapeutics at the Emory University School of Medicine. Dr. Mayberg shared experiences and valuable insights from her work as an expert witness when brain-imaging evidence has been presented for the purposes of causation or mitigation.

Dr. Mayberg described herself as being "dazed and confused" by her first experience in the forensic arena in 1992. Since then, she has testified in more than 50 capital cases for both the prosecution and defense. Her experiences have led her to consider how brain imaging can be interpreted (and misinterpreted) in a legal context.

As a neurologist and expert in brain imaging, Dr. Mayberg shared the thoughts she often considered in preparing for trial. A fundamental question usually asked is whether there is evidence of brain damage "not otherwise specified." Inherent in the term "brain damage" is the idea that there may be a neurological and/or psychiatric disease or disorder. However, symptoms may arise as a consequence of many other etiologies.

Dr. Mayberg compared and contrasted the evolution and utilization of new technology to analyze the brain in the clinical and forensic setting. Instruments such as CT Scans, fMRI, MRI, PET and SPECT scans were developed to narrow differential diagnoses and ultimately assist in making diagnosis, to track changes in response to treatment, such as tracking changes in SPECT scans after initiating treatment for bipolar disorder, and to identify markers of disease.

The use of scans in a forensic setting, however, may give the appearance of being more objective than the standard clinical examination. A colleague of Dr. Mayberg referred to this phenomenon as the "scientific awesomeness factor." Whether scientifically generated data is probative or prejudicial is related to how the information is presented in court. Dr. Mayberg opined that expert testimony should not only present the scientific data, but should also interpret it to minimize the probability of introduction of inferences and conclusions that have no scientific support.

She discussed the use of PET scans in confirming disease, noting that a scan pattern that is reliable and specific for a psychiatric diagnosis has never been scientifically proven. Similarly, a scan pattern does not predict what someone is like. In addition, she pointed out that PET scans provide a "30 minute snapshot" of the person's circumstances and gives no information about the retrospective mental state of an individual.

"Dr. Mayberg opined that expert testimony should not only present the scientific data, but should also interpret it to minimize the probability of introduction of inferences and conclusions that have no scientific support."

The ethical repercussions of the use of brain scans in court were also raised. Dr. Mayberg opined that any abnormality a juror sees could give rise to reasonable doubt irrespective of whether the abnormality is scientifically valid or specific. As she succinctly queried, does a scan predict diagnosis? Does diagnosis predict behavior? And therefore, does a brain scan predict behavior? Such inferences must be carefully considered.

Using *Roe v. Simmons* as example, Dr. Mayberg presented a concise and compelling overview of some of the issues that have been raised related to culpability and neurological development. She referred specifically to amicus curiae briefs that presented a maturational argument from which inferences were drawn. Related thought-provoking questions worth pondering include: What would it mean if one were precociously mature? For example, if a 13-year-old had a brain that appeared to be as mature as an 18-year-old, should the individual be prosecuted as an adult?

Dr. Mayberg concluded her lecture by discussing cases in which the use of PET scans in court were unsuccessful: in the 1999 trial of Mafia boss Vincent Gigante in New York, and in the 2007 Lisa Montgomery case in Kansas City, PET scans were unsuccessfully introduced as diagnostic evidence of disease. In the latter case, a PET scan result that reportedly diagnosed pseudocyesis was disallowed in court because it failed the Daubert test.

MUSE & VIEWS

A witty US Supreme Court Justice!

"It's not unprofessional to give free legal advice, but advertising that the first visit will be free is a bit like a fox telling chickens he will not bite them until they cross the threshold of the hen house."

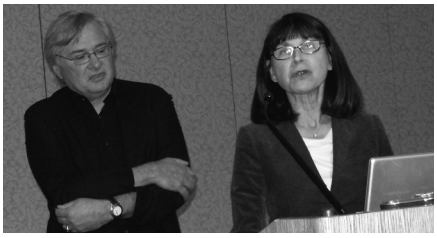
Source: http://thinkexist.com/quotation/it_is_not_unprofessional_to_give_free_legal/227541.html

Submitted by Charles Scott, MD

Carole Goldberg, Esq. and Duane Champagne, PhD:

Indigenous Ways of Justice: Healing Individuals and Communities

Brian Cooke, MD



AAPL members were treated to a stimulating lunch lecture on Friday, October 22, 2010 delivered by Carole Goldberg, Esq and Duane Champagne, PhD: "Indigenous Ways of Justice: Healing Individuals and Communities." Goldberg is the Jonathan D. Varat Distinguished Professor of Law and Director of the Joint Degree Program in Law and American Indian Studies at UCLA. Champagne is a member of the Turtle Mountain Band of Chippewa from North Dakota, a Professor of Sociology and American Indian Studies, and member of the Faculty Advisory Committee for the UCLA Native Nations Law and Policy Center.

Goldberg and Champagne are co-authors of a major report, *Law Enforcement and Criminal Justice under Public Law 280* (2008), and recently received a $1.5 million grant from the National Institute of Justice to conduct a nationwide study of the administration of criminal justice in Indian country (i.e., the many self-governing Native American communities throughout the United States). Alleviating some concerns from the audience, the speakers reported that their work was done in collaboration with and involved extensive consultation with Indian country leaders. This AAPL presentation highlighted research that has emerged from this grant. From their extensive experience, they asserted that issues relating to criminal justice in Indian country continue to be high profile.

Setting the stage, Goldberg noted that the most frequently perceived occurring offenses in Indian country were domestic violence, driving under the influence, and drug-related offenses. These offenses, however, had divergent attention from law enforcement. In what has been described as a "maize of injustice," they explained the complex system of criminal jurisdiction in Indian country. The three-part system of criminal jurisdiction in Indian country involves the tribes, the States, and the Federal. For example, if there is a non-serious crime against one Indian to another, only the tribe will have the jurisdiction.

"This system includes an interwoven matrix of native cultures, native communities, tribal courts, state and country courts, Bureau of Indian Affairs courts, US culture(s), and the US public."

Further complicating the issue is that criminal justice administration varies from place-to-place. The speakers focused their attention on detailing a six-component understanding of what variables contribute to the effectiveness of Reservation Criminal Justice. These factors include control (i.e., who controls the jurisdiction, and includes perceived legitimacy and accountability), management of effectiveness, fairness (including discrimination and politicization), culture compatibility, intergovernmental cooperation, and resources.

Champagne detailed the "complicated system" of multi-cultural and multi-institutional Indian country courts. This system includes an interwoven matrix of native cultures, native communities, tribal courts, state and country courts, Bureau of Indian Affairs courts, US culture(s), and the US public. He proposed that understanding who administers and controls the courts, police, and jails is "one of the most effective ways of understanding the patterns [in Indian country criminal justice]." Their research clearly demonstrates a pattern of disagreement between tribal and state respondents in perceptions of criminal justice. More emphatically and with concern, Goldberg noted that, "Many things are not going well in Indian country."

The lunch talk concluded with crème brulee and a quick taste of a case analysis from the Tulalip Reservation, which is subject to Washington State jurisdiction. The speakers had been sent there to evaluate the reservation's Alternative Sentencing Program – a type of indigenous jurisprudence to target the mental, physical, and spiritual health of the offender. The speakers' analysis focused on the issue of a road that crosses through the Reservation but was not adequately patrolled by State police for drunk driving.

On a larger scale, Champagne and Goldberg concluded that their effort is to promote cooperation within the system and to look ahead to policy changes that would improve criminal justice within Indian country.

MUSE & VIEWS

Famous quotes from Oliver Wendell Holmes

"The character of every act depends upon the circumstances in which it is done."
Source*: Schenck v. United States*, 249 U.S. 47, 52 (3 March 1919).

"A page of history is worth a volume of logic."
Source*: New York Trust Co. v. Eisner*, 256 U.S. 345, 349 (1921).

Submitted by Charles Scott, MD

"Roughing It"

Stephen Zerby, MD

The challenges of clinical mental health work in forensic settings such as detention centers, jails, prisons, or community-based programs are great. The goal of this column is to stimulate discussion to bring to light these challenges and ultimately devise strategies to provide improved care to offenders with mental illness. We encourage you to share your experiences in this column, and forward any stories, comments, suggestions, or ideas to zerbysa@upmc.edu.

As forensic psychiatry fellowship recruitment season winds down, an obstacle comes to mind. The level of control one has over didactic and rotation schedules contrasts with other important factors over which one has little control, such as the settings in which we provide clinical care. Such settings can prove challenging to "sell" as they are far different than the usual mental health settings that are competitors for the services of graduating residents. Most mental health professionals are not the toughest people around, and their presence in forensic settings can seem incongruous, especially because their clientele often prove to be dangerous types. The four chief purposes of the correctional system include containment, punishment, rehabilitation, and deterrence. The mental health clinician's role in providing for inmates' mental health needs indirectly aids inmates' compliance with the punitive aspects of their sentences - rehabilitation is the one area in which mental health professionals play a direct role. Sadly, rehabilitation can sometimes be difficult in an environment designed primarily for security purposes. The mental health professional is often in the middle of competing interests of punishment versus rehabilitation.

The physical settings of jails and prisons are often stark and intimidating. Upon entering a traditional mental health clinic, the practitioner sometimes passes through a waiting room of patients and their relatives, or other loved ones. While the standard mental health clinic has its security needs, the feel of the clinic is more therapeutic than security-oriented, unlike a correctional setting where searches and metal detectors greet clinicians each day, as they come to work. Pagers and cell phones may not be permitted, and internet access may be lacking. The end of the workday may be delayed by unforeseen circumstances such as lockdowns. Clinical areas may lack the customary accoutrements of standard mental health facilities and the work environments simply may not feel therapeutic. In traditional mental health settings, staff conflicts are often resolved through processing and problem-solving, but in forensic settings, one must be prepared for the more direct means in which staff members communicate with each other.

> *"Presenting oneself as too unlike correctional staff risks appearing as an 'outsider,' alien to the environment, which may decrease the comfort level of staff to effectively communicate their thoughts with one."*

While the blunt manner of communication in forensic settings can have its drawbacks, unexpected benefits can follow. On one occasion, when I was evaluating an inmate and poring through records with multiple vague diagnoses, a correctional officer made a rather forceful joke implying a specific diagnosis that had never been mentioned by any of the multiple psychiatrists who had treated the inmate over the years. Further evaluation actually confirmed the presence of the disorder, leading me to follow a rule of always listening to what the correctional officers had to say. Front-line forensic setting staff has in the past mentioned to me their observations of inmates, questioned the possibility of inmates suffering from the effects of past trauma, offered specific diagnoses, or provided their own hypotheses about the inmate's psychopathology. Unless there is a good reason to do otherwise, this information can be considered important collateral information. Correctional treatment teams sometimes include correctional officers as an integral part of the team. They know inmates well and are great sources of information and insight. It is wise to have good relations with them, as they also serve as our protectors.

The question of how a mental health clinician conducts him- or herself and interacts with forensic staff and inmates reflects competing tensions. Presenting oneself as too unlike correctional staff risks appearing as an "outsider," alien to the environment, which may decrease the comfort level of staff to effectively communicate their thoughts with one. "Street cred" may pave the way for the clinician to connect with inmates. Clinicians who work in forensic settings do need some understanding of the outside lifestyles of inmates, including some of their lingo. Front-line staff such as correctional officers or other experienced staff can serve as excellent translators. I have conducted clinical interviews with forensic staff as translators, converting my questions into language more accessible to the inmate, and vice versa. This also improves the efficiency of interviewing as one can be weighed down by repeatedly asking for definitions of street lingo or descriptions of their alternate lifestyles. However, crafting a persona that better "fits" the setting runs the risk of no longer appearing like a mental health professional, and can lead to the unintended result of lowering staff's respect; one must at least seem like a doctor in order to be treated like one.

Some of the more powerful and revealing experiences I have had in forensic settings include seeing experienced, hardened staff speak with

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Caged in by Mental Health Budget Cuts

A. Kenison Roy, III, MD, Doreen A. Taravella, LAC, JD

The St. Tammany Parish Jail has been under scrutiny lately for the containment procedures that are employed with suicidal and homicidal inmates. Richard A. Webster, a staff writer for *New Orleans City Business* wrote a story entitled "Held in Captivity" on July 1, 2010.[1] About a week later he wrote another one entitled, "ACLU Presses St. Tammany for Jail Reform."[2] Following this, *The Times-Picayune* published an editorial entitled, " 'Squirrel cages' in St. Tammany jail are inhumane for suicide watch: An Editorial."[3] These stories highlight the practice in the St. Tammany Parish Jail of placing suicidal or homicidal inmates into 3x3x8 foot cages for their "protection." This protective isolation and observation of inmates with mental illness, who are considered to be a danger to themselves or others, has been heavily criticized. These cages were originally designed as booking cages so that pre-trial detainees could be processed into the jail. The same cages that have been repurposed to protect inmates during an acute suicidal or homicidal crisis and provide an opportunity for the inmate to deescalate have been referred to colloquially as "squirrel cages." These articles also reference a press release from the American Civil Liberties Union (ACLU) that decries this practice but, apparently, neither the journalist nor the ACLU solicited any input from the St. Tammany Parish Sheriff, Jack Strain, or the Medical Director of the St. Tammany Parish Jail, R. Demaree Inglese, MD.

The ACLU and the Advocacy Center of Louisiana (ACL) filed suit against the State Department of Health and Hospitals and its secretary, Alan Levine, as well as against the Eastern Louisiana Mental Health System CEO, Mark Anders, and the Director of the Feliciana Forensic Facility in Jackson, Michelle Duncan.[4] The suit seeks an injunction requiring that the state provide immediate mental health treatment to inmates who have been committed to the Feliciana Forensic Facility. Feliciana is the only facility in Louisiana for the treatment and incarceration of mentally ill inmates who are deemed unfit for trial. The lawsuit uncovered the difficulties that the St. Tammany Parish Jail has faced since budget cuts have forced the paring down of services in the state mental health treatment programs. These challenges have prompted this controversial caging response to inmates assessed as being at high risk for suicide and homicide. At issue is this caging response.

"How did a jail system determine that the use of metal cages is an appropriate response to the perceived danger of an inmate to self or others?"

The jail has been designed to include an intake area equipped with holding cells and a space to process incoming prisoners. In the space allotted to process incoming prisoners, there are these previously described "booking cages" that are constructed of metal wire grid on three sides and Plexiglas on the fourth side. On the other side of the Plexiglas is the work area for the intake deputies. This area is always populated with deputies who can clearly see and monitor the inmates in the booking cages. When an inmate meets the criteria for containment in the booking cages, he/she is put in the cage and observed by the deputies until a physician on the jail's medical staff assesses that the inmate's risk potential has diminished to the point that he/she is safely able to be reassimilated into the general prison population. Dr. Inglese has reported on the St. Tammany Parish Sheriff's Department website that inmates are rarely held in the booking cages for more that twenty-four hours and that the jail has instituted a medical call out on Saturdays and Sundays to minimize the amount of time that an inmate waits for a reevaluation of suicidality.[5]

How did a jail system determine that the use of metal cages is an appropriate response to the perceived danger of an inmate to self or others? In an attempt to understand this response, the authors interviewed Sheriff Jack Strain on August 23, 2010. The sheriff, an affable and candid law enforcement professional, provided additional information.

According to Sheriff Strain, the mental health crisis in St. Tammany Parish is "bad and getting worse." The parish of approximately 300,000 residents had 35 completed suicides and 400 attempts last year. This is compared to 4 homicides in that same population last year which is a reversal of the usual ratio of suicide to murder.

Sheriff Strain said that, years ago, if law enforcement officers apprehended an individual who committed a crime and appeared to be mentally ill, they would take that individual to Southeast Louisiana State Hospital and the individual would be placed into the mental health system for treatment. Following treatment and probable improvement, the prosecutor would sometimes prosecute the criminal without pretrial incarceration. However, due to budget cuts, the availability of mental health treatment at Southeast Louisiana State Hospital has dramatically decreased over the years, such that there is no emergency psychiatric service in St. Tammany Parish and no ability to present the individual on an acute basis to an inpatient mental health facility for psychiatric care. This absence of psychiatric medical capability limits the options of law enforcement officials to suicide attempts, as well as the crimes that are committed as a symptom of, consequence of, or in the context of, severe mental illness. Witnessing the

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completed suicides or the often permanent and disfiguring self injuries associated with suicide attempts takes an emotional toll on the other inmates and the deputies who are responsible for keeping the peace in St. Tammany Parish. It is also a job hazard. This type of vicarious traumatization is something that the prison is trying to avoid by decreasing the number of suicide attempts and completed suicides. Squirrel caging inmates is one of the tools employed for such. It should also be noted that Sheriff Strain stressed during the interview that squirrel caging an inmate was reserved only for inmates whose suicidal ideation was such that their risk level was extremely high in terms of probability of suicidal behavior occurring imminently and the lethality of the method being contemplated. Less restrictive methods of preventing suicide are preferable and they are used when appropriate. Inmates are placed in the cages only when a physician believes that the inmate requires constant observation so that intervention to interrupt an attempt in progress is available. The inmate must have been gauged as being in clear and present danger of harming self or others before this extreme caging solution is warranted.

Inmates in the cages are allowed only limited clothing which usually consists of cut off scrubs or jumpsuits and a short sleeved shirt. This is done to ensure that the inmate will not have access to long pieces of fabric that could be used in hanging or suffocation deaths.

Generally, about 87% of prison suicides take place within an inmate's cell. Additionally, the suicide rate of violent inmates is nearly triple that of nonviolent ones.[6] Of particular concern to St. Tammany parish is the fact that smaller jails have suicide rates that are five times higher than those of larger jails.[7] Suicide typically ranks in the top three leading causes of death in inmate populations. Most of these suicide deaths occur shortly after initial incarceration. Because of increased anxiety and agitation associated with being arrested, inmates are at the greatest risk immediately after they enter prison.[8] Approximately 8-15 % of prisoners have a serious and persistent mental illness.[9] There has also been a dramatic increase in the number of drug offenders who are incarcerated. Both of these groups are at high risk for suicide.

Sheriff Strain acknowledged that law enforcement officers do not have the same training or academic orientation to psychiatric conditions as do mental health professionals. They have some sensitivity training but certainly have not acquired the expertise that would qualify them to treat mental illness. As the parish jail system increasingly becomes the repository for mental health patients who were incarcerated because of involvement in a felony or have a designation of "unfit for trial" status, the solution necessarily becomes one with a criminal justice slant rather than a solution that might be construed by mental health professionals. In Louisiana, the appropriate and designated facility for the retention of individuals charged with a felony whose mental illness renders them unable to stand trial is the Feliciana Forensic Facility in Jackson, LA. That facility, which has been full for several years, has a long waiting list. Consequently, those inmates who would be suitable forensic candidates become wards of the parish jail systems instead. The jails are challenged to develop creative ways of preserving life while achieving the ultimate goal of safely containing criminals.

"The inability of law enforcement officers to access mental health facilities, services or professionals puts the onus of the psychiatric management of arrested individuals into the hands of criminal justice personnel."

The number of mentally ill inmates has increased over time and includes pretrial detainees and those charged with felonies that have not gone to trial and do not (yet) have a diagnosis of mental illness. Some of these latter detainees also have become suicidal. Individuals who are incarcerated are at higher risk for suicide than people in the general population because of depression and sense of hopelessness associated with their loss of liberty. The sheriff reports 4 successful suicides in fifteen years, and countless suicide attempts perpetrated by persons charged with felonies. He further contends that no inmate who has been placed in a booking cage has died by suicide. Thus, this caging response to suicidality, while having detractors, is effective.

Sheriff Strain describes the case of a 27 year old who stabbed her grandmother and tried to kill her parents. This event happened 27 years ago and the young woman was brought to Southeast Louisiana State Hospital. The individual did not ever enter the St. Tammany Parish Jail but rather was treated in a forensic facility within the mental health system. In contrast, he describes a recent case involving an elderly individual who, while a patient in a nursing home, beat her roommate to death. This individual was incarcerated at the St. Tammany Parish jail because mental health treatment was not available any longer. The sheriff says that in the past, prior to the budget cuts in mental health services, law enforcement personnel were not asked to deal directly with such mentally ill inmates.

What changes other than the reduction in mental health services have created this crisis? The sheriff recounts a sequence of traumatic events that have exacerbated the level of mental health pathology within the prison body. Of course, Hurricane Katrina had a big influence on the mental health of St. Tammany Parish,

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not only because of the direct effect on the citizens of the parish but also because of an increase in population attributable to the influx of those who had lost everything in their former homes. This effect was followed by subsequent storms (Rita, Gustav) and more recently a downturn in the economy and now the BP oil spill. There has also been a huge increase in the incidence of problems with alcohol, prescription drugs, and street drugs.

The sheriff says that people are not asking for help because they are intimidated by the absence of services. The sheriff is emphatic that "the jail reflects the community." He says that there are 1-2 people on suicide watch every day. There are 8 inmates in jail because they are incompetent to stand trial for psychiatric reasons. He says that the state has ignored an obligation to treat these patients and they have defaulted to the criminal justice system.

In an attempt to expound on the information presented in the ACLU press release and to offer some explanations to the citizens of St. Tammany parish, Sheriff Strain has produced a DVD.[10] In this, the sheriff says that the cage solution is only utilized when the physician staff of the jail identifies an inmate's suicidal ideation as absolutely unambivalent and therefore extremely likely to result in death or when an inmate's violence towards others is apparently inevitable. The Sheriff and the Medical Director appear on the recording identifying the advantage of this cage solution. Among other advantages, such as the proximity of the deputies and the constant visibility of the prisoner, the booking cages are so small that an inmate cannot gather enough momentum to "bash their head in."[11]

Dr. Inglese says that inmate confinement in booking cages is the final response in a continuum that begins with placing the individual in a smaller cell or in isolation. If these strategies do not work and an immediate threat of suicide or homicide is determined, then the detainees are placed in the booking cages. The time of incarceration in these booking cages is an average of one day but has been up to a week for some individuals. A comparison of the cage response is made by Dr. Inglese to another alternative for protecting suicidal inmates that involves leather restraints. The comparison to restraints, although based on older practices, portrays the use of booking cages as more comfortable and humane than "being tied down, spread eagle, in restraints."[12] The caging solution is seen as a safer alternative. In addition, a sheriff's office employee, Major Tim Lentz, states that the sheriff's office spends more time on mental health issues than on traffic. This indictment of the absence of mental health services in the parish is a result of sequential reductions in funding beginning with Governor Edwin Edwards and continuing today.

In the segment of the DVD that is allotted to the ACLU's comments, there is an echoed claim that Louisiana doesn't provide adequate funding for mental health services. There is also the allegation that prisoners are kept in booking cages for weeks at a time and that these cages are used by the sheriff's office for punishment. Sheriff Strain vehemently denies the latter point. In addition, there are the contentions that prisoners underreport suicidality to avoid the cages and that other prisons in Louisiana have found other more humane ways to address this problem.

So, how did this unfortunate caging solution evolve? It seems to reflect the confluence of several factors. The inadequacy of mental health services is certainly key. The inability of law enforcement officers to access mental health facilities, services, or professionals puts the onus of the psychiatric management of arrested individuals into the hands of criminal justice personnel. Clearly, these personnel are not trained mental health professionals and their orientation is towards the protection of society. The mental health professional's respect for the medical origin of behavioral disorders and concern for the dignity of the individual is in significant conflict with the criminal justice and law enforcement professional's mission to protect the public and punish the offender. The decisions endorsed by elected officials in the past several administrations to reduce the availability of mental health services have been clear and well documented, so this caging response by the jail system has become the response of the law enforcement effort. St. Tammany's police force, with their inevitable criminal justice perspective, are the designated professionals dealing with an untenable mental health situation. The caging solution achieves the goal of preventing suicide, other self harm, and injury to others. Instead of casting stones at this unorthodox practice, it may be necessary to find a way to fund mental health services so that they may be delivered to inmates by mental health professionals instead of by criminal justice personnel.

Elected officials have persisted in the practice of slashing mental health services when budget problems loom. We continue to elect officials who incrementally, sequentially and repeatedly participate in the reduction of mental health services. As professionals in mental health, we have a lot of work to do to convince the public that psychiatric illnesses are just that, and not conditions that people have the resources to handle within themselves. Such illnesses are not weaknesses and certainly not chosen. They are treatable. If we become able to provide community-based treatment options, the need for squirrel cages and other law enforcement solutions will diminish and many mental health patients will be helped before they become identified by the criminal justice system.

A. Kenison Roy is President of Louisiana Psychiatric Medical Association, and Doreen A. Taravella is an attorney in Louisiana.

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1. Webster, R. "Held in captivity". New Orleans City Business July 1, 2010.
2. Webster, R. "ACLU presses St. Tammany for jail reform". New Orleans City Business July 8, 2010
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Ask The Experts

Dear Drs. Kaye and Sadoff,

In the process of completing our publication, "Ten Ways to Destroy a Forensic Psychiatry Intern's Interest in Forensic Psychiatry," we read Drs. Kaye and Sadoff's remarks in "Ask the Experts" (AAPL Newsletter, April 2010 p.11) concerning experts sitting in during opposing side's expert's evaluation and/or testimony. Dr. Kaye's thoughts were of particular interest: Dr. Kaye stated that while some of his colleagues felt the presence of another person "limits the interview, or influences the answers," he "never found this to be a problem and welcome the presence of another expert." Dr. Kaye stated that his colleagues maintain a "position (that) is a holdover from the old psychoanalytic school of thinking and should be buried."

While Dr. Kaye does not specifically identify the "old psychoanalytic school of thinking" that should be laid to rest, we believe that its burial is premature. Psychoanalytic thinking has a significant place in forensic psychiatry that is worthy of discussion and it is an ill suited topic for morbidity and mortality rounds. In our view, psychoanalytic writings, "old" and new, can be put to good use for forensic psychiatrists in training. If Freud or his progeny are used as touchstones for "the old psychoanalytic school," we believe that it is important for candidates to seek out forensic psychiatric training that teaches what Freud and his followers thought, to understand the contemporary critiques of their work and, most importantly, keep alive the thought that it was the revolutionary methodology and process of Freud's thinking, and not always his "old" conclusions, that can significantly contribute to the practice of forensic psychiatry.

For the record, scientific research has shown that third-party observers necessarily affect the responses of the interviewee to various types of interviews in varying degrees, including interviews conducted by forensic psychiatrists. There are several well accepted constructs that codify these effects, including those from cognitive, experimental, and research psychology, and psychoanalysis, the latter using the terms transference and countertransference.

Forensic psychiatry is a field of great potentialities. A candidate who seeks out training in forensic psychiatry needs to be comforted by the knowledge that he/she will be supervised by senior practitioners exposed to many schools of thought, that questioning the views of any major theoretician or contributor, "old" or new, is a commonsense and acceptable expectation, and that attending gatherings where respected colleagues may sharply disagree with each other is encouraged. More importantly, forensic psychiatry interns should learn that we are in an era where cargo cult pseudoscience has largely been replaced by science and scientific integrity, that the imprimatur to bury "old" schools of thinking without any scientific basis is meaningless and inhibits one's professional development, and that forensic psychiatry training programs can be counted upon to instill in candidates the type of forensic peripheral vision that is integral to today's practice of forensic psychiatry.

Timothy Michals, MD
Steven Samuel, PhD

Response

I appreciate the thoughtful and lengthy comments on a single sentence I wrote in my response to the previous question regarding having a colleague hired by the opposing side sit in on a forensic evaluation. Obviously, I struck a nerve with my friend and fellow Jefferson Medical College colleague Dr. Michaels and his associate Dr. Samuel. However, I think these fine men have read way too much into what I actually said. I respect the long history of psychoanalysis and the contributions made by Freud to our field. I further endorse residents learning this material as part of residency training.

I am not aware of any forensic fellowship that is teaching a "psychoanalytic" approach to forensics. Rather, the approach more commonly used is one using a scientific evidence base. An opinion must be able to withstand a Daubert challenge for admissibility. It is questionable if an opinion based on a psychoanalytic theory would withstand such a challenge.

My comment was limited to the significance placed by psychoanalysis on the specific form necessary for therapy. In analysis, confidentiality is considered critical and fundamental to the process itself. In that construct, only the doctor and patient may be present and any infringement on this "frame" (as Langs described it) is considered destructive and avoided.

The very nature of the forensic evaluation is that there is no confidentiality, that numerous other parties have input into the data set, and that others will receive copies of a report containing very personal information, which will be used for legal purposes and not necessarily in the best interest of the evaluee. The Ethics Guidelines of AAPL mandate such a warning be given prior to conducting any forensic evaluation, an opinion supported by case law.

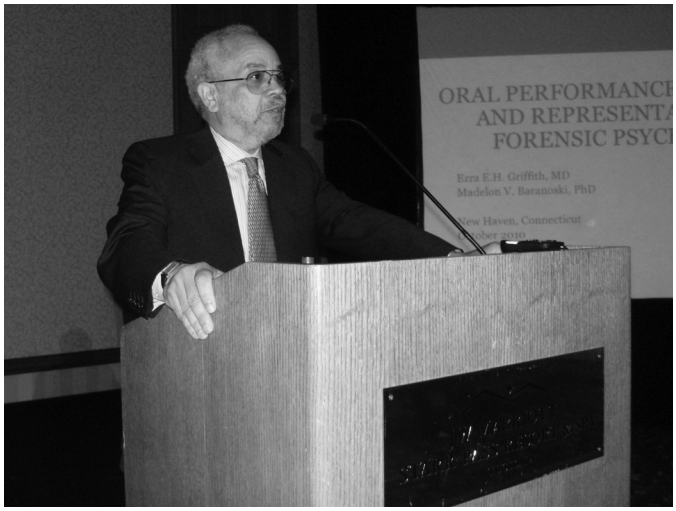
While I agree that there is evidence that having another person present (or even audio or video taping) may in some cases affect the interview process or material elicited, the courts clearly allow for this, and forensic fellows need to be trained and prepared for conducting evaluations under real world, sometimes hostile, conditions.

My colleagues can sleep soundly knowing that I have no interest in burying psychoanalysis. It should remain an option for those who wish to pursue such specialized training. However, the mandate of traditional analysis for strict confidentiality actually died years ago in the forensic world, and deserves to be respectfully buried.

Sincerely,
Neil S. Kaye, MD, DFAP

2010 ANNUAL MEETING - Photo Gallery

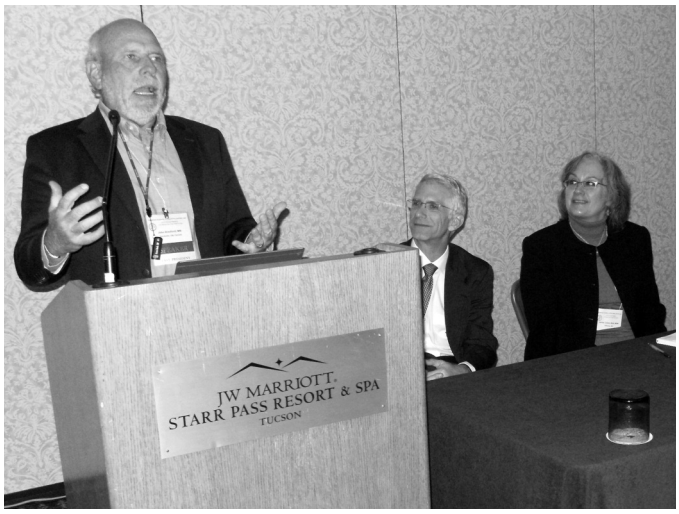
Joe Bloom, MD receives a standing ovation as he accepts the Golden AAPL award.



Ezra Griffith, MD gives one of the Isaac Ray lectures.

Park Dietz, MD accepts the Seymour Pollock award from Renee Binder, MD.

David Rosmarin, MD is honored with the Red AAPL award.



John Bradford, MB gives the other Isaac Ray lecture.

Happy faces at the committee reception, what a feast!

2010 ANNUAL MEETING - Photo Gallery

New AAPL Leaders: (left to right) Drs. Scott, Ash, Pinals, Thompson, Weinstock and Norko.

Susan Hatters Friedman's superior teaching skills were acknowledged with the Best Teacher award.

And the Young Investigator award goes to Camilla Lyons MD.

Rappeport Fellows strike a professional pose with Victoria Harris, MD.

Fun time a the mock trial.

Take a hike! What a pleasant experience in Tucson...

Trading Places

Susan Kimmel, MD

It is a Monday morning and, as on most Monday mornings, I am off to perform ECT. We have learned our antidepressants are not as effective as originally advertised, so ECT has experienced a bit of renaissance. Today we have 14 patients scheduled in ECT. This is an average number these days, with our record being 19 patients in what is supposed to be one half day of clinical work. After evaluating and treating my 14 patients in ECT, I am off to see an overbooked afternoon of treatment refractory mood disorder patients. As ECT was busy, I am late as I rush from the hospital to my outpatient office. I have been doing this for years now, but the stress and pressure of so many very ill patients to see and never enough time is something I have never adjusted well to. Ah, the good old days!

Overworked and a bit bored with the same old, same old, I had the brilliant idea that a fellowship in forensic psychiatry would be the answer to my mid-career dissatisfaction. I traded my busy, albeit routine and relatively predictable, practice, for the life of a forensic fellow. It is safe to say this has been anything but boring and predictable. I do believe some cautioned me to be careful what I wished for!

The reports are supposed to be how long? We have to type the reports ourselves? And where is my administrative assistant? No office or computer, really? My office is in a cardboard box in the trunk of my car. I have learned some new computer skills, although I am still pathetically behind my co-fellows. I can now fax, schedule my own appointments and type faster than I could in high school typing class. These were not exactly the things I was planning on learning this year. In addition, there is the added angst of not having any idea where I am going, which has forced me to learn how to use my GPS. I spent two decades of my life feeling comfortable and assured with my treatment decisions. No one questioned my clinical judgment, or the way I wrote a note, or dared to offer any feedback. The transition from safe and comfortable to new and unsure of myself has not always been easy. But more days than not, it is invigorating.

Instead of giving the same lectures year after year, I get to learn new information day after day. I have traded being the teacher for being the student, and only from having the perspective of teaching have I truly learned how wonderful it is to be the learner. It is not always easy or ego building, but it is rewarding and enjoyable. It is the opportunity of a lifetime, and because I have already had a relatively long career, I feel well positioned to enjoy it all the more. My former residents are now my supervisors, and I have found they have more to teach than I can learn.

"Most of what I have learned to do better, such as violence risk assessments, suicide risk assessments, competency assessments, and insanity evaluations, will markedly improve my skills as a clinician."

I do sincerely believe this will make me a much better psychiatrist. For one thing, I am much less paranoid about the malpractice issues. I have a better understanding of the legal system and my duty. I firmly believe the ability to worry less about practicing defensively will allow me to focus more on providing the best patient care I can. Most of what I have learned to do better, such as violence risk assessments, suicide risk assessments, competency assessments, and insanity evaluations, will markedly improve my skills as a clinician. In addition, one of the most thought-provoking things I have seen is what can happen when patients do not receive the treatment they need or the clinician is not as thorough as he/she should be. Seeing it from the other side will maybe give me the energy and motivation I need on those days when I am overworked and tired.

Mid-career fellowships may not be for everyone, but for me, this has been fabulous. One thing about forensic psychiatry is it is not boring or predictable. Just when I think I've heard it all, something new comes along. I am fascinated by the not-so-routine psychopathology I have seen, which has more than balanced out the drudgery of tedious report writing. So, when you are up at 2 a.m. trying to finish a report, try to remind yourself how fortunate you are that you will have a job that will never become routine. Forensic psychiatrists are a lucky group of individuals who have the luxury of an interesting career with the flexibility to pursue vastly diverse areas of interest. My forensic fellowship will be the end of my formal training, but it has provided me with the opportunity to continue to learn, improve my clinical skills and leave the predictable behind. My goal is to learn something new every week and be grateful I have had this opportunity. I may celebrate the end of the chaos when this fellowship is over, but I have thoroughly enjoyed returning to the role of student.

Susan Kimmel, MD is a fellow at Case Western Reserve University.

Debra A. Pinals, MD

Barcai v. Betwee (2002)

Philip J. Candilis, MD
(To suggest members for this feature, email philip.candilis@umassmed.edu)

An award-winning fellowship director, AAPL councilor, treasurer, and vice-president-elect, Debra Pinals, MD, came to forensic psychiatry through contact with über-mentor Thomas Gutheil. Born and raised in Ohio, Dr. Pinals completed her residency at the iconic Massachusetts Mental program with Dr. Gutheil, and returned to his Harvard-Bridgewater fellowship some years later. A brief stint at NIMH studying the pathophysiology of schizophrenia kindled her special interest in the legal and ethical issues surrounding psychiatric research, especially in the informed consent issues surrounding placebo-controlled studies.

Within the Ohio Department of Mental Health, Dr. Pinals' forensic background blended well with the public sector, as she served in the leadership of a state hospital forensic service. Returning to Massachusetts to administer a forensic service for one of the oldest state hospitals in the nation and to direct the law and psychiatry fellowship at the University of Massachusetts Medical School, Dr. Pinals was ultimately appointed the commonwealth's Assistant Commissioner for Forensic Services – the person responsible for the delivery of forensic services within the Department of Mental Health.

Focusing on broader systems issues within the state, Dr. Pinals oversees how laws and statutes guide forensic practice, balancing classic interests of individuals and communities: are the individual's clinical and legal interests appropriately balanced? Is risk assessment in an era of community care appropriately conducted? These can be particularly weighty questions in a state that has no court oversight of insanity acquitees after release.

Among her duties as state forensic director is oversight of the commonwealth's Designated Forensic Professional Program, one of the first training and monitoring programs of its kind. Developed in the early 1990s, this program trains, supervises, and accredits practitioners as they learn the nuances of report-writing and state law. Pinals' ongoing oversight of a quality improvement program to monitor state-sponsored reports is a key component of the program that assures forensic quality. It has become an expected part of the court clinic services that the forensic system operates.

"Dr. Pinals' background in forensics and informed consent would prove useful in a remanded trial in the aftermath of Hawaii's Barcai v. Betwee *(98 Hawaii 470, 50 P.3d 946; 2002), a case addressing the use of therapeutic privilege."*

Dr. Pinals has also found herself testifying to the legislature on forensic matters, most recently on the role of forensic evaluators in committing substance users involuntarily. Her clarification of role duties contributed to the legislative panel's understanding of the distinction between forensic and clinical work, and enhanced interagency collaboration in managing these special commitments.

Dr. Pinals' background in forensics and informed consent would prove useful in a remanded trial in the aftermath of Hawaii's *Barcai v. Betwee* (98 Hawaii 470, 50 P.3d 946; 2002), a case addressing the use of therapeutic privilege. Therapeutic privilege is the ethics doctrine that allows physicians to withhold information from patients because it may be harmful to them. It is a rarely invoked exception to the information disclosure requirement of informed consent that presumes incapacity to handle the information at the heart of patient-physician collaboration.

In this case, the patient, Mr. Barcai, was not informed of the risks of neuroleptic malignant syndrome (NMS), and may have died from NMS after treatment with neuroleptics. The physician, Dr. Betwee, and associated experts, argued that Mr. Barcai was psychotic at the time he required treatment and could not have understood the information concerning NMS. Moreover, his paranoia and fear of nurses may have made information about NMS frightening to hear. In any case, they argued, NMS was not part of routine consent disclosures. The Hawaii Supreme Court remanded the case to the circuit court to determine whether the therapeutic privilege applied. Dr. Pinals subsequently consulted for the plaintiffs.

For Dr. Pinals, the disclosure standard for Mr. Barcai would have required more information related to the potential risks of NMS. In her opinion, he had experienced NMS symptoms just prior to his rechallenge with antipsychotic medication, and in cases when NMS has recently arisen or has not fully resolved, the relevant risks would be especially material. To some degree, Mr. Barcai could also recognize the danger and contribute to collaborative decision-making surrounding his medications and diagnosis. Consequently, Dr. Pinals believed that the data did not demonstrate that therapeutic privilege applied in Mr. Barcai's case. Although the court ultimately found for the defense, the case and testimony were an extraordinary effort to solve some of the most unsettled questions of informed consent doctrine.

In addition to her work assuring report quality and clarifying forensic practice for legislators, Dr. Pinals' work served as another example of an AAPL member contributing at the forefront of law and psychiatry.

The Fixated Threat Assessment Centre

New Approaches to Public Figures Threat Assessment in the United States

Dr. David James

Serious assaults on politicians in Western Europe are generally committed not by terrorists, political groups or criminals, but by isolated loners.[1] The majority are mentally ill and many give warning signs of the danger they will constitute. In the UK, the Home Office (interior ministry) realized that their threat assessment and management systems to deal with terrorists and groups were highly developed, but none existed to evaluate risks posed by lone individuals. They termed these people "fixated." By fixation was meant an intense and idiosyncratic preoccupation with a person, cause, or grievance, pursued to an obsessive and pathological degree. A research project was commissioned, involving experts from the UK, Australia and the USA. Its brief was to determine the characteristics of those making inappropriate or threatening approaches or communications to public figures, and to develop practical interventions to assess and manage the risk. An early conclusion of the research program, which has so far produced eleven papers in scientific journals, was that a new policing unit was needed to deal with the fixated threat and that this needed to contain a strong mental health component. From this arose the Fixated Threat Assessment Unit (FTAC).

FTAC, which has a national remit, is part of the protection command of London's Metropolitan Police Service. Its unique feature is that it is jointly staffed by police officers and by forensic psychiatry personnel from the National Health Service (NHS). Rather than simply having psychiatrists or psychologists with whom it can consult, the psychiatric staff are members of the police unit, while remaining employed by the NHS. Police officers and psychiatric nurses, supported by two forensic psychiatrists and a psychologist, jointly work on cases referred due to inappropriate attentions to senior politicians and members of the Royal Family. The case workers have access to standard policing information resources, and in addition, the mental health staff have access to NHS databases. The latter staff are able to acquire detailed medical information without infringing confidentiality restrictions: they then decide what it is legitimate to share with police colleagues, on public safety grounds. The combination of police and health information permits a rapid and detailed risk evaluation and the formulation of a management plan.

> *"By fixation was meant an intense and idiosyncratic preoccupation with a person, cause, or grievance, pursued to an obsessive and pathological degree."*

This may sometimes involve arrest, but in most cases, involves catalyzing and facilitating rapid intervention by services in the areas in which referred individuals reside, including both mental health agencies and police. The presence of psychiatric staff in the team overcomes the interagency barriers that would normally be faced in such circumstances. FTAC deals with around 900 cases a year. UK mental health law has a lower standard for compulsory detention than most states in the US. Of the first hundred cases with which FTAC dealt, 55 were admitted to hospital and a further 30 received psychiatric care in the community.[2] By intervening in cases of disturbed individuals harassing public figures, FTAC also aims to protect those most vulnerable to the individuals' disturbed actions – those close to them and members of the general public. By ensuring mentally ill people receive care, it contributes to their health as well as the safety of others.

FTAC's purpose is not to attempt the impossible task of predicting what an individual will do in the future. Rather, it aims to identify that small proportion of cases, among which are likely to be found those that may go on to constitute a threat. This involves examination of cases for factors known to be associated with risk. It was realized that risk is not a single entity. Other than the risk of violence, for which the base rate is very low, there are the more common risks of persistence, escalation, disruption, and psycho-social damage, each of which has different associations, which also differ according to the underlying motivation. The FTAC research group, having initially striven to view public figure threat assessment as different from stalking, finally came to the conclusion that the two phenomena shared similar sets of risk factors, once ex-intimate cases are removed from stalking samples. A public figure section was incorporated into the Stalking Risk Profile,[3] the structured professional judgement tool developed by Paul Mullen's group in Melbourne. This is now used, in computerized form, at FTAC. The FTAC approach is occasioning interest elsewhere in Europe, with a similar unit being established in the Netherlands. Consideration of the fixated, alongside terrorism and group protest, is now being incorporated into UK risk assessment, for instance for the London Olympics. FTAC is not seen as an alternative to behaviorally-focussed policing, but as a complementary approach. The FTAC joint-working model may constitute a prototype for future joint developments between police and mental health services in the UK.

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Introducing Neuroimaging Data Regarding PTSD to Triers of Fact

Stuart B. Kleinman, MD, Chair, Trauma and Stress Committee

Advances in neuroscience promise to greatly increase understanding of Posttraumatic Stress Disorder (PTSD). Data generated via neuroimaging particularly promise to transform expert testimony regarding diagnosis and perhaps even behaviors of those with this condition. The utility of testimony regarding such is, however, currently significantly limited by both the still relatively limited neuroscientific understanding of PTSD and, paradoxically, the inordinate influence neuroscientific data may exert upon the judgment of triers of fact.

Weisberg, Keil, Goodstein, et al.[1] illustrate the power and potential peril of joining neuroscience data with other data employed to explain a phenomenon. To assess how such data affects the way people consider psychological explanations, they designed three experiments in which subjects were asked to rate the value of four different explanations for each of 18 psychological phenomena, e.g., mutual hostility, attentional blink, and perceptions of others' knowledge. One set of explanations for each phenomenon contained no neuroscience data. One of these represented a "good explanation" and the other a "bad explanation" for the phenomenon. "Good explanations" were based on how each phenomenon was genuinely understood by "researchers," and "bad explanations" were essentially circular restatements of the phenomenon. Identical or virtually identical irrelevant neuroscience data were added to each of the two explanations, creating a set of "good" and "bad" explanations with, and a set of "good" and "bad" explanations without, irrelevant neuroscience data. The following illustrates these sets of explanations for biased judgments of others' knowledge, i.e., the "curse" of self-reference.

The 18 phenomena utilized were intended to be "accessible" for those without psychology or neuroscience training. In experiment 1, subjects (with mean age of 20.1; education level unspecified) were randomly assigned to explanations with and without neuroscience data. Subjects generally accurately differentiated between the "good" and "bad" explanations not containing (irrelevant) neuroscience information. However, the explanations containing irrelevant neuroscience information were considered significantly more satisfying than those that did not. Ratings for "good" explanations were not altered by adding irrelevant neuroscience information. In contrast, ratings for "bad" explanations not containing such were significantly lower than those that did.

Experiment 2, because it contained a smaller number of subjects, employed a within rather than a between subjects design. Subjects were students enrolled in an introductory cognitive neuroscience class. To examine how presumably increased knowledge and sophistication regarding cognitive neuroscience affected related judgment, the students' assessments were obtained both at the beginning and end of the class (prior to the final examination). These subjects, just as did the "novices" in Experiment 1, regarded the explanations containing irrelevant neuroscience information to be more satisfying than those that did not. Unlike the subjects in Experiment 1, they regarded both the "good" and "bad" explanations as better when containing irrelevant neuroscience information; their assessments of "bad" explanations, however, increased much more than did their assess-ments of "good" explanations. Moreover, their presumed acquisition of greater neuroscience sophistication did not alter how they rated explanations.

Experiment 3 used the same design as Experiment 1, but utilized neuroscience experts as subjects. Unlike the less neuroscientifically sophisticated subjects in Experiments 1 and 2, those in Experiment 3 did not regard the explanations with irrelevant neuroscience information more highly. Moreover, they considered "good" explanations containing

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Table 1. Sample Item

	Good Explanation	Bad Explanation
Without Neuroscience	The researchers claim that this "curse" happens because subjects have trouble switching their point of view to consider what someone else might know, mistakenly projecting their own knowledge onto others.	The researchers claim that this "curse" happens because subjects make more mistakes when they have to judge the knowledge of others. People are much better at judging what they themselves know.
With Neuroscience	**Brain scans indicate** that this "curse" happens because **of the frontal lobe brain circuitry known to be involved in self-knowledge.** Subjects have trouble switching their point of view to consider what someone else might know, mistakenly projecting their own knowledge onto others.	**Brain scans indicate** that this "curse" happens because **of the frontal lobe brain circuitry known to be involved in self-knowledge.** Subjects make more mistakes when they have to judge the knowledge of others. People are much better at judging what they themselves know.

Neuroimaging Data

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such information to be significantly less satisfying than those without such data. The ability to recognize poor use of neuroscience information produced negative ratings of explanations with such data. Especially relevant to how data are presented to jurors, Weisberg and colleagues[1] suggest that individuals may be biased towards "lower level" explanations of "macroscopic phenomena." Even when not irrelevant, "lower level" data proffered regarding highly complex, multiply determined "macroscopic" behaviors and mental states may not only inadequately explain, but even mislead people regarding such information.

Functional imaging studies employing symptom provocation and cognitive probe techniques have generated important data regarding brain regions involved in PTSD neurophysiology. Complicating both neuroimaging study design and data interpretation, there may be two physiologically different subtypes of PTSD[2].

Lanius, et al.[2, 3] have identified two symptom and neurophysiologically defined PTSD subtypes, flashback/reliving/hyperarousal and dissociative, and note[2] that while approximately 30% of patients they have studied using script-based imagery provocation experienced a dissociative response, most PTSD neuroimaging literature has focused on the flashback/reliving/hyperarousal response.

Supporting that different brain regions are more associated with one subtype than another, Lanius, et al.,[2] using fMRI to compare a sample of PTSD subjects with a flashback/reliving/hyperarousal response to those with a dissociative response to a provocative trauma script, found that the latter group had greater activation of the thalamus, right superior parietal lobule and cingulate gyrus, left angular gyrus, and bilateral medial prefrontal cortex, while the former had greater activation of the left inferior parietal lobule, left precen-tral gyrus, and bilateral prefrontal cortex.

Additionally, the dissociative subtype, unlike the flashback/reliving/hyperarousal subtype, did not demonstrate increased activation of the amygdala.

Consistent with the importance of exaggerated amygdala response, and illustrating the promise of diagnostic utility of neuroimaging, a fMRI study using a masked faces paradigm (i.e., photographic stimuli of fearful, happy, and neutral expressions) found that the magnitude of amygdala response to fearful vs. happy masked faces differentiated those with combat-induced PTSD from those exposed to combat but without PTSD with 75% sensitivity and 100% specificity.[4, 5] Exaggerated amygdala response occurred independent of significant frontal cortex activation.

> *"...the magnitude of amygdala response to fearful vs. happy masked faces differentiated those with combat-induced PTSD from those exposed to combat but without PTSD with 75% sensitivity and 100% specificity."*

Despite optimism engendered by such studies, questions regarding how PTSD neurophysiologically manifests and can be identified via neuroimaging include:

- Whether there are significant gender-based differences in manifestation.
- Whether significant differences in duration of chronic PTSD (as opposed to between acute and chronic PTSD) manifest differently. Individuals evaluated regarding psychiatric-legal issues are not typically seen for months or years following a traumatic event.
- Whether different trauma types manifest differently. For example, does 'Complex PTSD' manifest differently than other PTSD, such as that produced by single acute events during adulthood?
- Whether significantly different severities of PTSD manifest qualitatively differently.

Additional questions include:

- What neuroimaging models, e.g., symptom provocation vs. cognitive probes, are most diagnostically useful, and
- Whether individuals without PTSD can intentionally generate neuroimaging manifestations of PTSD, and, if so, how will neuroimaging differentiate malingered from genuine PTSD.

Because of the important unanswered questions and the power of neuroscience information to influence how individuals assess explanations containing such data, testimony including neuroimaging based data, depending on how they are used, risks being more prejudicial than probative.

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Dark Side of the Moon: Evidence-Based Medicine and Forensic Neuropsychiatry

Manish A. Fozdar, MD. Forensic Neuropsychiatry Committee

"Evidence Based Medicine" (EBM) has been the buzz word in our profession for last few years. What is evidence? Law.com defines evidence as "Every type of proof legally presented at trial (allowed by the judge) which is intended to convince the judge and/or jury of alleged facts material to the case." Medical evidence is mainly derived from peer-reviewed published studies.

The purpose of developing the concept of EBM was to discourage the use of misinformed treatment approaches, develop logical medical protocols and disseminate uniform educational material.[1] Unfortunately, good and bad go together as dark comes after light. Misuses and misinterpretations of EBM are common. An example is applying evidence based guidelines to every patient, notwithstanding the fact that in the real life medical practice, outside academic centers and research laboratories, patients come in various shapes, sizes and forms. One antipsychotic does not work for all psychotic patients.

Another important caveat is the temporal relationship between published EBM and current state of research. Scientific knowledge in general and neuroscience in particular are advancing at a rapid pace. This creates a significant lag time between development of new knowledge and incorporation of that knowledge into everyday clinical practice. One example is the rapid development of new neuroimaging techniques. An MRI image of brain taken with 7T or 10T (T=Tesla) magnet machine is far more revealing than one taken with 1.5T or 3T magnets. Other imaging techniques such as Diffusion Tensor Imaging (DTI), Magnetoencephalography (MEG), Magnetic Resonance Spectroscopy (MRS) etc. have shed new light on the pathophysiology of various neurological disorders that have until now remained obscure.

With DTI we can now see demyelination of white matter fiber tracts in the brain of chronic alcohol users whose MRI findings are often normal. Use of MEG has helped locate certain epileptic foci in the brain due to congenital malformations that were not seen before. These epileptic foci then could be treated surgically leading to permanent epilepsy cure in many patients. Mild traumatic brain injury (mTBI) and blast related concussions are other areas that have benefited from advancement of neuroscience.

"My biggest argument is with experts who overwhelmingly engage in forensic practice at the expense of ongoing clinical practice and hence lack cutting edge clinical knowledge."

Bearing in mind the above observations, one can argue that EBM in some ways is outdated. It may be a good starting point to develop guidelines, but dogmatic adherence to those guidelines can have unintended consequences. Examples include discouraging the use of appropriate treatment approaches that are not listed in EBM guidelines; insurance companies' dictating only certain treatment approaches and not allowing certain diagnostic procedures; limiting patients' rights to seek consultations at academic centers where cutting edge research is going on.

The practicing forensic neuropsychiatrist often faces such dilemmas in certain controversial areas. Let us consider an example of mild traumatic brain injury. Conventional wisdom is that most symptoms as a consequence of mTBI resolve within a year or so. Anything residual beyond that point is either psychological in nature and/or in the realm of symptom exaggeration/malingering. Often the brain imaging findings in these cases are normal. Some published consensus documents support the above contention regarding the course of mTBI patients.

The problem is when a practitioner sticks to this "gospel truth" with unwavering devotion because of his/her allegiance to EBM. The greatest discoveries in neuropsychiatry have been through old fashioned clinical medicine where an astute observer will observe (a) clinical finding(s) in certain patients repeatedly and follow them over a period of time before reporting their findings. Discovery of Wernicke's speech area by Karl Wernicke is such an example.

Similarly, a certain subset of mTBI patients present with a constellation of symptoms that become chronic in nature. They often have "normal" brain imaging studies and other tests. Some symptom examples are persistent dizziness, posttrauma visual syndrome, apathy, obsessive-compulsive symptoms, pain and cognitive deficits. This is not an infrequent occurrence in my clinical practice. They are not involved in litigation, have strong psychosocial background and want to return to their pre-injury level of functioning. They pass all the effort testing and have no unusual findings on the validity measures of psychometric testing. In the forensic arena, such cases often become contentious, eliciting two diametrically opposite views from experts. How can we explain this?

When an expert dogmatically pursues only one line of argument that all the mTBI induced deficits resolve within a year, it is often ignored by that expert that many factors affect the outcome of mTBI. Kinetic forces leading to motion injuries versus static forces can both cause "mild" TBI when a person does not lose consciousness or loss of consciousness is brief. Classification of TBI based on loss of consciousness, retrograde amnesia and other measures is arbitrary. Therefore mTBI is a misnomer in some cases. When advanced

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Postpartum Psychosis, Forensic Psychiatry and the DSM

Susan Hatters Friedman, MD, Renée Sorrentino, MD and Joy Stankowski, MD
Gender Issues Committee

Postpartum psychosis (PPP) has been described since the time of Hippocrates. Often abrupt, it begins within days to weeks after delivery, and includes symptoms ranging from psychosis to dysphoric mania and delirium.[1] PPP is often a psychiatric emergency necessitating inpatient treatment for safety, and mood stabilizing antipsychotic medications. PPP symptoms may wax and wane, causing inconsistent collateral reports. Women may hide their symptoms due to fear of being stigmatized or of losing custody of their children. The majority of those with PPP will have eventual diagnoses of bipolar disorder, schizoaffective disorder, or schizophrenia. Others have no psychiatric diagnosis.

Rapid mood changes (including mixed mood symptoms), rarer types of hallucinations (such as olfactory or tactile), rapidly formed delusions, disorganized thinking, insomnia and confusion are characteristic of PPP.[1] PPP is rare, afflicting 1-3 per thousand mothers. However, PPP is of particular importance to forensic psychiatrists because of its reported high rate of infanticide—4% when untreated. Infanticidal behavior has been associated with delusions about the infant. Forensic psychiatrists may be called upon in risk assessments and insanity evaluations, as well as Infanticide Act evaluations outside of the US.

Though the US does not have an Infanticide Act, at least two dozen other nations do, including the United Kingdom, Canada, Australia and New Zealand.[2] The British Infanticide Act (of 1922 &1938) allows a woman, who kills her infant in the first 12 months of life to be charged with infanticide (which is akin to manslaughter) rather than murder. Initially, in the early 1900s, this was based upon the concept of lactational insanity, and it was expected that "the balance of her mind is disturbed by reason of her not having fully recovered from the effect of giving birth to the child." Probation with psychiatric treatment is a common disposition. Throughout the world, the New Zealand Infanticide Law is unique. Under the New Zealand Crimes Act, 1961, a woman may be found guilty of infanticide if she kills a child of hers under age 10. She may be imprisoned only for up to 3 years.

As psychiatrists are aware, the Diagnostic and Statistical Manual of Mental Disorders (DSM) was created by the American Psychiatric Association to provide a manual that covers all categories of mental health disorders for both adults and children. The manual is nontheoretical and focused mostly on describing symptoms as well as statistics concerning which gender is most affected by the illness, the typical age of onset, the effects of treatment, and common treatment approaches. The scientific community of psychiatrists establishes mental disorders defined in the DSM. In order to be eligible as a mental disorder in the DSM, a clinical syndrome must be supported by research analysis, clinical expertise and scientific advancement.

"Despite the description of postpartum psychosis for centuries in the literature and among clinicians, it is challenging to explain to the court that the DSM does not recognize such a disorder."

The fact that postpartum psychosis does not exist in the DSM suggests some discrepancy in the scientific community about the nature of the illness. Postpartum psychosis is not considered a distinct disorder by the DSM-IV-TR. Affective disorders, psychotic disorder not otherwise specified, or brief psychotic disorder diagnoses are sometimes given. Also, some DSM disorders specify "with postpartum onset," if the symptoms occur within 4 weeks of delivery. The absence of a specific disorder of postpartum psychosis in the DSM raises the question about the credibility of such a diagnosis.

The counterpart, postpartum depression (PPD), is a DSM diagnosis—formally listed as Major Depressive Disorder with postpartum onset. There is some public awareness of PPD, and the diagnosis would certainly be accepted by judge and jury—upon which to predicate an insanity (or infanticide) plea.

The challenges that arise in using postpartum psychosis as a mental illness eligible for an insanity defense, relate to the credibility of testimony about an illness that does not exist in the DSM. Despite the description of postpartum psychosis for centuries in the literature and among clinicians, it is challenging to explain to the court that the DSM does not recognize such a disorder. If psychiatrists can't agree on the clinical entity, how can we expect the Court to? Defendants with an indisputable diagnosed mental illness are the most successful at obtaining insanity defenses. Defendants in whom the mental illness is questionable due to the absence of a clearly defined disorder are found sane by the court's standards and are held responsible for their crimes.

The prognosis for PPP is based on the factors that contributed to the condition. Women who have PPP associated with an underlying severe mood disorder, such as bipolar illness, have an increased risk of recurrence.[3] Such women should be monitored carefully during subsequent pregnancies. Treatment planning should be based on

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Pima County Jail

Barry Morenz, MD and Kenneth Busch, MD, Chair of International Relations Committee

The International Relations Committee sponsored its 11th yearly site visit at the Pima County Jail Program during the 41st Annual Meeting. The site visit was coordinated through the local host, Dr. Barry Morenz, Associate Professor of Clinical Psychiatry at the University of Arizona. The jail is located just south of downtown Tucson. The jail can house up to approximately 2,000 inmates and has two pods for the mentally ill and an infirmary for people with medical or medical and psychiatric difficulties.

Lieutenant John Meister, who is Director of Mental Health Services at the jail, escorted our group on the tour to 1 Sierra, a jail pod built specifically with seriously mentally ill and potentially dangerous inmates in mind. The pod houses up to approximately 50 inmates on two levels, separated by a raised, central, partially open area for staff that provides easy viewing of every inmate in his cell. Large windows of heavy unbreakable glass facilitate the viewing but do compromise privacy. Correctional officers who work on this pod are handpicked and must be willing to volunteer for service on the mental health pod and receive 40 hours of mental health training before being assigned to one of the mental health pods. There is one full time and a few part-time psychiatrists who provide medication consultation, and one psychologist and several masters' level counselors who provide counseling to inmates with serious mental illness. Behavioral strategies of withholding privileges are utilized to help gain the cooperation of disruptive inmates on the mental health pod. There are two padded cells, one on either side of the pod, and a restraint chair that can be used if necessary for violent inmates. Injections can be given while an individual is restrained in the chair because of the open construction of the chair. As seriously mentally ill inmates' symptoms begin to decrease, they are moved to a lower acuity pod, called 1 Alpha, or to the general population. On the tour we were escorted by Lieutenant Meister to 1 Alpha, which was a quieter pod with more privacy and fewer disruptions. Seriously mentally ill inmates who require detoxification or other medical interventions can be housed in the Infirmary, which the group also toured.

After the tour Deborah Joseph, PsyD, RN and Michael Christiansen, PhD, both forensic psychologists, along with several staff members, provided didactic presentations to give us a solid understanding of the in-jail restoration to competency program. Once an individual has been determined incompetent to stand trial, Dr. Joseph or another member of the team evaluates the individual within 48 hours. Individuals who are found incompetent to stand trial are not housed together in any particular area of the jail. They may be in the general population, administrative segregation, or one of the mental health areas described above. Staff will treat and attempt to restore inmates to competency wherever they are located. Sometimes small groups of inmates can be brought together for education about courtroom proceedings if they are not a security risk. The in-jail restoration program begun in 2007 is estimated to have saved 3.8 million dollars for Pima County, in fiscal year 2010. The average length of stay of inmates in the program is 82.49 days. 84% of inmates are restored while 16% are deemed not restorable.

One advantage of the in-jail restoration program is that all visits are video visits that are recorded and all phone calls (except attorney calls) are recorded and are available for staff to review. These recordings have been very helpful in detecting malingerers. Considerable effort is expended to obtain all relevant collateral information regarding inmates' prior hospitalizations and psychiatric or medical treatments. Sometimes if an inmate in the program is in the general population, it may be difficult to obtain good documentation in the records from the correctional officers. When inmates are housed on the mental health pods or in administra-

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Juvenile Aggression

Bradley Freeman, MD, Child and Adolescent Committee

Childhood aggression is a normal and expected part of a child's development. Understanding the motivation for aggressive behavior is critical. Aggressive behaviors are thought to be used first as a means of communication in children who are preverbal. As children develop, their communication skills improve, aggression generally declines (though there is an increase in antisocial behavior in adolescence as described below), and they typically become pro-social members of society. Nevertheless, studies suggest that aggression is one of the most stable characteristics throughout childhood and adolescence.[1, 2] Most studies examine physical aggression because this is both the most easily recognizable form of aggression and also perhaps the most socially unacceptable form.

In addition to utilizing aggression as a means of communication, toddlers begin to show aggressive behavior for other reasons as well (e.g., to demonstrate dominance). From their developmental perspective, "might makes right." This is obvious on the playground, where larger children seem to dominate the landscape of the daycare or preschool. Parents and other adults must be obeyed not on moral grounds, but merely because they are bigger and stronger. In grade school, boys begin to engage in rough and tumble play with their fathers. Depending on the role and behavior of the father during the play, this can sometimes lead to future physical aggression.[3]

In early childhood, parents must assist their children in distinguishing which behaviors are harmful and socially unacceptable. By middle childhood, peer relationships become more important and most children realize that aggressive behavior does not help to build friendships. In adolescence, the incidence of aggressive behavior increases markedly (but then begins to decline in young adulthood). Adolescents may use aggressive behaviors such as posturing and verbal threats in addition to physical aggression. Adolescents who are physically violent obviously should be evaluated for psychological/psychiatric symptoms or impairment and their psychosocial environment should be assessed thoroughly.

The extant literature generally classifies aggression into two, perhaps three, distinct categories. When assessing violent or aggressive behavior, it is imperative that the evaluator consider the context of the behavior.

"However, there is also a growing amount of data supporting the heritability of "fearless dominance",[7] aggression, and other potentially psychopathic traits[8], which suggest that biological and genetic factors may be important in the development of aggressive behavior."

The first type of aggression is commonly referred to as proactive, or predatory, aggression. This is defined as aggressive behavior with an established motive. Think of the adolescent who steals alcohol because he/she is underage. This type of behavior generally goes against social and cultural norms and potentially results in criminal behaviors or, at the least, significant other types of consequences. The second type of aggression is reactive aggression. This is defined as an aggressive response to a stimulus. Although most individuals who defend themselves fit into this category, this type of aggression is certainly not benign. Some children and adolescents can react strongly to stressors or stimuli that may not be considered threatening by others. This is especially true of traumatized children in whom a raised hand or a stern look might be misinterpreted as a significant threat to their physical integrity or even their life. This notwithstanding, these individuals tend to have less criminal behavior than individuals who primarily engage in predatory aggression. The motive for reactive aggression tends to be self preservation or the safety of another. For example, consider a meek twelve-year-old child who gets into fights at school because of bullying, or a fifteen-year-old girl who kicks a boy because he looks like her sexually abusive cousin. A third type of aggression arises from psychosis. In this type of aggression, there is either no plausible motive or the individual has significant thought disorganization.

As mentioned earlier, aggression is a fairly stable character trait. Youth that were not aggressive in the past can, however, exhibit aggression in the future, especially during adolescence. For these individuals, it is important to consider their psychosocial environments. By way of example, newfound friendships with antisocial peers, alienation from more pro-social peers, pressure from others, physical abuse, and substance use can contribute to new-onset aggression. Fortunately, adolescent-onset aggression tends to be related to environmental effects which, if alleviated, can potentially eliminate the behavior (e.g., a child who is bullied or a single mother who begins dating a partner who is abusive to her children). Sometimes, aging/development in and of itself helps youths desist from this behavior.

Categorizing a child's or adolescent's aggressive behavior is an important step in identifying appropriate interventions, developing legal strategies, and ascertaining fairly the severity and type of punishment to be imposed. In assessing the culpability of a child or adolescent who commits

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American Medical Association 2010 Interim Meeting Highlights

Robert T.M. Phillips, MD, PhD, Delegate, Barry Wall, MD, Alternate Delegate, Katya Frisher, MD, and Ryan Hall MD, Young Physician Delegates
Howard Zonana, MD, Medical Director

The American Medical Association's (AMA) Interim Meeting focuses on advocacy issues. Your AAPL delegation participated in the November 2010 AMA Interim Meeting, held in San Diego, California.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act. AMA participated actively in deliberations before this effort at health system reform was enacted, and the result – gains for patients but uncertainty and omissions for physicians – has been the major focus of deliberation of the AMA House of Delegates all year. The November 2010 mid-term elections occurred three days before the AMA Interim Meeting began, so at the Interim Meeting the House of Delegates focused on AMA's advocacy agenda for the new Congress. Your delegation found that while AMA continues to have strong and diverse opinions about health system reform, AMA's internal tone was more pragmatic at the Interim Meeting.

A chief AMA focus remains finding a permanent solution for the Sustainable Growth Rate (SGR) formula, part of a complicated mechanism that determines physicians' Medicare payments. The prospect of greater and greater mandated Medicare payment cuts has been a major concern for the AMA over the past few years. In 2010 alone, Congress intervened four times – sometimes belatedly – to avoid large cuts in physician Medicare payments. AMA is trying to stave off cuts for 13 months (from December 2010 to December 2011) while seeking a permanent repeal of the SGR. Meanwhile, AMA is also promulgating to its members the various Medicare participation options that physicians have, including opting out of Medicare. AMA has also drafted a bill to allow patients and physicians to contract freely for payments that differ from the Medicare schedule while allowing patients to use their Medicare benefits. Private contracting would allow physicians to set fees and charge patients more than standard Medicare rates.

AMA is also working with the federal government on innovative delivery reforms, such as bundled payments, medical homes and accountable care organizations (ACOs). At the Interim Meeting, the House of Delegates adopted a series of principles regarding the establishment and operation of ACOs. The guidelines state that the goals of an ACO are to increase access to care, improve the quality of care and ensure efficient care delivery.

> *"AMA has also drafted a bill to allow patients and physicians to contract freely for payments that differ from the Medicare schedule while allowing patients to use their Medicare benefits."*

Ethics-related meeting highlights include the following:
Professionalism in the Use of Social Media: The AMA Council on Ethical and Judicial Affairs (CEJA) has an ongoing project to update the AMA Code of Medical Ethics. As a part of that project, it issued new guidelines, approved by the House of Delegates, that provide ethics guidance of physicians participating in online social networking.
Pediatric decision making: CEJA also issued new guidelines, approved by the House of Delegates, providing ethics guidance to physicians regarding disclosure of health status to children and adolescents.
Physician Stewardship of Health Care Resources: A controversial CEJA report offering ethics guidance for physicians in managing limited health care resources was referred back to the Council for further revisions. Concerns were addressed that the report does not adequately consider the potential impact of recommendations in the absence of tort reform, that considering cost in treatment recommendations is in tension with physician's primary obligation to their individual patients, and that such guidelines may conflict with practice guidelines promulgated by various medical specialities.
Physician participation in executions: The House reaffirmed existing policy on physician participation in executions. Specifically, AMA policy is that a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. This policy was last reaffirmed in 2004.

Other meeting highlights include:
Physician health programs: AMA's Council on Science and Public Health issued a report that reviews the development and operation of physician health programs. It will continue work on developing guidelines addressing design and implementation of such programs for physicians with addiction, mental health disorders, cognitive impairment, physical illness, and disruptive behavior.
Cannabis use: AMA will now urge that marijuana's status be re-scheduled to a status either equal to or less restrictive than the Schedule III status of synthetic THC (Marinol), to reduce barriers to needed research and to increase availability of cannabinoid medications to patients in need.
AMA as the "Organization of Organizations": The House of Delegates referred a proposal to study transforming the AMA from an association of individual, voluntary members

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Juvenile Culpability

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developing biologically, physically and psychologically. As such there is a higher probability that if the right services are put in place, they can be rehabilitated. It is in this area that the input of psychiatrists and psychologists is urgently needed by the courts to highlight the differences between the developing brains of children and those of adults.

Mr. Stevenson opined, however, that "truth and reconciliation" should be in place before progress can be made given the marked disparity in the justice system's handling of race. He buttressed his point with a statistic that shows that 81% of children "sentenced to die" in prison are either African Americans or Hispanics, a trend that goes against the notion of fair justice - race should not be a basis to conclude that any child is "beyond redemption." In his view, the criminal justice system is characterized by hopelessness and lack of empathy that has led to conclusions that children should die in prison for committing serious violent crimes. He expressed disappointment at society's willingness to kill or incarcerate individuals that are "broken," and noted that the US was the only society in the western world that still allowed the death penalty.

Mr. Stevenson called on the scientific society to lead the way in the fight for a fair treatment for children convicted of violent crimes. He believes that given the tremendous influence of forensic psychiatrists, they should be at the forefront of this fight; they have a responsibility to fight for what is right. In his opinion, the courts have been performing "magic" for several years now by "just" turning children into adults without any clear scientific justification. It is therefore the duty of mental health professionals, especially forensic psychiatrists, to ensure this unjust practice stops.

Mr. Stevenson concluded his talk by stating that although reshaping society's views about juvenile culpability was a difficult task, he would press on. His motivation comes from the promise he made to his grandmother prior to her death, that he will always "do the right thing." She had told him he could always attain whatever goal he set for himself. Further, he is motivated by a deep belief that no matter how bad a child may appear, he/she can always be rehabilitated. He implored everybody in attendance not to be deterred by the difficulty of the task, but to always keep their eyes on the goal.

Prosecutorial Access

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lege and protects against the compelled disclosure of confidential communications. This privilege belongs to and protects the client. The attorney work-product doctrine, while not a true evidentiary privilege, belongs to and protects the attorney. Its purpose is to stimulate the production of information for trials, and it rewards an attorney's creative efforts by giving his work product a qualified privilege from being shared with others.

3. Pope v. State, ibid. at 366
4. U.S. ex rel Edney v Smith, 425 F. Supp 1038 (1976)
5. U.S. ex rel Edney v Smith, ibid. at 1054.
6. Imwinkelried, E.J. *(1990)* The Applicability of the attorney-client privilege to non-testifying experts: Reestablishing the boundaries between the attorney-client privilege and the work product protection. *Wash. L.Q., **68,** 19.* Maringer, E.F. (1993). Witness for the prosecution: Prosecutorial discovery of information generated by non-testifying defense psychiatric experts. *Fordham Law Rev., **62***, 653.
7. Wisc. Stat. § 905.04. c) Condition an element of claim or defense. There is no privilege under this section as to communications relevant to or within the scope of discovery examination of an issue of the physical, mental or emotional condition of a patient in any proceedings in which the patient relies upon the condition as an element of the patients claim or defense, or, after the patients death, in any proceeding in which any party relies upon the condition as an element of the partys claim or defense.
8. Wisc. Stat. § 905.04. (b) Examination by order of judge. If the judge orders an examination of the physical, mental or emotional condition of the patient, or evaluation of the patient for purposes of guardianship, protective services or protective placement, communications made and treatment records reviewed in the course thereof are not privileged under this section with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.
9. Jaffee v. Redmond, 518 U.S. 1 (1996)

Roughing It

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concern and sensitivity about inmates, at least privately, while reverting to their tougher, hard-bitten persona once again, in front of colleagues. Like professional athletes who pound on each other and play through tremendous pain only to subsequently speak with sensitivity and emotion after the game, the work persona can be tailored to fit the setting.

Returning to the challenges of forensic psychiatry fellowship recruiting, selling the benefits of working in a challenging environment geared foremost toward security is formidable but not insurmountable. These settings may not be a draw for many psychiatrists, however, and this raises the question of whether the clinical environment of forensic settings should be addressed by organized psychiatry.

If psychiatrists are to be expected to provide high quality services to inmates, is it not counterproductive for such settings to lower their morale, thereby affecting the doctor-patient relationship? Effective intervention by mental health professionals in these dangerous settings, may improve the security situation.

Fixated Threat

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Dr. David James is Consultant Forensic Psychiatrist, North London Forensic Service, London, UK

Letters To The Editor

Dear Editor:

My esteemed colleagues, Neil S. Kaye, M.D. and Bob Sadoff, M.D., answered the question of a colleague confronted with a patient abused by her husband in a manner that appears to be entirely reasonable.

Nevertheless, I would like to report that over the years, when I combined my forensic and psychotherapy practices, whenever I encountered a wife who was physically abused and in danger, and who refused to adhere to my recommendation for her to leave the home, I terminated the psychotherapeutic relationship and gave her the name of two other psychiatrists she could contact.

I followed the same policy in regard to suicidal patients who did not follow my recommendation. I recall cases that ended tragically because of failure to follow my recommendation.

Sincerely,
Emanuel Tanay, M.D.

Dear Editor:

I wanted to let you know that I enjoyed your short article about Martin Blinder, and have used a summary of it as the basis for one of my website psychiatry and law "updates."

You can view the update at the address below (click on "Current Updates"; it's currently the top one), or go directly to it at http://www.reidpsychiatry.com/index.html#Twinkie0710

Thanks for writing about Dr. Blinder, and for providing this reminder of how non-credible the media can be!

Regards,
William H. Reid, M.D., M.P.H.

2010 Research Poster Award

Robert L. Trestman, PhD, MD, Chair, AAPL Research Committee

At the 2010 AAPL Annual Meeting, the Annual Research Poster Award competition was held. The intent of the award is to enhance the research orientation of AAPL's membership and recognize those efforts. Six members of the AAPL Research Committee served as judges. Each Judge reviewed all the posters displayed at the conference. The Posters were rated on Clarity of Hypothesis, Methodology, Analysis, Scientific Value, and Practical Significance to the field of forensic psychiatry.

This year, 33 posters were exhibited, reflecting the broad interests of AAPL's membership. On behaif of the AAPL Research Committee, I am pleased to announce that the winner of the 2010 Annual AAPL Research Poster Award is *"Is Methamphetamine Use Associated with Female Offending? An Analysis of the 2007 National Survey on Drug Use and Health."* The authors are Sandra Antoniak MFS MD, Stephan Arndt PhD, and Susan Schultz MD, who are all at the University of Iowa.

We look forward to continued enthusiastic participation in research efforts more broadly, and in the submission of research (both empirical and scholarly) to the Annual AAPL meeting.

Caged in

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12. Ibid.

AMA

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to an umbrella group for state and specialty societies. The idea has been raised in past years, but the new proposal said the issue deserves another look because of declining membership.

National health system reform will remain a work in progress for many more years. The official implementation timeline in the bill stretches to 2019. Much has yet to be codified in regulation. These realities constitute a challenge to doctors and professional medical organizations – led by AMA – to be vigilant, organized and engaged for years to come.

Did You Know?

The 2010 Annual Meeting By The Numbers...

4 presentations on doing research

67 attendees from Across the world

46 first-time presenters

106 presentations

32.5 CME hours

Dark Side of the Moon

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neuroimaging techniques become clinically available, we may be able to detect neuropathology in these cases. Functional neuroimaging research is showing us that brain changes consistent with Alzheimer type of dementia are present in patients years before clinical onset of the disease.

My biggest argument is with experts who overwhelmingly engage in forensic practice at the expense of ongoing clinical practice and hence lack cutting edge clinical knowledge. One prominent forensic psychiatrist testified in a high profile criminal trial that schizophrenics do not show cognitive deficits on neuropsychological testing!

Without the background of clinical acumen, theoretical application of EBM guidelines become dangerous and I might argue unethical. I have seen experts deciding the merits of the entire case just based on brain imaging findings or effort testing on psychometric testing. While in fact, clinical history and examination, collateral information, diagnostic testing, premorbid factors, psychosocial factors, personality traits and expert's own clinical "gut feeling" derived from years of clinical wisdom are all the factors that should be weighed in any forensic case.

If you have worked with epilepsy patients, it is a common experience to come across patients who are written off as having pseudoseizures. One of the reasons is that they never had an abnormal EEG and symptoms may be unusual. Tertiary care epilepsy centers often get these referrals where patients get thorough work up with advanced neurodiagnostic procedures and get diagnosed with certain types of epilepsy.

I conclude with this question to my colleagues: Should our collective clinical acumen and experience constitute at least some part of our *Evidence-Based Medicine?* I welcome any criticism and suggestions.

Reference:

1. The Mythology of Evidence-Based Medicine. By Jerold J. Kreisman, February 4, 2010. http://www.psychiatrictimes.com/display/article/10168/1518990

Postpartum Psychosis

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symptom acuity, drug tolerability, breastfeeding plans, and success of past pharmacologic regimens. Minimizing stress and sleep loss can help prevent a symptom outbreak. The risk of both recurrent PPP and potential infanticide can be diminished with prevention, monitoring, and early recognition and treatment.

Women who commit infanticide as a result of PPP rarely commit other violent crimes. Overall, perpetrators of domestic violence related homicide (including infanticide and filicide) have a lower recidivism rate when compared to perpetrators of homicides associated with altercations or commissions of felonies.[4] Moreover, an Argentinean study recently found that such offenders typically do not require high levels of security or forensic monitoring after their crimes.[5]

March, proposed four solutions to the challenge of using postpartum psychosis as a legal defense. These include: maintaining the existing system; statutory resolution by creating an automatic presumption of insanity; creating a new test for postpartum psychosis; and offering alternative sentencing options.[6] The proposal to maintain the existing system is helpful only if the existing system allows for education of the court. If the court is educated about the general acceptance in the psychiatric community of postpartum psychosis, the existing system may consider the insanity defense. The creation of an automatic presumption of insanity is obviously problematic, as not all persons with any disorder are insane. The creation of a new test for postpartum insanity challenges the integrity of the legal system. What then would prevent the creation of new tests of insanity for other disorders? This approach is unwieldy and creates unpredictability in the law. Lastly, alternative sentencing options for postpartum mothers is reasonable in that it addresses the treatment needs of the mothers and the likelihood that these mothers will not reoffend. However the proposal to create alternative sentencing for postpartum mothers does not eradicate the criminality of the act and carries the ramifications and stigma of a criminal conviction.

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Nominations for AAPL Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2011.

Any regular AAPL member who would like to be considered for a position should send a letter to the AAPL Office with a statement regarding his/her interest in serving and a brief summary of activities within AAPL.

Open officer positions are: President-elect (one year); Vice-President (one year); Treasurer (two years); Secretary (one year). Councilors serve for three years. Attendance at both the Annual and Semiannual Council Meetings is expected of all officers and councilors.

Please send statements of interest and activity to Peter Ash, MD, Chair, Nominating Committee, AAPL, P. O. Box 30, Bloomfield, CT 06002 by March 15, 2011.

Pima County Jail

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tive segregation, the documentation tends to be excellent. The formulary at the jail is somewhat limited. Clozapine has not been used. Benzodiazepines are rarely used. The jail is not set up to administer medications on a p.r.n. basis; they are restricted to administering medications on a daily or twice-daily basis. When inmates are released from the jail, there are efforts to connect them with aftercare and they are provided several days of medication to tide them over until they can see a psychiatrist in the community. One psychiatrist is hired approximately 12 hours a week for treatment of inmates at the restoration program.

The social workers on the staff do most of the education regarding court process. They use a variety of strategies to educate inmates about court process. For instance they have clay figurines of various personnel in court that they use as courtroom models. Social workers will also have inmates write down their understanding of court proceedings repeatedly to insure they understand the concepts they are teaching them and quizzes are administered regularly. A workbook about court process and personnel is provided to each inmate in the restoration program to study between educational sessions with the social workers. Most of the education provided is individual but sometimes groups of inmates learn together if there are no security threats. One technique that is used is to show episodes of the television show Law & Order for the group with the social workers stopping the show at key places that illustrate some aspect of court process the social workers are trying to teach to the inmates.

The site visit at Pima County Jail was well-received by the participants. We were especially impressed with the accomplishments of the restoration program. We thank Dr. Morenz, Lieutenant Meister and Staff for being wonderful hosts and for arranging such an outstanding program.

Juvenile Aggression

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aggressive or other antisocial acts, the juvenile and adult criminal justice systems examine the individual's characteristics and abilities (among other things) in order to make determinations related to their blameworthiness, criminal responsibility, and culpability. The court must understand both the youth's personality traits and the precipitating events or stressors related to the behavior(s). Psychometric measures such as the Psychopathy Checklist-Youth Version (PCL-YV), Childhood Psychopathy Scale (CPS), and Antisocial Process Screening Device (APSD) are sometimes employed to attempt to help determine the youth's core personality traits and risk of recidivism.

There is evidence that antisocial behavior (including violent antisocial behavior) occurs most frequently during adolescence. This suggests that aggression generally could be a transient, though important, adolescent developmental phenomenon.[4] In *Roper v. Simmons,*[5] the United States Supreme Court acknowledged youths' not-yet-fully-formed decision-making capacity, vulnerability to external coercion, and unformed character (and capacity for change). The Court found these compelling categorical mitigators of the culpability of youths convicted of the most serious crimes,[6] and therefore found that the imposition of the death penalty on individuals for crimes committed prior to age 18 violated the 8th Amendment's prohibition on cruel and unusual punishment.

Individuals who maintain that a child is the product of his/her environment are partially correct. Although children can be extremely resilient to stressors, they can be quite susceptible to the influence of conduct-disordered peers, parental modeling of aggression, physical abuse, and other criminogenic factors. However, there is also a growing amount of data supporting the heritability of "fearless dominance,"[7] aggression, and other potentially psychopathic traits,[8] which suggests that biological and genetic factors may be important in the development of aggressive behavior. In all likelihood, most youths' aggressive behavior is related to both "nature" and "nurture." Obviously, the skilled child and adolescent forensic psychiatrist should consider both etiologies in order to understand the youth's behavior. In certain circumstances, each may serve as a mitigating factor with regard to a youth's culpability.

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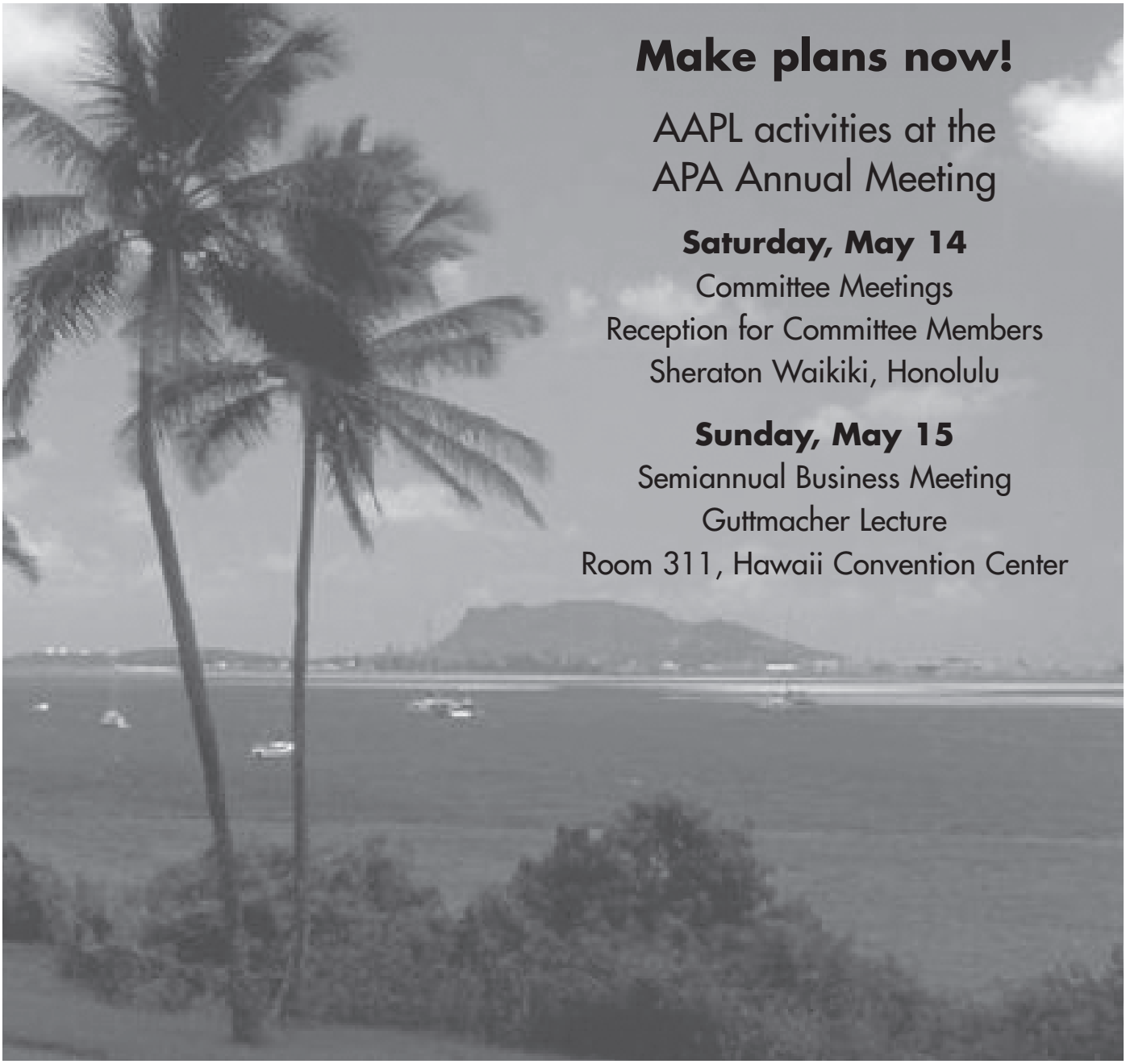

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